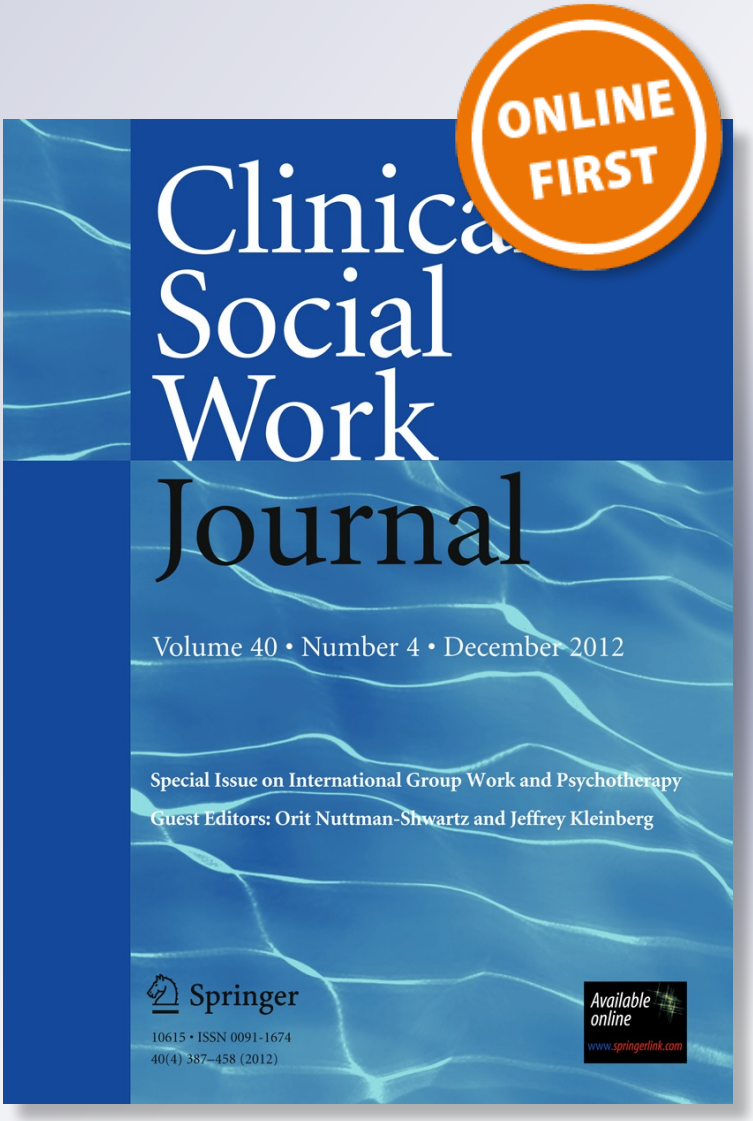
FamilyLive: Parental Skill Building for Caregivers with Interpersonal Trauma Exposures

Sarah Gardner, Teresa Loya & Corine Hyman

Clinical Social Work Journal

ISSN 0091-1674

Clin Soc Work J
DOI 10.1007/s10615-012-0428-8



Springer

Clin Soc Work J
DOI 10.1007/s10615-012-0428-8

ORIGINAL PAPER

FamilyLive: Parental Skill Building for Caregivers with Interpersonal Trauma Exposures

Sarah Gardner · Teresa Loya · Corine Hyman

Abstract Mental health treatments for emotionally traumatized children incorporate family and caregiver-child therapy sessions to promote child recovery and minimize developmental disruption. Such sessions require that caregivers regulate their emotions to remain productively engaged in the therapeutic process. However, caregivers with histories of unresolved interpersonal trauma have difficulty with emotional regulation. Interpersonal trauma also negatively affects the ability to reflect on one's own and others' feelings and intentions. This limitation interferes with caregiver engagement in psychotherapy relationships aimed at supporting child trauma work. FamilyLive is an innovative caregiver-focused family therapy model that uses a one-way mirror, a specially trained reflecting team, structured routines and individualized verbalizations to address this complex clinical phenomenon. Guided by the literature on attachment and trauma, FamilyLive has yielded anecdotal successes and positive pilot results. FamilyLive is a viable approach to engaging caregivers with histories of interpersonal trauma in trauma-focused child and family therapy relationships.

Keywords Trauma · Interpersonal trauma · Engagement strategies · Reflecting team · Caregiver skills

S. Gardner (✉) · T. Loya
The Family Center at Kennedy Krieger Institute,
1750 E Fairmount Ave, Baltimore, MD 21231, USA
e-mail: gardner@kennedykrieger.org

C. Hyman
Maryland General Hospital, Outpatient Behavioral Health Center, 827 Linden Avenue, Baltimore, MD 21201, USA

Introduction

Treating emotionally traumatized children within their primary caregiving systems produces more lasting child and family level benefits and for this reason, family and caregiver-child therapy sessions are incorporated into evidence based treatment models such as Trauma Focused Behavioral Therapy (TF-CBT) and Alternatives for Families Cognitive Behavioral Therapy (AF-CBT) (Kolko 1996; Cohen et al. 2006). However, these and other trauma treatment models require that the child's caregiver participate in a working therapeutic relationship, accept feedback, manage potentially distressing content, regulate his/her emotions, view the child in reality-based terms and integrate the meaning of experiences adaptively. Unfortunately, for caregivers with unresolved interpersonal trauma exposures, these abilities may be compromised. FamilyLive is an innovative therapy model designed to address this complex clinical phenomenon. Informed by the literature on attachment and trauma and decades of clinical practice, FamilyLive is yielding positive child, caregiver and family changes (reported anecdotally) and increases in individual and family strengths on the Behavioral and Emotional Rating Scale, (BERS) Second Edition (Buckley and Epstein 2004) as measured in our ongoing pilot study (Gardner and Belcher 2012). [National Child Traumatic Stress Network Quality Improvement Initiative Database]. Unpublished raw data.

