



WASHBURN
CENTER FOR CHILDREN



DEVELOPMENTAL REPAIR: A Training Manual

*An Intensive Treatment Model for Working with
Young Children Who Have Experienced Complex Trauma and
Present with Aggressive and Disruptive Symptoms*

by Anne Gearity, PhD, LICSW

Acknowledgements

This manual reflects the work of many people over many years. Anne Gearity PhD, LICSW, the author of this manual, has been the theoretical and clinical leader of this effort over the last decade. Dr. Gearity's consultation and training at Washburn Center for Children has provided the conceptual basis for a different understanding of the young children who are often treated in Day Treatment Programs. Her influence on how treatment is done at Washburn and on the children and families served has been enormous.

This project was also supported by Tom Steinmetz, M.A., Program Director, and by Arlene Schatz, LICSW, Clinical Director. The daily implementation and supervision of the program has been led by Lauren Nietz, LICSW, Washburn's Day Treatment Program Supervisor, and Willie Winston, PhD, and Lawrence Foley PhD, the program's previous supervisors. In addition, the tireless work of the day treatment staff and interns was critical as these staff had to learn a new model while it was being developed and refined and then implemented it with challenging young children and their families.

This project would not have happened without the multi year funding from the Archibald Bush Foundation that supported the development of the program model and the evaluation design. Jane Kretzman, program officer at the Bush Foundation, was an enormous resource; supporting and strengthening this work as the project evolved. In addition sustained grant support from the McKnight Foundation, the Cargill Foundation, the General Mills Foundation and Allianz enabled the model to be implemented when traditional payments for treatment were not adequate. United Behavioral Health, Blue Cross Blue Shield and Hennepin County provided additional support as payers.

Trisha Beuhring PhD, of the University of Minnesota's Institute on Community Integration, was the evaluator of this project and was an integral part of the team that developed the evaluation framework and design for this effort. Yvonne Pearson edited early drafts of this manual and Lora Joshi, president of Aajo Design, did the creative design.

National Advisory Council members Stuart Hauser MD, Joseph Spinazzola PhD, Dee Wilson PhD, and Leslie Koplou MS, CSW, helped shape the work of this project. Local Advisory Council members Glenace Edwald PhD, PsyD, LP, Mark Sander PhD, LP, Kristine Martin MSW, LICSW, Jim Baxter PhD, CPHQ, CBHE, and Matt Eastwood PhD, MPA, LP, LMFT added significant value as the project developed.

This treatment model was implemented at Washburn Center for Children, a 125 year old children's mental health agency in Minneapolis, Minnesota. The challenges of implementing and evaluating new research and new models in a community setting are many. The Board of Trustees of Washburn Center for Children recognized the importance of this effort and supported the organizational and financial framework which enabled this project to happen.

Finally, a special thank you to the hundreds of children and families who have participated in the day treatment program at Washburn. Their courage, resilience and growth are inspiring and what have motivated this effort over the last ten years.



Steve Lepinski MHA
Executive Director
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Author's Preface

This manual is the work of many creative and dedicated people. While I did the actual writing, the ideas and interventions for Developmental Repair came from collaboration with Washburn staff, and with the children and families who came to us seeking help. These children taught us how their behaviors were their best efforts to manage painful emotional dysregulation. Their families taught us how hard it can be to raise children without positive community support. Washburn staff experienced dysregulation contagion, and then became interested in thinking about these children, and regulation, differently. While Developmental Repair has been designed as a group treatment model for young children, many of these ideas are applicable to children of all ages, in individual and community settings.

Writing a manual is a daunting task: to reduce complex clinical processes into clear instructions that capture the richness of interactions that very at risk children need. I have tried to illustrate this richness in two ways. One is with my use of we: I wrote descriptions of our collective experiences as we conceptualized this repair model. I also provided examples of specific language and actions we used to join children and help them join us.

These children have experienced complex trauma, described as the pervasive negative impact of chronic or repetitive traumatic experiences, including too little adult protection. One child in our program lamented, "I don't want it to be all my fault." These children cannot be blamed or asked to solve their difficulties alone. Developmental Repair is a framework for interventions that help children access new learning and positive community support so they can heal and grow.

