Trauma–Focused Child–Parent Psychotherapy in a Community Pediatric Clinic: A Cross-Disciplinary Collaboration

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The integration of mental health services in primary health care clinics has the potential to create a coordinated approach to treatment that addresses the mental health origins of many leading medical problems. This integrated approach can serve an important preventive role in early childhood because long-term mental health and medical problems often originate in the first years of life. Early childhood mental health specialists, particularly social workers and child psychologists, can collaborate productively with primary health providers in the early identification and treatment of behavioral and mental health problems in families with young children (Groves and Augustyn 2004; Cohen et al. 2008).

Parents often develop a deep trust in the capacity of pediatricians to keep their child healthy and to address the child's illnesses, and this positive attitude often leads them to turn to the child's doctor for advice as the first recourse when facing troubling child behaviors at home or at school. In detailing a philosophy of holistic pediatric care, Brazelton (1992) highlights the importance of developing meaningful relationships with each family member in order to strengthen the pediatrician's understanding of the interpersonal and contextual dynamics that influence a child's growth and development. Because of this unique window into the child's first relationships, the community pediatric clinic holds special importance as a place for early identification of disturbances in the parent–child relationship and the effects of trauma (Groves and Augustyn 2011). Pediatricians, social workers, and psychologists embedded in the communities that they serve have an opportunity to better understand the ecological influences—such as socio-economic status, community violence, and trauma—that may have a negative impact on the parents' capacity to

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provide adequate care and which significantly shape the young child's early development. Cross-disciplinary collaboration builds long-lasting relationships that foster greater communication and the sharing of resources. The pediatrician's capacity to respond effectively is greatly enhanced when immediate referrals can be made to on-site social work and psychological services.

In this chapter, we describe a unique model of collaboration between pediatricians and mental health specialists at a pediatric clinic in San Francisco. Pediatricians at this clinic routinely screen for the kinds of traumatic experiences that have been shown to predispose children and parents to a variety of long-term physical and mental health problems and work with an integrated team of mental health professionals to proactively address these problems. We proceed by describing child–parent psychotherapy (CPP) as the treatment of choice for traumatized young children and parents, and assert the importance of thoughtful, well-timed engagement, and collaboration when working with marginalized populations. This model of collaborative treatment is proposed as having the potential of replication in communities facing similar challenges.

The Pediatric Clinic as Mental Health Setting

The Bayview Child Health Center (BCHC) is a pediatric clinic located in the Bayview Hunters Point neighborhood of San Francisco. Although historically a predominantly African American neighborhood, the Bayview is increasingly diversified with a growing percentage of Pacific Islander, Asian, Latino, and Caucasian residents. Although the neighborhood is ethnically and culturally diverse, many residents are affected by poverty, lack of access to health care, lack of education, and ongoing exposure to gang and drug related violence. One fifth of the neighborhood's residents live in poverty (Northern California Council for the Community 2004).

Community violence and other violent crimes affect many families who live in the neighborhood. In this context, ongoing stress and chronic intergenerational and complex trauma take a heavy toll on the physical and emotional wellbeing of the families seen by clinic staff. BCHC was established in 2007 to address health disparities and to reduce rates of asthma hospitalization and raise rates of immunization in a neighborhood that, at the time, had only one other pediatrician, but the largest number of children of any neighborhood citywide. The BCHC medical director quickly recognized the important influence of ongoing exposure to trauma on the physical and emotional well being of her patients (Burke et al. in press; Tough 2011).

BCHC staff strive to understand and address the impact of traumatic experiences on the physical and mental health of their patients, and the clinic was founded with the belief that physical and psychological services must be integrated in order to effect long lasting change. The clinic serves patients with a staff of two full-time pediatricians, three medical assistants, and one practice coordinator. The mental health team comprises one social worker, one master's level clinician working as a case manager and parent advocate, and two clinical psychologists. With private funding

from Tipping Point Community, the clinic has established a partnership with the University of California, San Francisco, Child Trauma Research Program as part of an special initiative to provide on-site early childhood mental health services for children aged zero to five identified as having trauma exposure and/or behavioral and mental health problems. This initiative is part of a larger effort to more broadly implement trauma–focused CPP in collaboration with community agencies (Hernandez Dimmler et al. in press).

BCHC is first and foremost a primary care clinic with in-house mental health services as opposed to being a destination for patients seeking mental health care. The trauma screen devised by clinic pediatricians is based on the adverse childhood experiences (ACE) study (Felitti et al. 1998), a longitudinal study of more than 15,000 middle class, Kaiser Permanente patients that showed a correlation between adverse childhood experiences, such as sexual abuse, neglect and trauma, and risk for disease later in life.

The ACE screen is part of a comprehensive program intended to address the impact of adverse childhood experiences as a major risk factor for chronic disease (Burke et al. in press). Clinic pediatricians initially screen every patient for trauma including physical and sexual abuse, substance use, neglect, domestic violence, parental incarceration, history of mental illness, and past or current involvement of child protective services. Once pediatricians have administered the screen, they begin a consultation process with social workers and psychologists at the clinic to determine the appropriateness of a referral to mental health services.

This consultation process begins when pediatric staff present families at the multi-disciplinary rounds—a weekly consultation group that consists of a child and adolescent psychologist, a social worker and psychologist trained in child–parent psychotherapy, a case manager, and two pediatricians, in order to discuss patients and to strategize about how to effectively offer services. After an intervention plan is formulated, services are coordinated to address the physical and mental health needs of the child and family. These services may include referral for brief consultation with a staff therapist, case management, outside psychological, educational or neurodevelopmental assessment, and family, individual or child–parent psychotherapy.

In addition to providing a forum for discussion of families, the multi-disciplinary rounds process gives medical staff the opportunity to reflect on their experience of the traumatic material generated in their interviews with patients. Clinicians and care providers exposed to patients with traumatic histories are at risk of experiencing burnout as a result of secondary traumatization (Figley 1996; McCann and Pearlmann 1990). The collaboration between the mental health and pediatric teams seeks to encourage an organizational culture that values reflective capacity, self-care, and the mitigation of secondary traumatization. The multi-disciplinary rounds process intends to mitigate secondary traumatization by providing staff with a forum to reflect on the overwhelming or upsetting images and affect generated by the ACE screen.

The mental health team has weekly meetings intended to reflect on organizational process, presentation of challenging clinical material, and to discuss how to more

effectively engage hard to reach families. The mental health team also provides in-service trainings to clinic staff related to mental health.

Viewing Trauma Through an Attachment Lens

Our interdisciplinary model of collaboration has roots in an ecological/transactional model of conceptualization and treatment (Cicchetti and Lynch 1993; Lieberman and Van Horn 2009). This approach assumes that healthy development and psychopathology are the result of the mutual influences between both risk and protective factors within the child such as genetic biology, and environmental influences such as the parent–child relationship, the family, community, and cultural context (Bronfenbrenner 1977). When considering the impact of trauma, our approach involves developing a better understanding of the quality of the child's primary attachment relationships as a significant part of the context in which the trauma occurred.