FamilyLive addresses the frequent complaint in clinical settings that families led by caregivers with their own histories of interpersonal trauma do not respond well to traditional engagement strategies and progress is slow or not sustained. Psychological barriers to constructive caregiver involvement in and progress through child trauma treatment include the following: poor adult self-regulation,

Published online: 06 January 2013

unstable interpersonal relationships, disorganization in daily life and family patterns, negative caregiver attributions towards the child, lack of confidence in ability to positively affect child's behavior and lack of capacity to form and sustain a recovery-oriented narrative (Collins et al. 2010). Van der Kolk et al. provide some underlying reasons why traditional treatment may not work with families led by women caregivers who have experienced interpersonal trauma. Women caregivers who have experienced interpersonal trauma, including problems accepting criticism, managing others' viewpoints, being assertive and maintaining work and personal relationships (van der Kolk et al. 1996). Given the discomfort experienced when negotiating relationships in general, some adult survivors of interpersonal trauma may find the working alliance required by a standard family therapy intolerable. This can lead to problems with getting services started, early drop-out or insufficient follow through on recommendations for change, leading to concerns about child safety and welfare. FamilyLive places priority on establishing and maintaining therapeutic engagement with caregiving adults (biological, foster, therapeutic foster care and kinship) with significant difficulty participating in helping relationships stemming from interpersonal trauma exposures.

FamilyLive originated as a response to difficult to engage families presenting for services in the outpatient mental health clinic at The Family Center at Kennedy Krieger Institute in Baltimore, Maryland. The Family Center provides mental health evaluation and treatment services to children traumatized by exposures to sexual and physical maltreatment, neglect, domestic and/or community violence. Although every family's story is different, a multigenerational history of failed protection and disrupted attachment may contribute to children being removed from their families and difficulties with reunification. To address these patterns, a team of Family Center clinicians combined principles of structural family therapy with object relations theory to create The Developmental Interactional Model (Strieder et al. 1994). In the decades since, Family Center staff created FamilyLive by incorporating specialized engagement strategies, a narrative approach to producing change (Freedman and Combs 1996), a non-pathologizing stance and a strict adherence to strengths-based and skill-oriented interventions. These additions are consistent with the SAMHSA-funded National Center for Trauma Informed Care's (http://www.samhsa.gov/nctic/) definition of trauma-focused services.

In recent years, the traumatic stress literature has focused increasingly on the negative implications of interpersonal or relational trauma, defined by various authors as a type of psychological trauma involving interpersonal loss within significant caregiving relationships (Briere and Spinazzola 2005). Interpersonal trauma has negative implications for individual development in several domains including regulating emotions, maintaining stable self-concept, trusting others, and attributing meaning to events in a coherent and adaptive manner (Briere and Spinazzola 2005). Interpersonal trauma can also interfere with an individual's capacity for "mentalizing," which is defined as thinking and feeling with compassion about one's own and others' thoughts and feelings (Fonagy et al. 2002). This capacity is seen as crucial to one's ability to regulate affect (Fonagy and Target 2005; Fonagy et al. 1995). Based on the concept of mentalizing, "reflective function" is understanding behavior in light of underlying mental states and intentions (Slade 2005). "Parental Reflective Function" is defined as the parent's capacity to hold the child's mental states in mind, even in the face of strong emotions (Slade 2005). Mentalizing and reflective function are essential to effective parenting which calls for the ability to reflect on one's own and one's children's responses in a way that promotes consistent, nurturing and safe interactions (Fonagy et al. 1991). Deficits in capacities for mentalizing and reflective function limit an individual's ability to carry out parenting tasks, help children learning to manage emotions and benefit from psychotherapy relationships focused on child or on family problems. Typically, caregivers with histories of interpersonal trauma are most challenged in interactions with adults and children that remind them of times they felt devalued or unsafe. This sensitivity can undermine treatment when it leads to treatment drop-out or major derailments in the process. To protect engagement, FamilyLive focuses on caregiver well-being during sessions through focusing on physical and emotional safety and comfort, maintaining clear boundaries and careful attunement. Further, FamilyLive places priority on the caregiver's health and mental health status and monitoring sources of social support. This clinical activity is captured in the "Engagement" circle surrounding the developmental ladder framework in Fig. 1. Over time, caregivers recognize that traumatizing experiences and relationships account for some of their problems managing themselves and their families. With this recognition come a decrease in self-blaming, an increase in consistent self-care behavior and the ability to coherently articulate the impact of bad experiences on present day functioning. This gradual improvement is represented through the vertical shapes ("Caregiver Attachment Narrative") framing the ladder rungs in Fig. 1.