In building this model, I was also supported. I am especially grateful to Jane Kretzmann, our grant officer from the Bush Foundation in St. Paul. Jane moved us farther than any of us imagined we could go. This manual was initially her idea. To Stuart Hauser, MD, of Harvard University and Judge Baker Children's Center, who provided invaluable guidance and encouragement until his untimely passing in 2008. This manual honors his conviction that resilience is possible when adults help children. To Tom Steinmetz, who was the first change agent in this program transformation and continues to champion improvement throughout Washburn and in the community. And to Meghan Kimmel whose editing moved my manuscript from confusion to coherence.

To all the professionals at Washburn, and to others in our Minneapolis community who have joined in this effort to build Developmental Repair, this manual is dedicated to you.



Anne Gearity PhD, LICSW

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1 Introduction

- A Paradigm Shift In Working With Very At Risk Children
- Developmental Repair: A New Approach
- Constructing This Manual



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A PARADIGM SHIFT IN WORKING WITH VERY AT RISK CHILDREN

Children with aggressive and disruptive behaviors are coming to community attention at increasingly early ages. They are identified through child welfare, in early education and day care, at entry to kindergarten, in schools and in mental health centers. Many have already been excluded from school, day care and other settings. Their older counterparts disrupt schools and terrorize neighborhoods, despite community efforts to alter this developmental trajectory towards increasing violence and social estrangement.

To label these young children as behaviorally deviant overlooks children's desperate efforts to survive endangering experiences. Their histories of early risk experiences cause them to feel—and act—out of control.

Interventions that use external control to promote change do not generalize to other settings, or inadvertently reinforce power struggles and more behavioral reactivity. Interventions that target family change are effective when family involvement is coupled with consistent community inclusion, but achieving significant change in multi-problem families takes time that rapidly developing young children do not have. These children become very at risk when development is so compromised that aggressive behaviors persist, their families remain ineffective in changing these patterns and they become estranged from the larger social community as a result.

In 1998, the staff at Washburn Center for Children began an extensive process of evaluating the best practices for serving these very at risk children. Washburn, a non-profit community mental health agency in a mid-size city, had served these children for many years but struggled with treatment efficacy, especially as children's symptoms and needs increased. Intervention difficulties corresponded with what other agencies, schools and day care centers in the area and nationally were experiencing. Despite the growing need, there was scant evidence of

interventions that were consistently successful in working with this population. Over this next decade Washburn, with generous funding from the Bush Foundation (St. Paul, MN), has developed, implemented and started to evaluate a new intervention model for young children with aggressive and disruptive behaviors; this model is called Developmental Repair.



Developmental Repair: A New Approach

Developmental Repair is an intervention for young children (ages 3 to 3rd grade) who need intensive early intervention because their aggressive and disruptive behavior is harming themselves and others, and

they have not been able to benefit from usual community resources. Unlike most children, even those with less severe behavioral problems, these very at risk children are unable to make this developmental transition from home to larger community participation.

Developmental Repair shifts how these young children are perceived. Instead of assuming that these young children intend to be aggressive or disruptive, we see how their early development has been compromised by persistent trauma and relational stress. Children's behaviors reveal their efforts to cope with too few resources, including too little adult protection. These very at risk children need intensive and sensitive intervention to alter a maladaptive trajectory towards conduct disorders. They need repair of core developmental capacities that permit more positive adaptation. This intervention must be relational because this developmental learning always relies on interpersonal experiences with caregiving adults. Intervention must help children acquire developmental skills that are normal for their age, such as self-regulation. And it must directly address children's social alienation, lest they become further disconnected from their peers and the larger community.

Developmental Repair frames children's behavioral difficulties as the result of compromised early learning. Self regulation of emotions and behaviors emerges from primary relationship experiences and is at the core of developmental adaptation and a critical component of developmental organization. Children must learn to maintain and regain equilibrium in response to inevitable disruptions and change. The role of adults is to provide supplemental regulatory help, through soothing and guidance, especially when experiences overwhelm or exceed children's developmental abilities to cope. Unlike most children, however, these very at risk children do not expect adults to provide regulatory help. While they may yearn for adult attention, experience tells them that adult involvement adds to their dysregulation. Aggressive behaviors reveal their distress but also serve to approximate self regulation, restoring a sense of control even as their actions cause more problems and distress. They become trapped in patterns of dysregulating behaviors that keep them aroused and alone.