Trauma in the first 5 years of life is profoundly disruptive of a child's expected developmental trajectory and often has a negative impact on the parent–child relationship. Infants and young children may remember traumatic events long after they occur, and these memories can have profound effects on their play, development, and expectations of the caregiver (Gaensbauer 1995). Following a traumatic event, the parent's past and present circumstances—including early attachments and trauma history—influence their ability to function as a developmentally critical protective shield for their child (Freud 1926/1959). When past traumas or unresolved developmental conflicts are evoked by the present trauma, the parent may find it impossible to provide the sense of safety needed to regulate the child's fluctuating emotional and physiological states (Lieberman and Amaya-Jackson 2005; Scheeringa and Zeanah 2001). As a result, an attachment system that has evolved to provide protection, physiological and affective regulation, and a sense of safety for young children may become a source of fear, insecurity, and dysregulation.

When both caregiver and child experience a traumatic event—such as when a child witnesses domestic violence involving the parents—they may come to remind each other of the trauma. The parent's own symptoms of traumatic stress may be triggered when the child's dysregulated affect and behavior remind her of the event, and her own distress may interfere with her ability to respond supportively to the child (Lieberman and Van Horn 2005, 2008).

Trauma symptoms reflect the child's developmental stage, and in the first year of life may include prolonged and inconsolable crying, motor agitation, disorders of feeding and sleep, and blunted affect. In toddler and preschool age children symptoms may include reckless behavior, engaging in disinhibited or dangerous behaviors and precocity of self-care (Lieberman and Van Horn 2005; Scheeringa and Zeanah 1995a, b). According to the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised* (DC: 0–3R), symptoms of Post Traumatic Stress Disorder (PTSD) in early childhood include re-experiencing the event through repetitive posttraumatic play, recurrent recollections

of the event, nightmares, physiological distress, flashbacks or dissociation, as well as numbing of responsiveness, disruption of the child's development and increased arousal (National Center for Infants, Toddlers and Families 2005).

There is a striking similarity between the behavior of children classified as having a disorganized attachment relationship to their mothers and those who have experienced traumatic events. For example, children with a classification of disorganized attachment may appear disoriented in relation to their surroundings, show contradictory behaviors in rapid succession, may be inhibited in their exploration, and show dysregulation of affect. Similar behaviors are observed in children who experienced violence and chronic traumatic experiences, raising the possibility that exposure to trauma may be a factor in the etiology of disorganized attachment (Lyons-Ruth and Jacobvitz 1999; Lieberman and Amaya-Jackson 2005). The mutually influencing nature of attachment and trauma make it critical for mental health providers to be attentive to trauma history in the presence of a disorder of attachment. Some caregivers, especially those with histories of trauma themselves, may find it difficult to understand the connection between the traumatic event and the child's behavior and may mistake symptoms of traumatic stress as unexplained defiance, oppositional behavior, attention problems, rebelliousness or tantrums. The parent may then begin to make negative attributions about the child, coming to believe that the child is "bad," "angry," "a liar," or "manipulative" (Silverman and Lieberman 1999).

Since avoidance and minimization are two common mechanisms of psychological protection following a traumatic event, caregivers may also seek to downplay the significance of the trauma. Parents may have trouble speaking about the trauma directly with their children or believe that their children do not remember the trauma, even when the children's play indicates that they are remembering and reenacting traumatic events that occurred before the acquisition of language (Gaensbauer 1995). Alternatively, a caregiver may be affected by the trauma in such a way that their own anxiety, hyper vigilance, and misapprehension of danger leads them to become overly protective, anticipating danger when there is no realistic reason for it and over-interpreting developmentally expectable behaviors as manifestations of the traumatic exposure.

When a family seeks treatment or advice for a child's behavioral problems, they often do so without necessarily making an explicit connection between the behavior and the trauma. In part because of the disorganizing effects of trauma, parents may wait to seek treatment or advice until their child's behavior becomes severe enough at home or school that it begins to fundamentally disrupt the child or parent's ability to function.

In the setting of a community pediatric clinic, pediatricians are often the first provider to hear about these concerns, making them a particularly important part of the system of care and an influential figure in the referral process.

Although pediatricians have the opportunity to identify behavioral, emotional, and developmental problems in their earliest stages, they may be unaware of mental health resources in the communities they work or unsure of how to utilize available resources. As a result, they may feel pressure from parents to prescribe psychotropic medications to address the symptoms of depression, anxiety, or hyperactivity that may be linked to trauma, rather than referring to mental health providers. For this

reason, there is a vital need for social workers, psychologists, and pediatricians to work together on an early intervention/prevention model of treatment as a way of addressing the needs of traumatized children.

Trauma–Focused Child–Parent Psychotherapy in the Pediatric Clinic

Child–parent psychotherapy is an evidence-based form of clinical intervention that focuses on improving relationships between parents and children aged zero to five and takes place in joint sessions with the parent and the child (Lieberman and Van Horn 2005, 2008; Lieberman et al. 2006). It is the treatment of choice for infants and young children who have experienced trauma. Contemporary CPP evolved from the groundbreaking work of Fraiberg (1980) who as a social worker and psychoanalyst was uniquely positioned to develop a model of treatment of infants and parents that was attuned to the intrapsychic "ghosts" of the parents past as well as to the concrete social and psychological needs of vulnerable young children (St. John and Lieberman in press). Psychotherapists trained in this approach take into account the type and severity of the traumatic event, the quality of the child and parent's individual functioning before the trauma, the quality of the attachment of both parent and child, and changes in the parent–child relationship since the traumatic event. One of the hallmarks of CPP is the routine integration of variety of clinical modalities such as developmental guidance, concrete assistance and advocacy, as well as perspectives informed by psychoanalytic theory, social learning theory, mindfulness, attachment theory, and cognitive-behavioral therapy.

Child–parent psychotherapy's goals include evaluating and strengthening the parent–child attachment and improving the overall emotional quality and sense of safety in the dyad (Lieberman and Van Horn 2009). In order to foster greater affective attunement and communication, therapists routinely offer translations of the child's behavior and affect during free play and parent–child interactions. This facilitates greater parental self-awareness and a deeper understanding of the child's subjectivity, both of which contribute to healthy parent–child relationships (Lieberman and Van Horn 2009). However, treatment is not limited to helping parents better understand and respond to their child's behavior. Thoughtfully timed provision of developmental guidance facilitates understanding and reduces anxiety, and concrete assistance with problems of daily living strengthens the therapeutic alliance and encourages self-care. Helping parents and children understand and make meaning of the trauma is a central focus of the work. This is achieved through the co-creation of a narrative that puts the traumatic events in context and allows parents and children to better understand the ongoing internal and external factors that trigger their symptoms (Lieberman and Van Horn 2009).