Following the developmental progression showed on the ladder in Fig. 1, FamilyLive helps caregivers build the five capacities which underlie "Parental Reflective Function." The capacities are: Awareness of Self, Affect Management, Emotional Perspective Taking, Interpersonal Relationship Skills and Personal Reflective Function. Each session can be rated in terms of which level of functioning the caregiver demonstrated the most consistently. Each individual

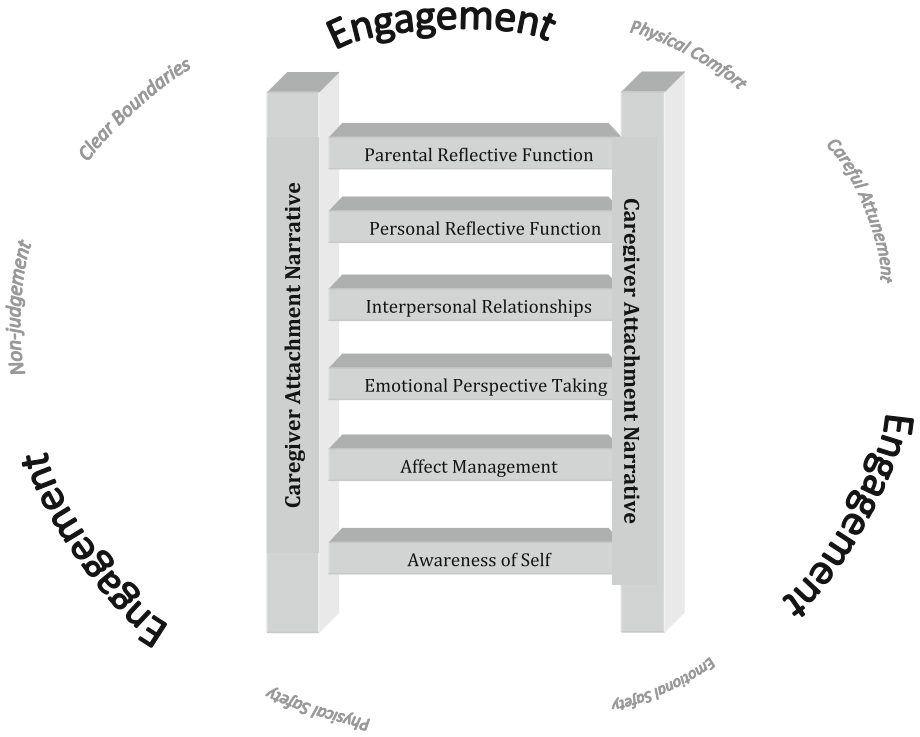


Fig. 1 FamilyLive develpomental ladder

skill can be rated on the following scale: not present, needs development, emerging, conditionally present or consistently present. Caregivers practice and rate themselves on new skills during sessions and report on their successes using them outside of treatment. In times of stress, caregivers may lose ground on a previously mastered skill or revert back to an earlier skill level on the ladder. As the treatment progresses, these setbacks are shorter in duration and caregivers learn to minimize their impact on parenting. At the beginning of FamilyLive, the primary focus is basic caregiver functioning (Awareness of Self and Affect Management) and as those skills develop, sessions concentrate on parent child or family therapy goals and ultimately child-focused trauma work.

Families find out about FamilyLive through the child and family's current treating clinician who uses a standard script to explain the purpose and mechanics of the model prior to the making the referral. The script is written simply and can be given to families as a hand-out. The script explains that "we have a special service" which has "helped a lot of families faster than regular sessions." The script describes the meeting room, the one-way mirror, the Team, the call-ins and the video recording, indicating that the latter is optional. The script takes a collaborative tone and emphasizes that the Team is "interested in hearing what parents have to say about how things are going." The model requires that families have no less than three months of non-progress in child or family focused mental health services and that caregivers attend every session. The physical set up for FamilyLive consists of two rooms connected by a one-way mirror. The "treatment room" is brightly lit and includes a telephone on a small table, comfortable chairs, a large clock and a microphone installed in the ceiling for transmitting sound. When facing the one-way mirror, individuals on the brightly lit side of the mirror see themselves reflected back and cannot see into the darkened room. The darkened room connected to the treatment room is the "observation room" and contains chairs, a telephone and audio-visual equipment. Recording equipment is not essential but at a minimum, the space should include audio transmission equipment. Video recording of sessions is only done with explicit written permission from the caregivers.

Following a standard format for every first FamilyLive session, the treating clinician (hereafter referred to as the "In-Room Clinician") explains the physical set up to the family and what to expect during the session. This includes an explanation about the one-way mirror, the Team behind the mirror and the Team's telephone calls. The In-Room Clinician explains that the team will communicate through telephone calls directly into the session to ask questions or offer suggestions which he or she will then pass on to the family immediately. These calls are referred to as "call-ins" or "verbalizations." The family is given the opportunity to meet the Team during the first few minutes of the first session, at the end of the first session or not at all. If the family chooses to meet the Team, all team members walk into the "treatment room" and introduce themselves to all

the family members, beginning with the caregiving adults. The Team Lead explains that the word "team" is useful because it is plural and gender-neutral, indicates that he or she will always be present for scheduled sessions and that any changes to team membership after the first session will be made known to the family at the beginning of subsequent sessions. Whether or not the family chooses to meet the Team, team members will enter the session unobtrusively whenever necessary to deliver tissue, snacks, hot beverages and materials for particular activities.