Engaging Hard to Reach Families

The mental health team originated with the understanding that the mental health needs of the community could only be met when those needs are identified and responded to flexibly and individually. Using a dual lens of attachment and trauma, psychotherapists at the clinic use a variety of means to understand and engage families.

Families who reside in marginalized communities affected by chronic violence, trauma, and poverty are often reluctant to engage in psychological treatment (Seligman and Pawl 1984; Kiefer 2000). Engagement with systems of care requires a level of trust and a stability of primary attachment relationships that is often absent in the families from such communities. Rates of missed appointments and unreturned phone calls are high. Because of unexpected moves, homelessness, financial stress, and other reasons, patients may change phone numbers frequently and working numbers are suddenly disconnected. Without a way of contacting or following up with a family, staff can become frustrated and disheartened.

BCHC was founded to facilitate an early intervention/prevention model of treatment in the service of a larger public health perspective. However, because of ongoing emotional and socioeconomic stress and lack of trust of systems of care, many families wait until symptoms are significant before coming to the clinic to see the doctor. Some African American families may be reluctant to seek mental health services once established at the clinic because of the longstanding stigma related to mental health services in the African American community (Sanders Thompson et al. 2004; Diller 1999).

Patients who have developed a strong bond with the pediatric staff including front desk staff and medical assistants tend to engage more readily. The front desk staff is crucial in building rapport with families and in helping them feel at ease and are often more aware of the life stories of the families served than members of either the pediatric or mental health teams. They observe families in the waiting room and often witness unfiltered interactions between family members. They often know how to contact a family when that family has been out of touch, for instance, because two family members had a falling out and the parent and child moved. In fact, many families come to think of clinic staff as being "like family." For this reason, clinic staff is a vital part of the dialogue between the pediatric staff and the mental health team. This strong rapport and sense of connection with the front desk staff is one important reason why families accept the clinic as a place for their child's mental health care.

Impediments to Engagement

Families who have been mandated by social services to attend therapy can be particularly reluctant to form a therapeutic alliance because of feelings of powerlessness and their association of the therapist with the social service agency. Although from the standpoint of the therapist, CPP is not a mandated service, psychotherapy is often a requirement for families where child abuse or neglect is suspected or has

been confirmed and CPS is involved. There are significant challenges in developing a therapeutic relationship with a family when the family feels that the treatment has been forced upon them.

Similarly, not every family who has experienced trauma is ready for treatment. In fact, because avoidant behavior is common in families who have experienced trauma, the task of engagement becomes that much more difficult. These families may underreport adverse experiences, downplay symptoms, or minimize the pediatrician's concerns.

When speaking to a parent about mental health issues, the pediatrician takes care to address the patient's primary concern regarding the wellbeing of the family. Parents may present concerns about their child's behavior more readily than personal feelings of depression or anxiety. Pediatric staff has become attuned to the way that parents present their concerns and attempt to be respectful of the parent's level of functioning and readiness for treatment. This parallels the CPP assessment process, in which the therapist begins with the parent's primary concern about their child and proceeds from there.

Engaging multiply stressed families in child–parent psychotherapy often involves beginning with a family's greatest need rather than addressing the traumatic incident right away. This is especially true of families who have been referred, but are not seeking treatment. Families who live in poverty are often in ill health, lack adequate transportation and family support and are often uninterested in beginning a course of talk therapy. As a result, engaging families in the concrete aspects of their needs (i.e., physical health, services such as respite and daycare, and establishment of appropriate benefits) is often the most effective way to engage families in psychotherapy.

For example, following up on a referral by the child's pediatrician, a clinician was met with silence after presenting clinical services focused on trauma. After hearing that the overwhelmed mother's greatest concern was keeping her five children's clothes clean at home and that her rented washing machine had just broken and would be too costly to repair, the clinician offered to help the mother find a new one. The subsequent relationship that formed as a result of the clinician's genuine efforts on the family's behalf led to critical involvement when the family experienced a crisis. As in clinical social work, such concrete interventions are helpful when engaging patients from marginalized communities.

Concrete interventions may also occur in the context of advocacy. This includes interfacing with the legal system on behalf of patients, helping to review and complete important documents with patients, and clarifying important information with other caregivers and systems. When thoughtfully employed, such well-timed interventions may also be considered to be nonverbal interpretations (Renschler 2009).

Home visiting is another aspect of initial or ongoing engagement of families who are difficult to reach. For example, following a client's surgery for a debilitating leg injury, the clinician offered to travel to the family's home for therapy rather than allow the treatment to falter because of the patient's difficult life circumstances. The mother was touched by this accommodation, which allowed a deepening of the therapeutic relationship. Because the family lived in a dangerous neighborhood, the

visits evoked the mother's protective feelings for the therapist, which allowed her to feel, and more deeply express, her feelings of vulnerability about herself and her child due to living in an area where community violence was common.

Culture and Class

Issues related to cultural differences between clinician and patient may present initial impediments to engagement. Despite this, there can be significant advantages to treatments that involve therapists and patients of different ethnicities. Clinicians, working in communities where the predominant ethnicity is different than their own, have a responsibility to develop the capacity to reflect on their own cultural background, biases, and assumptions and to seek out culturally appropriate consultation. It is the clinician's readiness to address issues of culture and class in treatment and supervision that determines in part whether treatment will falter due to cultural differences (Diller 1999). For this reason, reflective practice is vital to implementing a diversity-informed approach to mental health treatment (Gosh Ippen and Lewis 2011).

Some African American patients may feel that a white clinician cannot understand their experience or they may associate the white therapist with a system of care that has historically been anything but helpful (Williams 2008). However, it can be significant when a strong relationship is formed between a therapist and patient of different ethnicities in a spirit of mutual respect and collaboration. This is especially true of patients who have never had a close relationship with a person of another ethnicity. In one instance, an African American woman revealed to her white therapist that she had been taught to "never trust the white man and never tell the white man your problems." When she followed her African American pediatrician's advice and pursued treatment with a white therapist, the resulting relationship caused her to reflect that, "some things are more important than the color of your skin."

The clinician's willingness to engage in a thoughtful, self-reflective process around his or her own cultural biases, ethnic background, and socioeconomic status and how these elements differ from those of their patients is an important part of addressing issues of culture and class in child–parent psychotherapy. When therapists take this into account, they are better able to understand not just the larger cultural context of their patients and of the community, but the culture specific to the individual and the family as well. Ultimately, this approach facilitates flexible adaptation to the specific needs of each child, parent, and family (Lieberman 1990; Diller 1999; Devore and Schlesinger 1981).

Case Example

The following case example serves to illustrate the advantages to providing child–parent psychotherapy in the context of the community pediatric clinic. In this case, the referral from the pediatrician, typically a useful introduction to mental health

services, was tainted by the pediatrician's earlier referral of the mother to child protective services on suspicion of neglect. This left the mother feeling betrayed, resentful, and reluctant to engage with services. As the clinician would learn, the mother's attachment history left her untrusting of close relationships and without close friends or significant family support. From an attachment perspective, the mother's capacity to be emotionally available and attunement to her own daughter improved as her she developed a strong relationship with the clinician. This relationship served to facilitate the gradual repair of longstanding hurts that had existed in her relationship with her own mother which impaired her own ability to be attentive to her daughter and left her without a healthy model of parenting. The co-location of medical and psychological services at the clinic allowed for the later repair of the damaged relationship with the pediatrician as well. As the mother's self-awareness increased by talking about herself in therapy, a new experience for her, she developed a greater capacity to nurture and respond to her daughter's changing needs. As the therapeutic relationship strengthened, a traumatic event involving mother and child threatened to damage the mother's fragile attachment to the therapist as well as to derail her growing bond with her child.

Presenting Problem

Charlene[1] was a 25-year-old, African American, first-time mother when she was referred with her 5-month-old daughter Nia, for CPP by Nia's pediatrician. Born 8 weeks premature at three pounds, Nia had been diagnosed with nonorganic failure to thrive after she continued to struggle to gain weight several months after being released from the hospital. For the first few months of Nia's life, the medical team at the clinic worked closely with the family to understand the causes of Nia's weight problems. According to the pediatrician, there was no known physiological reason that Nia should not be gaining weight, but she was increasingly concerned about Charlene. The staff observed that Charlene often seemed annoyed and overwhelmed by her daughter's cries. On several occasions, they witnessed Charlene telling her newborn to "shut up." At other times, her affect was flat and she seemed distracted and inattentive. Despite giving her careful instructions about how to feed and care for Nia, the pediatrician was concerned that Charlene's apparent postpartum depression was affecting her capacity to care for daughter.

After several weeks of unsuccessful psychosocial intervention, including concrete assistance, modeling, and detailed parenting instruction by the clinic case manager and medical staff, Nia's pediatrician recommended that she be hospitalized to further assess the cause of her failure to thrive. Nia gained a significant amount of weight during this four-day hospitalization but quickly lost these gains following her return

[1] In this case example, names and identifying information have been changed to protect the confidentiality of the patient and family.

home. In order to ensure greater supervision and care for this family, and from the pediatrician's perspective, to save Nia's life, the clinic case manager, at the request of the pediatrician, informed Charlene that they would be filing a report with child protective services (CPS) due to suspicion of neglect. At the time, Nia was under the third percentile for weight and was thought to be in considerable danger due to her low weight.

Following a team decision meeting arranged by the Child Protective Services social worker, and discussion of the case at multi-disciplinary rounds, child–parent psychotherapy was recommended to attempt to address both Charlene's possible postpartum depression as well as any other potential psychosocial causes for the Nia's failure to thrive. At the team meeting, Charlene's mother, whom Charlene and Nia lived with at the time, accused her daughter of neglectful behavior and publicly scolded her. She seemed angry with Charlene and insinuated that it might be better if Nia were removed from her care altogether. Despite this, CPS determined that as long as Charlene would agree to participate in a variety of supportive services—including child–parent psychotherapy—and if Nia began to gain weight, Nia would stay at home with Charlene. Charlene and Nia were then referred to a psychotherapist at the clinic who is trained in CPP.

Initial Assessment: Sharing the Mother's Perspective

When the clinician first met Charlene, Charlene was withdrawn and her affect was flat. In the initial sessions, she wore headphones over her ears with the volume turned loud enough that the clinician could hear the music. The clinician initially understood this to be a reflection of her depressed mood as well as her anger about being referred to therapy against her wishes. In fact, the clinician was aware that from Charlene's perspective, CPS was ordering her to attend psychotherapy or risk losing her baby. The clinician imagined how this might leave Charlene feeling powerless, undermined, angry, and potentially humiliated both as a mother and a new parent. Charlene insisted on referring to the clinician by his professional title and full last name.

As the therapy was considered mandatory, the task of building rapport and safety in the therapeutic relationship presented a special challenge. Initial attempts to engage Charlene and to establish rapport focused on acknowledging her lack of choice in coming to treatment and empathizing with her about the stress of CPS involvement. With this in mind, the clinician also attempted to find ways to offer her more choice within the framework of the treatment. The clinician focused a great deal in the first session on clarifying his role as separate from that of the pediatrician and the CPS social worker. He also focused on clarifying confidentiality and on helping Charlene—who had never seen a therapist before—know what information was considered private and when information would need to be shared. The clinician stressed that in the event that something needed to be shared, such as if he learned that a child was being hurt, he would always tell her what he was going to say first, and if possible, the two of them would tell someone about it together.

In the first session, rather than focusing on the presenting problem, which he imagined might have put Charlene on the defensive, the clinician focused on concerns she had about Nia and how things were going at home. The clinician said that even though he understood that it was not her idea to receive services, he thought that therapy could provide a space for her experience as a new parent and to talk about the things that had been stressful for her and Nia. The clinician also told Charlene that the three of them could work together to better understand some of the reasons for her child's difficulty with weight gain. Although guarded at first, Charlene seemed relieved. It would take many more weeks before she began to open up about feelings of betrayal by the pediatrician and her mother due to the CPS report.

As the clinician and Charlene completed the administrative paperwork necessary to begin work together, Charlene said that she felt that she and her daughter had spent more time in doctor's offices filling out paperwork and being examined than getting to know each other at home. The clinician took this as another opportunity to offer Charlene a choice with respect to the early treatment. A typical CPP assessment at CTRP lasts 5 to 6 weeks and involves a number of psychological measures that assess the functioning and the history of both parent and child. This process can evoke strong feelings in many parents and can be especially difficult when a parent feels disempowered and distrustful of the system of care. With this in mind, the clinician outlined the traditional assessment process but offered Charlene the option of choosing how she would like to proceed and inquired what if any questions she would like to learn more about her and her daughter. Charlene seemed surprised and asked if it would be okay to just start by talking and the clinician agreed to this. This approach reduced the sense of scrutiny and eased the feeling that she was at "another doctor's office." Charlene began by talking about her most immediate concern: Her frustration and exhaustion from Nia's frequent night waking.

Charlene reported being sleep deprived and considerably frustrated with Nia's waking. Early therapeutic work involved understanding and normalizing this behavior and helping Charlene to develop a consistent sleep routine for Nia. Discussions of sleep issues—a common complaint among new parents—allowed the clinician to express empathy and to collaborate with Charlene in a way that further strengthened the therapeutic relationship.