FamilyLive Components

FamilyLive's key components (see Fig. 2) are the In-Room Clinician, the Team Lead, the One-Way Mirror and Verbalizations, whose purposes are described in the following section.

In-Room Clinician

The In-Room Clinician makes the initial referral to FamilyLive, describes the model to the family and handles all communication related to scheduling. The In-Room Clinician also documents all sessions in the child's medical record, makes referrals to other services as needed and informs the team between sessions about significant happenings, especially related to any risk. For all FamilyLive sessions, the In-Room Clinician escorts the family to and from the treatment room and provides the immediate emotional connection with the family. This includes engaging in all communication related to social norms (small talk), drawing attention to important information the Team may not have, relaying call ins from the Team to the family and asking follow up questions to help the family expand on responses to the Team's questions or suggestions. The In-Room Clinician does not provide his or her own opinions or interpretations to the family, evaluate positively or negatively the Team's call ins, establish the direction of the session or align with or against the Team. This neutrality corrects any bad feelings that may have developed between the In-Room Clinician and the caregiver, prior to the start of FamilyLive sessions. Typically, In-Room Clinicians experience a sense of relief that they are no longer alone in their more challenging clinical relationships. To maintain clarity about boundaries and to avoid potential splitting of the In-Room Clinician and Team members, the In-Room Clinician shares all between session communications with the Team and invokes the Team e.g., "The Team will be interested to hear your update about that…" or "It sounds like a good thing to discuss with the Team in the next Team session."

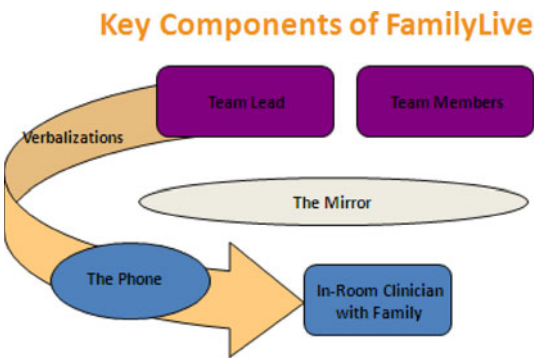


Fig. 2 Key components of FamilyLive

The Team Lead

The Team is led by a specially trained mental health professional, responsible for observing and keeping notes on each session in order to monitor the status of the family's engagement, progress towards treatment goals, current themes and risk. The Team Lead uses the telephone throughout the session, to provide the In-Room Clinician with verbalizations that are in sync with the caregiver's demonstrated functioning on the FamilyLive developmental ladder framework. These calls can also include supportive feedback to the In-Room Clinician, especially when the material and interactions are challenging. The Team Lead's major priority at the beginning of FamilyLive is to establish engagement and during the course of treatment, to address any potential ruptures in the therapeutic alliance. The Team Lead is responsible for generating questions that help the caregiver continue to move through the developmental steps towards Parental Reflective Function, which may at times include presenting a supportively worded challenge or observation. In addition to calling in with questions and affirming comments, the Team Lead uses play materials, hand written notes and paper and pencil tasks to facilitate the family's work on a particular topic. The Team Lead also assigns and follows through on homework assignments week to week. To maintain engagement when there has been a planned or unplanned lapse in sessions, the Team Lead arranges for between session check-in calls or sends hand written notes. Finally, the Team Lead maintains a disciplined practice of meeting with the In-Room Clinician before and after each session. This allows the In-Room Clinician to share any "between session updates" and comment on the experience of being in the treatment room with the family.

The One-Way Mirror

The one-way mirror establishes physical distance between the family and the Team, allowing the caregiver to take a chance on a relationship that might otherwise be too threatening if his or her early life did not include

reasonable adult-to-child interpersonal boundaries. The physical distance is offset by frequent back and forth verbal communication from the Team to the family through the In-Room Clinician, which demonstrates that the Team is extremely attentive to what is happening in the treatment room. This combination, separate but faithfully in contact, interrupts and corrects the poor social cueing and response patterns that the caregiver has previously experienced in significant relationships and maybe even in previous treatment (van der Kolk et al. 1996).

An understanding of the role played by physical reflection can be found in attachment and psychoanalytic studies, which assert the importance of mirroring in the development of basic human capacities including a sense of self (Lichtenberg 2003; Mahler et al. 1975). In FamilyLive, the Team becomes the primary focus of the caregiver's expectations and reactions. When looking towards the mirror in response to or anticipation of the Team's questions and comments, the caregiver sees his or her own image reflected back. This allows the caregiver to remain focused on his/her own experiences rather than becoming emotionally distracted. By reducing the interpersonal stimulation that could interfere with the therapeutic benefits of the experience, FamilyLive's specialized treatment setting supports an increase in the caregiver's capacity for self-observation, self-versus-other recognition, managing emotions and staying focused on the present reality (Madanes 1984). It is important to note that FamilyLive is not recommended for caregiving adults with active substance abuse problems or symptoms of psychosis. However, caregivers in recovery have demonstrated improved individual and parental functioning through FamilyLive.

Verbalizations

The primary treatment intervention in FamilyLive comes from Team Lead call-ins or verbalizations. Families adapt quickly to the routine of telephone interruptions and begin to positively anticipate the Team's messages. Sometimes these call-ins are timed to create deliberate interruptions meant to shift the focus, restore focus or create an opportunity for calming down if emotions are running high. The separation of the Team from the family allows the Team Lead to reflect about what is going on in the treatment room with less direct affective involvement. This is important because a caregiver's limited capacity to mentalize has negative implications for perceiving therapeutic relationships as helpful. According to Bateman and Fonagy (2008a), in the absence of the capacity to mentalize, the caregiver will find his or her own failures and those of the clinician to be unacceptable which may lead to a derailment of the treatment process. Bateman and Fonagy (2003) point out that in such situations, "Therapists need to retain their own abilities to mentalize, i.e., maintain mental closeness, focus on current mental states, and avoid excessive use of conflict interpretation and metaphor while paying careful attention to the use of transference" (p. 187). This can be very difficult to achieve in traditional treatment relationships, especially when clients are demonstrating lack of connection to the treatment process and don't seem to be making progress. In FamilyLive, the Team maintains a highly explicit form of reflective function, noticing subtle reactions to verbalizations and correcting misunderstandings throughout every session.

The Team responds to the caregiver's verbal and nonverbal communications with a degree of attentiveness similar to that which caregivers provide when caring for infants. According to Bateman and Fonagy (2008b), this style of reflecting is critical to providing a therapeutic response to adults with histories of interpersonal trauma because it helps them develop a more accurate and consistent awareness of their own affective responses. Specifically, the Team Lead provides "marked and contingent" reflections of the caregiver's experience. In infant social development, a caregiver generally responds to an infant's expression of feeling through verbal or facial feedback that is "marked," which indicates that the caregiver is acknowledging the infant's expression rather than expressing her own feeling. "Contingent" caregiver responses occur immediately following the infant's communication and therefore connect cause to effect within the relationship. According to Gergely and Unoka (2008), lack of marked and contingent mirroring by a caregiver interferes with development of the infant's capacities to regulate and ultimately name affect states.

More study is needed to understand the transmission of negative effects stemming from the caregiver's childhood interpersonal trauma exposures to his or her own children. A recent review of the literature found studies exploring child emotional and behavioral symptoms connected with various caregiver profiles including maternal depression, current exposure to intimate partner physical and sexual violence but a paucity of information about the mechanisms by which a caregiver's childhood interpersonal trauma exposures translate into child outcomes. Chu and DePrince (2006) found that children with betrayal trauma experiences had mothers who experienced higher rates of betrayal trauma. They noted that more research was needed to understand how a mother's dissociative symptoms may have contributed to a relational context in which child betrayal trauma was more likely to happen. Their work is important because it attempts to address the contributions of parental dissociation and parenting practices in the child's failure to learn to integrate states.

Clinicians working with caregivers with histories of unresolved interpersonal trauma often find that their clients

have difficulty maintaining focus on identified treatment goals. Chaotic and affect laden interactions during sessions or crises outside of sessions become focal, making it hard to achieve momentum towards change. Sometimes, families present with so much information, it is difficult for the clinician to understand what deserves priority attention. To address this, FamilyLive uses clear and predictable routines to provide organization and emotional containment. Greetings, farewells, scheduling, routine updating and shifts in the topics of discussion follow structured protocols. Caregivers are supported to make intentional decisions about everything from who should be in the room to how long to spend on a particular topic. As families progress through FamilyLive, they internalize the routines and start to demonstrate more volition about participating in the therapy and using the time constructively. Families also develop positive communication routines at home by setting aside time for important conversations.

Progress in the Model

FamilyLive combines the In-Room Clinician, "the Team," the one-way mirror and individualized verbalizations with structured routines to help the caregiver build the skills that underlie parental reflective functioning. Although movement through the model is based on skill mastery rather than a specific number of sessions, a typical length of treatment is nine months with an average of three sessions per month. The first step is Awareness of Self, which is defined as caregiver demonstrating that he/she thinks of him/herself as a person separate from others, attending to his/her own basic needs. Grienenberger et al. (2005) proposed the common existence of "limitations of reflectiveness that leave the caregiver unable to differentiate her own affects from those of her child." Moments or experiences in which a caregiver fails to differentiate her own emotions from those of her child are often distorted, may lead to misattributions, and otherwise mis-attuned responses to the child's distress. To address these limitations, the Team shows interest in the caregiver's own experience at a very basic level. The Team begins each session by inquiring about the experience of getting to the clinic that day and may call in about the caregiver's physical comfort in the room. Caregivers at this stage of development have often not been encouraged to consider themselves as separate people and to reflect on, acknowledge or attend to their own experiences. Further, they may blame their lack of self-care on their children. In one situation, the parent said of her children, "they are killing me slowly" and with further inquiry, the team learned that she was not eating, sleeping or drinking enough and her kids were concerned about this to the point of believing she would die.