When, after a few sessions, the new sleep routine began to pay off with Nia sleeping longer stretches at night, the therapeutic relationship benefitted as a result. Discussion of Charlene's experience of exhaustion allowed her to vent about an issue that was neutral and less charged than the CPS report. It also led the clinician to inquire more about Charlene's supports at home and to wonder aloud why, although she lived with her mother and sister, she seemed to feel so alone and unsupported during a time when any new parent would need support.

Early Treatment: Ghosts in the Nursery Emerge

Charlene tentatively opened up about her relationship with her mother and the clinician began to learn more about her history. Ever since telling her mother that she was pregnant, Charlene felt that her mother had turned her back on her, offering more criticism and judgment than support. Similarly, Charlene said that her older sister often sided with her mother, leaving her feeling isolated and alone. She said that she did not know why Nia was born prematurely and did not gain weight. The clinician wondered initially about maternal substance use, but toxicology reports were negative. Charlene expressed concern that because of Nia's prematurity and lack of weight gain she would grow up being frail, vulnerable, and unable to protect herself as an adult. She presented herself as streetwise and tough, a former high school track star who said she would never let another person get the best of her. Still, the clinician wondered about Charlene's own feelings of vulnerability and how this might be influencing her fears about her daughter.

As they continued to form a therapeutic alliance, Charlene and the clinician worked together to develop a better understanding of the scope of their work. For Charlene, two of the most important initial goals were helping Nia get more sleep and better understanding the reasons for her difficulty in gaining weight. She also expressed frustration with the CPS case and mentioned wanting it to be closed. Several implicit goals began to emerge over the initial weeks of treatment: Helping Charlene navigate her role as a new parent, better understanding her relationship with her mother, and encouraging greater responsiveness and understanding in her relationship with her daughter. As the initial treatment progressed, Charlene became very explicit about wishing to have a different kind of relationship with her daughter than she had with her mother. This desire opened a pathway of discussion that encouraged a deepening of self-awareness and reflection.

After 2 months of treatment, Charlene seemed to feel better and made more eye contact during sessions. Nia, because of her prematurity and her struggles to gain weight, was still underweight and often slept during sessions. This sense of quiet initially created space for Charlene to reflect on her experience of herself and Nia without any pressure for her to be responsive to Nia's needs. As Nia, now 7 months old, began to be awake for more of the sessions, the clinician began to address her directly in order to acknowledge Nia's subjectivity and his awareness of her as a person with her own needs and desires separate from her mother's. Similarly, Nia's vocalizations and smiles became another opportunity for reflection about the meaning of her behavior and about Charlene's experience in relation to her.

Charlene's wearing earphones during sessions left the impression of someone who sought to tune out the world around her. As sessions progressed, Charlene began to take out one earpiece to listen but would leave the other in with music still playing. As Nia's curiosity and capacity to reach out and interact with her mother grew, she would often grab at the ear phones and pull them from her mother's ears as if to say to her mother that she wanted her to be more present and pay more attention to her.

After 3 months of weekly treatment, Charlene began to take her earphones off during sessions. During a collateral consultation with the pediatrician, the clinician learned that Nia's weight was beginning to stabilize. Because of her lingering negative feelings towards the pediatrician, Charlene was especially reluctant to reach out to her for advice or support. The clinician worked to facilitate a repair in the relationship by asking for information from the pediatrician at Charlene's request, and encouraging her to ask such questions herself when she was ready to do so.

Feeding became an important part of the sessions. At first it appeared that Charlene needed to show the clinician how well she was feeding Nia by methodically preparing and giving her the bottle during session. Little by little however, Charlene began to ask the clinician to help with the preparation of the bottle. She would direct the clinician to fill the bottle with just the right combination of hot and cold water to arrive at the right temperature for Nia. Charlene would test the water before giving it to Nia and sometimes would send the clinician back to adjust the water temperature at her direction. The clinician understood this interaction as reflecting an important expression of care and support that Charlene did not feel comfortable asking for with her own family, but was increasingly feeling able to ask of the clinician. In contrast to the collaborative experience that developed in sessions around the preparation of Nia's bottle, at home Charlene continued to find criticism and conflict. For instance, Charlene began to use the blender to make homemade baby food. On one occasion, when Charlene forgot to unplug the blender, her mother became so upset with her that she hid it from her and told her that she could no longer use it. This hurt and confused Charlene, who expressed anger at her mother.

As Charlene began to open up about her significant relationships, the clinician asked more directly about her experience of Nia's birth and the following months. She initially struggled to put words to her experiences and later said that she had never been asked much about herself. She said that her family did not talk about such things. Charlene said that the pregnancy was unplanned but said little else about Nia's father, Anthony. According to Charlene, Nia had seen Anthony only a few times since the birth and he was not involved in her life. Regarding Nia's difficult birth, Charlene said that Nia had stopped growing in utero and needed to be delivered via emergency surgery. She described feeling confused, overwhelmed, and alone and was convinced that both she and Nia might not survive the surgery. She described feeling physically and emotionally disconnected from Nia as she recovered in the NICU for several weeks. She continued to worry that Nia might not survive. In addition to struggling with depression, Charlene used avoidance as a response to the trauma of Nia's prematurity and fragility at birth, part of a pattern of attachment that fends off emotional closeness as a means of protection against the danger of loss and resulting emotional pain.

Charlene revealed a pattern of distant relationships with family. She described a pattern of important people disappearing from her life without explanation, including her two brothers and father. Charlene's father now lived nearby but had 12 children from several different partners. Charlene described feeling close to and protected by him when she was little but had few interactions with him in recent years. As Charlene continued to discuss the dynamics in her family, she expressed longing for

a mother who could be there to support her in the way that she wanted. She painted a picture of her mother as a distant figure who rarely spoke with her or asked about her and whose support of her when she was growing up was limited to her athletic potential. Charlene got a scholarship to run track in college but a knee injury in her freshman year hampered her attempts to pursue that dream. She dropped out the following year and after a few years at home became pregnant. She said that her mother had stopped supporting her after she told her about the pregnancy, and often treated her as if she were a nuisance around the house. She said that she sometimes berated her and called her stupid.

Charlene said that she knew very little about her mother's history and family. She said that her mother had one sister who was mentally ill and who was apparently in a hospital somewhere. She also said that her mother had another sibling who lived nearby but whom Charlene barely knew and about whom her mother never spoke. Charlene revealed a culture of silence in her family, a culture in which members did not speak about important matters and showed little interest in or capacity for self-reflection. People who experience trauma often use avoidance and emotional distancing as a means of self-protection. The clinician modeled that knowledge can be safe. Putting words to feelings, encouraging greater capacity for self-reflection, and fostering a different kind of relationship between Charlene and her daughter became implicit goals of the evolving treatment.

As Charlene became more curious about her family during therapy, she asked her mother more questions at home. Each question was met with silence or rejection. One afternoon Charlene was in her mother's room when she uncovered personal papers on her mother's desk, one of which was her mother's birth certificate. The certificate had a different name listed for her mother's parents than she recognized, and her mother's birth date was the same but her maiden name was also different. Charlene confronted her mother with this information and her mother refused to address it, telling her to mind her own business.

The mystery surrounding her mother's identity and questions about why she had cut off ties with her parents stirred new questions and feelings in Charlene. The caring attention that she received in the therapeutic relationship caused Charlene to long for deeper relationships with the important people in her life. Charlene began to feel a kind of empathy for her mother, imagining that difficult things had happened to her when she was little that had impacted her ability to be the kind of mother that she wanted to be. She attempted to tell her mother how she felt about their relationship and how she would like their relationship to be. At one point, with the help of the clinician, she wrote a letter to her mother saying that she would like to do more things together and fight less.

These attempts to reach out to her mother led her to seek greater closeness in her relationship with Nia and to vow that things would be different between them. She was increasingly able to better care for herself and her daughter. As she began to understand and express her own relational needs, she was more able to be attentive and engaged with Nia, seeming to take pleasure in Nia's ever-changing development. Nia, now nearly 9 months old, was steadily gaining weight. Although still delayed due to her prematurity, she was sitting up and making gains developmentally. Charlene's

affect appeared brighter too. She seemed to enjoy our sessions and to feel safe to speak about the things in her life that concerned her.

Another sign of the strength of the growing therapeutic relationship was that when Charlene was mistakenly given a referral to a home visiting program offering similar therapeutic services, Charlene expressed confusion and declined to follow up on the referral telling the referring social worker that she already had a therapist. Charlene said, "I told her this is where we come to talk about things now."

A Disruption in Treatment: Experience of Trauma

When Nia was 10 months old, Charlene who had always been consistent in attending sessions, suddenly did not show up or call for the scheduled session. The clinician called and left a message on her phone but did not hear back from her. Later in the afternoon, the clinician received a call from the Child Protective Services worker, a clinical social worker, saying that Charlene had been attacked by Anthony while she was holding Nia during a visit to his home.

Charlene did not come to therapy for the next two weeks and did not return the clinician's phone calls expressing concern. When she arrived for the session the following week, the faint outline of a black eye was still visible. Charlene was wearing her earphones again and avoided eye contact. Nia was screaming inconsolably in the waiting room and Charlene appeared tired and withdrawn. She said that she had lost Nia's pacifier. Charlene sat down with a blank expression. She complained about Nia's unending screams. The clinician told Charlene that he had been concerned about them and that he had wondered where they were and how they were doing when he did not hear from them. Charlene did not respond. The clinician told Charlene that he had heard from the social worker that something terrible had happened and that Anthony had attacked her while she was with Nia. Charlene nodded. She said that he "got off a cheap shot while I wasn't looking." She described how she tried to defend herself and to protect Nia by putting her down on the bed so that Nia would not be hurt.

Charlene expressed feeling angry, betrayed, and confused. She described calling the police and filing a report. She said that she fled without Nia, leaving her in Anthony's apartment so that she could call the police. She said it was all that she could do. She explained that she feared for her life. The clinician acknowledged how difficult it must have been for both of them and how scared they both must have been. Nia calmed down but appeared exhausted and on edge.

It became apparent over the next few sessions that Charlene's depressive symptoms had returned and that her growing capacity to think about and care for Nia was being threatened by the recent trauma. At the start of one session, she left Nia in the waiting room while she went to the bathroom, leaving Nia screaming. Charlene expressed that she could no longer tolerate Nia's cries and that she did not know why Nia was crying or what to do about it. The clinician asked, "I wonder if she was frightened when she didn't see you. She must have wondered where you went and

when you would be back. With her cries she was saying, 'Where did my mommy go? Who are these people I don't know."' This led Charlene to reflect on her own feelings of distrust in other people and her desire to keep to herself and not leave the house. She revealed a history of verbal and emotional abuse from Anthony. She said that, when they were together, Anthony frequently called her stupid and told her she was worthless.

Despite such abuse, Charlene explained that she wanted Nia to know her father and to have a good relationship with him. She explained that this is why she sought him out for the visit that led to the violence. Charlene could not understand what caused Anthony to attack her. She wondered if he was using drugs or was mentally ill. The clinician continued to link Charlene's feeling of overwhelm, anxiety, and intolerance for Nia's cries with her experience of the violence, working to normalize her heightened affect by putting it in the context of the trauma.

After the trauma, Nia's sleep difficulties returned and Charlene withdrew further from her relationships with her family. During one session, as she was discussing the trauma, Charlene said quietly, "I'm having a moment." When the clinician asked what this meant, she said that it is a phrase she used when she felt upset and it helped her to calm down. The clinician asked where she felt this upset feeling and Charlene pointed to the core of her body. She said that she had been having this since the attack and that she worried that she was "going coo coo." The clinician worked to normalize this response to the trauma and explained the way that such stressful events can affect one's body. Despite the fact that this was frightening for Charlene, the clinician understood this revelation as a sign that Charlene's reflective function was improving, an important aspect of secure attachment relationships.

The clinician also worked to link Charlene's frustrations with Nia's cries with her scared and dysregulated feelings in the aftermath of the domestic violence. During one session, Charlene said, "She gets so upset when I am making the bottle. She gets so angry at me." The therapist said, "I think she is letting you know how hungry she is." Charlene said, "But she can't go on having a short temper like this. People will think she's crazy." The clinician linked this fear that others would think that Nia was crazy with her concerns that she would be "like Anthony" who had surprised her by becoming violent with both of them. Charlene said she was worried that Nia would be an angry person, that she would blame Charlene for what happened, and that she would treat Charlene the same way her father did.

During one session in which Charlene was discussing the impact of the violence, and Nia, 11 months old now, was particularly fussy, the clinician turned to Nia and said, "Your mommy told me that your daddy hit your mommy while she was holding you, and you were so little, and scared and couldn't do anything to stop it." Nia became very still and looked at the clinician with rapt attention and then turned back to her mother, burrowing her face in her shirt. Charlene said, "Do you think she remembers what happened? Nia, mommy is so sorry. Mommy loves you." She hugged Nia close. This exchange created the opportunity to reflect on Nia's experience of the trauma and to discuss how children her age remember scary experiences.

As the clinician and Charlene continued to discuss her feelings about the assault, Charlene expressed deep shame at being attacked in front of her daughter and at having her daughter see her as weak and helpless. She felt that she abandoned Nia when she left her with Anthony. Still, her ambivalent feelings about Anthony and her desire for Nia to know her father made it difficult for her to want to pursue charges against him. She eventually decided to proceed, saying, "He needs to learn that he can't hurt us like that." Anthony was convicted and sent to county jail. Charlene felt proud of herself for setting an example for her daughter but also felt fearful of Anthony's reaction once he was released.