Progress in this stage begins with the caregiver being willing to reflect on his or her own experience of everyday events and acknowledge his or her own needs. Soon, the caregiver begins to demonstrate internal awareness of his or her own experience and reactions by volunteering information about physical and emotional health as well as self-care efforts. As evidence of progress, the same parent began reporting weekly on her self-care patterns without direct prompting by the team saying, "I know you are gonna ask about my stress" and volunteering precise details about her sleeping, eating and fluid intake. In response to signs of progress, the Team provides specific affirmation during the session for health steps being taken by the caregiver between sessions.

In Affect Management, the Team works not only to provide affect containment in the session, but to raise the caregiver's awareness of his or her own emotional reactions and the effect of these reactions on others. The goal is for the caregiver to express a full range of emotions appropriate to the situation in a way that is physically and emotionally safe for self and others. In one example, a caregiver spoke anxiously about a difficult time over the week. The Team called in, "The Team is wondering what your heart rate is right now." This interruption and question caused the caregiver to take stock of the degree of arousal currently being experienced which allowed her to calm down. As with discussion of good self-care behaviors, caregivers begin to observe and comment on their own emotions in sessions prior to their learning to manage them in their daily environments. The Team reinforces evidence of self-awareness and emotional regulation whenever possible. When necessary, the Team recommends adult psychiatric and mental health services.

In Emotional Perspective Taking, the caregiver is supported to expand his or her own view from undifferentiated perspective taking (confusing his or her own thoughts and feelings with those of others), to third party perspective taking, which allows him or her to view interactions from a more objective perspective (Selman 1975). This includes demonstrating an understanding that another person experiences different emotions in response to the same situation or interaction. Increased skill in perspective taking allows caregivers to reflect on their own role in parent–child interactions and develop more positive attributions about others' intentions, including those of their children. In this stage, the Team might use Socratic questioning to gently expand the caregiver's ability to think critically about a difficult situation. In one situation, a caregiver felt unheard by community systems. She requested a meeting with the school and then later learned that the meeting was held without her. The Team asked the caregiver to "generate two guesses about how the school made the decision to hold the meeting before she arrived." The language in the

verbalization suggested to the caregiver that there might be an explanation other than the school's desire to keep her out of the process. Even if it turned out that there was an active effort to exclude, being able to perceive an alternative intent allowed the caregiver to think more flexibly about how to respond to the situation.

Work on Interpersonal Skills focuses on learning to communicate one's expectations of others, hold others accountable for their actions, initiate conversations regarding conflicts in safe and effective ways, set clear boundaries and seek support and guidance from an expanding social circle. Early work on interpersonal skills occurs during sessions through active coaching and reinforcement. As the work progresses, the demands for interpersonal skill improvement in personal relationships, especially intimate ones, may lag and require additional support and coaching from the team. For one caregiver, this meant learning to set limits on when she would respond to text messages from her partner. As caregivers practice new skills in daily life, they report more success with being heard by service providers in various settings. This does not always mean immediate "success" when advocating for particular services, but it can mean feeling more competent and confident about navigating voice mail systems and accessing supervisors when necessary. Once caregivers are consistently functioning well in interpersonal relationships, they report getting more out of social and other helping relationships.

Personal Reflective Function is the ability to identify one's thoughts, feelings and behaviors as separate and distinct from the thoughts, feelings and behaviors of others, while considering the interplay between the two. Initially, the caregiver's attempts in this area may be tentative or inaccurate. The team's role is to encourage the caregiver to reflect on experiences and provide affirmation when appropriate. Early work on this skill may involve giving the caregiver in session opportunities to slow down and study interactions as they occur. As caregivers develop this skill, they begin to spontaneously report on situations outside of sessions in which they felt more in control and successful because they stayed clear about which reactions were their own and which were not. With increasing confidence about reflecting on self in non parenting relationships, caregivers being to apply new skills to interactions with their children.

Caregivers demonstrate Parental Reflective Function when they provide "marked" (clearly coming from the caregiver) and "contingent" (occurring immediately in time) responses to the child's expressions and behaviors. Early evidence of Parental Reflective Function includes an increase in benign or positive interactions between the caregiver and child. Next, the caregiver learns to acknowledge his or her role in both positive and negative interactions with the child and initiates discussion of relevant topics with the child in a thoughtful and attuned manner. Notably, as skills develop in this area, caregivers become more adept managing their own affective responses which allows them to set and maintain limits with compassion.

In some families, child symptoms that were the impetus for the original referral for trauma-focused treatment abate when the caregiver demonstrates improved emotional regulation and consistent Parental Reflective Function. This happens because the caregiver is better able interpret and handle the child's behavior on a daily basis without becoming upset and may therefore elect to end FamilyLive sessions and all other therapies at our clinic. For other families, the child's entrenched symptoms of hypo or hyper arousal continue to interfere with functioning in various settings and the caregiver elects to participate in further child and/or family treatment. In those instances, the FamilyLive sessions come to a successful end and the caregiver and child are referred to a model that can address the child's individual emotional and behavioral symptoms more directly, with the caregiver as a productive partner in the treatment.