Putting words to these and other feelings seemed to give Charlene great relief but her "moments" continued, especially when she was reminded of the trauma. To more concretely address Charlene's anxiety, the clinician offered to show her several mindfulness-based breathing exercises and progressive relaxation designed to increase her ability to regulate her body when she became anxious or upset. After experimenting with these techniques at home, Charlene said that they helped her to calm herself down including after having a difficult exchange with her mother. Charlene would later remember to use the same techniques when feeling nervous before a job interview and reported them being helpful.

Re-experiencing the Trauma

After Anthony was sent to jail, his mother began to reach out to Charlene and to express an interest in seeing her granddaughter. Charlene was hesitant at first, but as they began to see more of each other, Charlene began to trust this maternal figure who expressed more warmth and concern for her than her own mother. This growing relationship was complicated when Anthony was released from jail and began coming to his mother's house. He also began calling Charlene to express interest in seeing Nia, which was a violation of the restraining order. Charlene resisted Anthony's attempts to get in touch with her and was clear that she did not want to see him.

One afternoon, when Nia was 13 months old, Charlene was startled when Anthony answered the door at his mother's house as she arrived with Nia for a visit. Charlene was terrified. She described later that her heart began to race and she began to sweat as she had visions of the assault. She was so flustered that, in an instant, she decided to leave Nia at the house for the visit and to go on a walk in the neighborhood to calm down. Later in session, the clinician and Charlene discussed Nia's reaction to being left with Anthony; Charlene was unsure. She was so flooded with feelings herself that she did not notice her daughter's state. The next week Charlene reported that Nia was fussy the whole week and that she was not sleeping well. The clinician wondered aloud if this was Nia's way of saying what it was like for her to see her father and that she, like her mother, was affected by seeing him. Charlene said she was not sure what Nia remembered about what happened or what she thought of her father. Later Charlene admitted that she was scared and was able to make a connection between Nia's fussy behavior after the visit and her own feelings about seeing Anthony. After

the session, Charlene called Anthony's mother to tell her that she did not want to see Anthony during the visits, as seeing Anthony was a violation of the restraining order and upsetting to her and Nia.

During this time, the clinician spoke directly with Nia, now over a year old, about seeing her daddy and about being with him without her mommy. When the clinician spoke to Nia about this, Nia would look at the clinician intensely. During one of these moments Charlene said, "I think she understands what you are saying. She remembers. She knows who she was with." The clinician understood this to be an important sign that Charlene was making connections between Nia's emotional experience and her awareness of the trauma.

Other aspects of Nia's behavior began to trigger Charlene's memory of the trauma. When Nia hit her mother in what appeared to be an accidental or playful way Charlene reacted to her by yelling at her to stop. Charlene feared that when her daughter became upset that she was "crazy like her dad." Other times she worried that her daughter "doesn't like me." The clinician attempted to carefully link these attributions to the experience of the trauma, which helped Charlene continue to integrate and recover from the effects of the assault. Her concerns about her relationship with her daughter also led her to express her longing for the loving, supportive relationship with her mother that she always wanted.

Improvement and Consolidation

As the treatment progressed, the collaborative relationship between the clinician and the CPS social worker became a critical part of the ongoing treatment. It was important to be transparent with Charlene about any communications with the social worker. Similarly, when the pediatric staff asked for updates about the case, the clinician asked Charlene what information she felt comfortable being shared and tried to limit information that was relevant to Nia's health and well being. Throughout the treatment, the CPS social worker was actively involved in monitoring Nia's progress and yet remained respectful of Charlene's privacy.

As Nia's weight and development improved and the end of the CPS case was in sight, the CPS social worker began receiving calls from Charlene's mother stating that Charlene was endangering Nia at home. Although Charlene's mother would not give specifics, the social worker was concerned. After a series of visits to the home and calls to the pediatrician and the clinician, the CPS worker began to believe that it was the relationship between Charlene and her mother that needed attention. During a consultation with the clinician, the clinician suggested a meeting between Charlene and her mother to be facilitated by a therapist at CPS. The social worker and the clinician agreed that mother and daughter could use a place to talk about their relationship and that this would best be done with another therapist. Charlene agreed that she did not want her mother to come to her child–parent therapy, because she felt it would be an intrusion into the safe space that was created. She and the clinician prepared a written list of feelings and thoughts that she would like to communicate

to her mother in the meeting including, "I would like us to spend more time together with Nia and go places like we did when I was little."

Charlene's mother cancelled the CPS meeting several times before attending a meeting. According to the social worker, Charlene's mother appeared angry and resentful of Charlene. She repeated her belief that Charlene was endangering Nia. She said that she did not clean up after herself and played loud music in her room at home. When Charlene invited her mother to meet regularly with the CPS appointed therapist and read her the list she had prepared, her mother was evasive. Finally, she agreed to meet the following week but did not show for the meeting. Charlene expressed sadness and confusion about this in her own therapy. Still, much to Charlene's relief, the social worker indicated that there was no reason for CPS to keep the case open any longer.

When the CPS case was finally closed, Charlene called the clinician to leave a celebratory message on his voicemail even though she knew he was out of town. Despite occasional setbacks, Charlene and Nia seemed to be recovering from the trauma. A significant shift occurred as Nia, initially delayed in her gross motor skills, began to crawl—and, later, walk—in the therapy room. As Nia explored the space, the clinician suggested to Charlene that they move to the floor so that they could interact more readily with Nia. The clinician also wondered what Nia might like to play with and invited Charlene to help choose toys that she thought Nia would enjoy. Charlene appeared reluctant at first but as she moved to the floor, it became clear how much Nia enjoyed this newfound attention and focus on her.

Charlene enjoyed this change as well, remarking that she wished that Nia could be so relaxed at home and saying that she wished she had more toys that she could play with there. The clinician and Charlene brainstormed about ways that Charlene could create developmentally appropriate toys for Nia out of common household items and Charlene experimented with this at home reporting that she and Nia had spent time together that was enjoyable and free of worry and stress.

As the work continued, Charlene's guilt and confusion about Nia's prematurity and early feeding problems, which were exacerbated by the domestic violence, occasionally led her to feed Nia whatever she wanted in order to reassure herself that she was a good mother. The clinician continued to work with Charlene to develop insight into these feelings. Also, as Nia became more mobile and moved into toddlerhood, Charlene struggled to set limits with her out of fear of upsetting her. Charlene disclosed that she tried to give Nia whatever she wanted because, when Nia got upset, Charlene worried that Nia would be a sad and angry person the rest of her life. With some well-timed developmental guidance, Charlene came to understand that limit setting was actually healthy for Nia and would eventually lead her to feel safer and more relaxed.

As Charlene gained confidence as a parent, she saw greater possibility that things could be different at home. Being able to observe Nia become more curious about the objects and toys in the office and to see her interactions and smiles at the clinician allowed Charlene to think of Nia differently. Similarly, as Charlene's relationship with the clinician grew, her ambivalence and conflict about Nia's attachment and

need of her receded. Her growing ability to experience trust and safety in another person continued to increase her capacity as a mother.

The mutual decision to move to the floor during sessions was especially significant because it helped to facilitate Charlene's acknowledgment of Nia's separateness as a person with interests, capacities, and ideas of her own—an awareness that was greatly impeded by the trauma. This was especially important because it challenged an intergenerational pattern in which Charlene had been treated by her mother as an extension of her mother's unfulfilled potential rather than as an individual with her own needs and desires. She was treated as the child who would fulfill her mother's dreams of going to college and of succeeding in ways that she never felt that she could.

Charlene's depression receded over the course of the treatment. She took appropriate steps to enroll Nia in daycare, sought training for new employment and got a job. She started saving money and looking for a place of her own where she hoped that she and her daughter would create an environment that would be more hospitable and nurturing of their relationship. She talked of returning to school to finish college in order to study sports psychology so that she could help young athletes succeed in their careers. Charlene's relationships with women also began to improve. She developed a trusting relationship with Anthony's mom and a relationship with her paternal aunt.

Nia's language capacities steadily developed which decreased her frustration. Charlene followed through on pediatrician referrals for speech and language evaluation, as well as a nutritionist visit to learn how to foster healthy eating habits. Most importantly, Charlene's capacity to reflect on and express a full range of feelings with respect to herself and her daughter markedly improved. Her work with the clinician helped her to better care for herself and her baby, both of which were impaired by the depression and her unresolved attachment relationships and compounded by the trauma. Although Charlene had faced serious challenges from her postpartum depression, the trauma of the domestic violence and lack of family support, her work with the clinician helped her have a different relationship with her daughter than she had with her mother.

Conclusion

Trauma damages the capacity to connect with others and to access one's internal resources (Lieberman and Amaya-Jackson 2005; Lieberman and Van Horn 2008). Charlene had never been in therapy and had had little opportunity to cultivate self-awareness. Her unresolved attachment relationship with her mother and postpartum depression caused her to have difficulty forming trusting, intimate relationships, including with her own daughter. Her feelings of abandonment by her mother put her at risk of repeating this dynamic with Nia. Prior to therapy, she continued in an abusive relationship that reinforced a depressive sense of herself. As the abuse

escalated and then turned into violence, Charlene's relationship with her daughter became impaired as both suffered the effects of the trauma.

The relationship with the clinician facilitated the repair of the trauma and allowed Charlene to strengthen her relationship with her daughter, improving her capacity to protect and nourish her and to become a secure base for her growing explorations, all key goals of child–parent psychotherapy (Busch and Lieberman 2007; Lieberman and Van Horn 2008). By developing a strong attachment relationship with the clinician, Charlene was able to better understand and express her feelings of hurt, disappointment, and anger about her relationship with her mother and to begin to trust another person. Her growing reflective capacity in the context of this relationship allowed her to make meaning of the trauma without it further damaging her relationship with her daughter. This in turn allowed her to develop closer relationships and to return to work.

Although the referral to child protective services was a source of rupture between the pediatrician and Charlene, Charlene later proudly celebrated Nia's weight gain with her, highlighting the importance of the gradual repair of the attachment relationship with her child's doctor, whose referral to CPS may have otherwise caused Charlene to leave the clinic.

When Charlene finally moved out of her mother's home, she did so in order to gain some independence and to create a safer emotional environment to raise Nia. One unintended consequence of the move was that Nia could no longer be seen at the clinic using the state-funded health care plan that required her to get care in her county of residence. Rather than simply referring her to another provider, Nia's pediatrician and the clinician worked together to ensure that Nia could continue to receive services at the clinic and to benefit from the trusted relationships that she had established there. While it remained a source of sadness for Charlene that repair was not possible in her relationship with her own mother, she used her growing internal resources to continue to make positive changes for herself and her daughter.

Recommendations for Practitioners

Families and children who experience trauma stand to benefit from the thoughtful, cross-disciplinary collaboration of medical and mental health providers in unconventional settings such as the community pediatric clinic (Groves and Augustyn 2011). In the case example, the clinic-based treatment and ongoing collaboration with the pediatrician allowed the clinician to support the mother as she navigated the complexities of the relationships between the doctor, her daughter, her extended family, and the CPS social worker. This collaboration helped to preserve the mother's fragile relationship with the pediatrician whose referral to CPS was initially experienced as such a betrayal. Had the patient been seen at another clinic, communication about the patient's care may have faltered, raising the possibility of further CPS intervention.

The co-location of physical and mental health services in community health settings acknowledges the fact that psychological problems are often the greatest barrier

to physical wellbeing. Practitioners of various disciplines hear different stories and hold different aspects of the families they serve. Bringing such differing perspectives together, in coordination of care, benefits families as well as the systems that serve them. Social workers and psychologists seeking innovative ways to engage high-risk families from socio-economically marginalized communities may consider closer collaboration with pediatricians. Pediatricians can also benefit from maintaining a heightened awareness of the impact of trauma on the health and well being of their patients (Burke et al. in press; Groves and Augustyn 2011). The trauma screen developed at BCHC is a useful tool to engage families in a conversation about the emotional and psychological consequences of trauma that put their children at risk for disease later in life. The screen de-stigmatizes the trauma, creating a dialogue about a topic that is often experienced as shameful.

The use of multi-disciplinary rounds is an effective way of mitigating the long-term effects of secondary traumatization and brings clarity to the referral process through direct consultation and the sharing of resources and expertise. The multi-disciplinary rounds process also relieves the pediatrician of the responsibility of delving into traumatic material with the patient. Medical doctors often are reluctant to ask about the emotional impact of trauma for fear of eliciting emotional material for which they have little training about how to respond (Groves and Augustyn 2011). Social workers and psychologists can support the community-based medical community by becoming engaged in forging closer alliances with doctors and nurses and by advocating for the use of a comprehensive trauma screen. Such alliances serve to mitigate the impact of trauma on children's physical, emotional, and psychological development. Trauma–focused interventions such as child–parent psychotherapy increase parents' ability to respond to their children's needs, and are effective in engaging hard to reach families cross-culturally (Lieberman 1990; Lieberman and Van Horn 2008; Gosh Ippen and Lewis 2011). At a time when medical and psychological services are increasingly specialized, this integrative model of cross-disciplinary collaboration provides an effective attachment-based treatment for children and families affected by trauma while strengthening our ability to support and learn from each other.

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