Building Parental Reflective Function: A Case Study

TL is a 6 year old girl whose biological mother was offered FamilyLive services as a last resort arrangement between the our clinic and the local Department of Social Services (DSS), who sought termination of TL's mother's parental rights for substantiated physical abuse. TL's mother had a history of explosive and threatening interactions with professionals in numerous systems. The FamilyLive Team used a non-blaming approach to helping TL's mother recognize her strong emotions. By maintaining overarching reflective function, the team resisted becoming punitive towards TL's mother and identified her strengths. As TL's mother developed skills in affect regulation, interpersonal communication, perspective taking and personal reflective functioning, she began taking more responsibility for own actions, including those related to the removal of her children. She advocated with DSS for the return of TL and her infant brother and elected to continue FamilyLive sessions after reunification. At that point, TL stopped meeting with her individual therapist and began attending weekly FamilyLive sessions which her parents (separated but working towards reconciliation) used to improve their co-parenting skills. When TL joined sessions, the Team provided coaching to support positive parent–child interactions and good teamwork.

TL's mother soon began making connections between present day difficulties and her own abusive upbringing, which included years in foster care. She did this in partnership with her husband who also had a difficult childhood but still remained connected to his family. As evidence of Parental Reflective functioning, TL's mother started generating empathic explanations for her children's

behavior that were connected to her interactions with them and became more open to feedback from significant others about her parenting.

Addressing Caregiver's Ambivalence about Raising Child: A Case Study

During FamilyLive sessions, the Team simultaneously monitors progress on the developmental steps as well as how the caregiver is doing with family organization, protection, boundaries, roles and communication. This is necessary because the daily requirements of raising children continue and impact the caregiver's availability to the treatment relationship. The need for this dual focus was demonstrated in the treatment of a seven year-old boy BW whose guardian and primary caregiver was his 70 year-old great aunt. At the time of referral, the caregiver presented as feeling victimized by family members, both historically and in the present, including BW. She consistently attributed malicious intent to BW's actions, placing a lot of pressure on the Team to fix his moral failings and resolve his behavior. BW presented as developmentally delayed in the social, emotional and educational realms with disorganized and bizarre thinking.

In the early stages of treatment, the team addressed the caregiver's basic self-care through questions about her health, diet and various illnesses. These discussions allowed the Team to notice the caregiver's ambivalence about her long-standing role as the only competent caretaker in the family. The Team suspected that her feelings about being burdened her entire life caused occasional lapses in her emotional and physical protection of the child. In response to questions from the team about her history caring for others, the caregiver shared that from the age of 10, she functioned as a caretaker in her family of origin. Through carefully paced discussions about the caregiver's view of the child, the Team addressed the caregiver's limited capacity for effective Emotional Perspective Taking, and over time, the caregiver was able to develop more useful and appropriate attributions. In talking about his leaving his toys on the floor where she might trip on them, she said, "but he can't be expected to pick up everything on his own. He's just a little boy." The team positively reinforced her heightened understanding of his intentions and capacities.

In the next session, the caregiver reported a recent experience involving a health event during the night that caused her to feel extremely vulnerable. With a lot of feeling, she reflected on BW's actions during the night as follows, "He couldn't….wouldn't, wake up and help me." In her time of distress, the caregiver initially reverted to an old and unrealistic pattern of thinking based on the disappointed expectation that she would receive the care she needed. With gentle encouragement from the Team, the caregiver shared a story of early sexual maltreatment involving suffocation in her room at night. She had not previously discussed this incident nor connected it to her present day situation. The following week, she corrected her unrealistic thinking and noted that her 7-year-old shouldn't be held responsible for monitoring her breathing at night.

In the sessions that followed, the great aunt continued to focus on her ambivalence about raising a child with special needs, given her age and health limitations. With support through the Team's verbalizations, she also confronted her resentment towards her niece for failing to meet her parenting responsibilities. This was difficult to acknowledge since a major source of the great aunt's sense of identity was her caregiving skill. The Team began to suspect that her investment in her role as the family caregiver might interfere with considering an alternative placement for the child even while at times, providing insufficient care. Team continued to support her self-care efforts while considering the long-term needs of the child. Ultimately, she decided it was in his best interests to be placed with her adult son and daughter-in-law who had previously demonstrated an interest in him and had successfully raised other children. Once she made this decision, she arranged for the legal transfer of custody, took steps to engage the child's new caregivers in his various services and finished with FamilyLive. Going forward, the in room clinician held regular therapy sessions in her office with the child and his new caregivers with the goal of supporting his adjustment.

Discussion

In this article, we described the negative effects of caregiver histories of interpersonal trauma on the underlying skills required to engage in and benefit from child-focused mental health services. We introduced FamilyLive, an innovative practice designed in response to the needs of children and families served in the outpatient program at the Family Center at Kennedy Krieger Institute in Baltimore, Maryland. We articulated the relevant contributions from the literature on attachment and trauma to provide theoretical support for the model and the developmental ladder (Fig. 1) used to describe current caregiving functioning. We described FamilyLive's specialized treatment environment and key components: the In-Room Clinician, the Team and the one-way mirror. These elements form a developmentally sensitive and strengths-based model for helping caregivers engage as constructive participants in child trauma treatment.

We look forward to describing in detail our current research study and outcomes in future publications. Our findings to date suggest that FamilyLive has particular

relevance in child welfare populations because of its emphasis on carefully engaging caregivers in family treatment, leading to improved outcomes. To deepen our investigation, we will study engagement-oriented verbalizations and develop practice tools for child serving professionals. We will also study the rungs on the developmental ladder to create an assessment instrument that will promote realistic service planning in child serving settings. In the next several years, we will continue to work with families in Baltimore, Maryland while developing more time and cost effective methods for training clinicians in other settings, both locally and nationally. These activities will allow us to reach more families, strengthen the empirical evidence for the model's benefits and build our understanding of the transmission of interpersonal trauma effects from caregivers to children. We remain committed to refining the model and making it more portable to help families reduce the impact of interpersonal trauma histories on primary relationships over time.

Acknowledgments Supported by The Substance Abuse and Mental Health Administration (SAMHSA) through the National Child Traumatic Stress Network (NCTSN).

References

Bateman, A. W., & Fonagy, P. (2003). The development of an attachment-based treatment program for borderline personality disorder. *Bulletin of the Menninger Clinic, 67*(3), 187–211.

Bateman, A. W., & Fonagy, P. (2008a). Mentalization-based treatment for BPD. *Social Work in Mental Health, 6*(1/2), 187–201.

Bateman, A. W., & Fonagy, P. (2008b). *Mentalizing in clinical practice*. Arlington: American Psychiatric Publishing.

Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress, 18*, 401–412.

Buckley, J., & Epstein, M. (2004). The Behavioral and Emotional Rating Scale—2 (BERS—2): Providing a comprehensive approach to strength-based assessment. *The California School Psychologist, 9*, 21–27.

Chu, A., & DePrince, A. (2006). Development of dissociation: Examining the relationship between parenting, maternal trauma and child dissociation. *Journal of Trauma and Dissociation, 7*(4), 75–89.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.

Collins, K., Connors, K., Davis, S., Donohue, A., Gardner, S., Goldblatt, E., et al. (2010). *Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions.* Baltimore, MD: Family Informed Trauma Treatment Center. http://fittcenter.umaryland.edu/TheModel.aspx.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Books.

Fonagy, P., Steele, H., Moran, G., Steele, M., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal, 13*, 200–217.

Fonagy, P., Steele, M., Steele, H., Leigh, T., Kennedy, R., Mattoon, G., et al. (1995). Attachment, the reflective self, and borderline states: The predictive specificity of the adult attachment interview and pathological emotional development. In S. Goldberg, R. Muir, J. Kerr, S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 233–278). Hillsdale, NJ: Analytic Press, Inc.

Fonagy, P., & Target, M. (2005). Bridging the transmission gap: An end to an important mystery of attachment research. *Attachment and Human Development, 7*(3), 333–343.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton.

Gardner, S., & Belcher, H. (2012). [National child traumatic stress network quality improvement initiative database]. Unpublished raw data.

Gergely, G., & Unoka, Z. (2008). Attachment, affect-regulation, and mentalization: The developmental origins of the representational affective self. In C. Sharp, P. Fonagy, I. Goodyer, C. Sharp, P. Fonagy, & I. Goodyer (Eds.), *Social cognition and developmental psychopathology* (pp. 305–342). New York, NY: Oxford University Press. (Retrieved from EBSCO*host*).

Grienenberger, J., Kelly, K., & Slade, A. (2005). Maternal reflective functioning, mother-infant affective communication, and infant attachment: Exploring the link between mental states and observed caregiving behavior in the intergenerational transmission of attachment. *Attachment & Human Development, 7*(3), 299–311. doi:10.1080/14616730500245963.

Kolko, D. J. (1996). Individual cognitive-behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1*, 322–342.

Lichtenberg, J. D. (2003). Communication in infancy. *Psychoanalytic Inquiry, 23*, 498–520.

Madanes, C. (1984). *Behind the one-way mirror, advances in the practice of strategic therapy*. Need City: Jossey-Bass Publishers.

Mahler, M., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant symbiosis and individuation*. New York: Basic Books.

Selman, R. (1975). Level of social perspective taking and the development of empathy in children: Speculations from a social-cognitive viewpoint. *Journal of Moral Education, 5*(1), 35–43.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development, 7*(3), 269–281. doi: 10.1080/14616730500245906.

Strieder, F. H., Gallagher, M., & Gardner, S. (1994). *Family therapy: A developmental interactional approach*. Baltimore, MD: Maryland Family and Children's Services.

van der Kolk, B. A., Pelcovitz, D., Roth, S., & Mandel, F. S. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaption to trauma. *The American Journal of Psychiatry, 153*(Suppl), 83–93.

Author Biographies

Sarah Gardner is a seasoned clinician and administrator with expertise in the impact of intergenerational trauma patterns on family functioning.

Teresa Loya is an experienced clinician trained in FamilyLive and Parent Child Interactional Therapy (PCIT).

Corine Hyman provides psychological testing and trauma treatment services to adults and children.