Developmental Repair focuses on changing children's internal functioning, rather than imposing external controls. Repairing the internal capacity for self regulation is at the core of this different intervention approach. Developmental Repair starts with helping children use new adults in a very intentional way—as regulating partners. Related developmental capacities—self awareness, emotion regulation, social reciprocity, and effortful control—are supported by, and contribute to, self regulation. When children become more internally organized and regulated, they can relinquish aggressive behaviors for behaviors that are more self-protecting and connecting to others.

Normal developmental processes provide a template for repair. Developmental Repair is not about returning children to infancy, but about understanding how disruptions in early experiences that support normal social and emotional learning put children at risk. Intervention cannot erase these earlier experiences, but can remediate these interactive skills that are missing or poorly formed. Developmental Repair assumes that these children need another chance to learn.

Providing new relationships that the child can depend upon for developmental support does not replace families. Developmental Repair helps parents attend to their children's immediate developmental needs. However, because many of the parents have had histories similar to their children, they often have similar vulnerabilities. Intervention scaffolds their parenting efforts with encouragement and tangible explanations about interacting in new ways with their children. Intervention works to repair this relationship. When children can function better within their families, and their communities, they contribute to change within the family by reducing parental stress. Ameliorating children's behavioral difficulties in the larger community also relieves a significant social stress for their families. Parents may then generalize their increasing effectiveness to other parts of their lives.



Developmental Repair targets children's ability to join the larger community. Joining the community must assure them that they belong, that they will be included and protected, as well as expected to adhere to rules and norms. While this model has applicability to individual work with very at risk young children, Developmental Repair is organized as a group treatment because these children are already failing in their community settings. Community collaboration is a critical component of this intervention model because these children need concerted and coherent services to help them connect to school learning and community participation even when their families cannot support this.

Constructing This Manual

This manual is organized in six sections.

The **first** describes this population and why these young children and their families challenge existing service approaches. The **second** section presents research that supports the intervention framework, and translates this research into practice applications. The **third** section describes the Developmental Repair Model: what adults do with children that supports repair. The **fourth** section addresses support for families and the **fifth** described support for staff. The **sixth** section provides practical directions for how Developmental Repair operates as a group treatment approach.

This model is not a recipe; rather it is a framework for thoughtful and engaging clinical interactions. This manual includes many examples of how this paradigm shift alters interactions with these children and repairs the developmental capacities that are at the core of their difficult behaviors. While some children may continue to need mental health and academic support throughout their childhood, they will hopefully be able to access these resources within the usual community system of care.

Benefits of early intervention have been clearly documented. To date, few interventions have helped these very at risk young children despite their significant need and the eventually staggering cost to society if they remain aggressive and disruptive. “The overarching question of whether we can intervene successfully in young children’s lives has been answered in the affirmative and should be put to rest. However, interventions that work are rarely simple, inexpensive or easy to implement.”¹ This intervention uses normal development as its primary lens. The cost is embedded in existing community funding and while implementation is challenging it is very possible with committed staff.

Developmental Repair is inspired by, and designed for, these young children who deserve a chance to grow up, find their talents, feel secure in the community and someday raise their own children well.



“The overarching question of whether we can intervene successfully in young children’s lives has been answered in the affirmative and should be put to rest. However, interventions that work are rarely simple, inexpensive or easy to implement.”¹

¹ Shonkoff, J., & Phillips, D. (Eds.), (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

2 Describing At Risk Young Children

- Very At Risk Young Children
- Primary Risk Factors
- Secondary Risk:
Threat Of Community Exclusion
- Intervention Challenges
- The Intervention Challenge



VERY AT RISK YOUNG CHILDREN

These children are young: ages three to eight (3rd grade). They are struggling in community settings, and many have already been suspended or excluded from school or day care. Most have been overtly aggressive towards adults and peers. Many demonstrate poor ability to adhere to the social norms that children of their ages are expected to manage and also struggle with prerequisites for academic learning (such as curiosity, tenacity, flexible attention and early literacy skills).

When these children become distressed, they resort to behaviors to externalize pain, and protect themselves. They look tough and defiant to hide their vulnerabilities: a propensity for intense fear arousal, hyper-reactivity to stress, and chronic anxiety. They perceive and react to danger and harm in situations that are not threatening. They do not look to adults for help. Children become *very at risk* when they experience an accumulation of serious risks, and have developmental difficulties related to these risks that significantly impact their functioning in the community. Characteristics of very at risk young children include:



Confusing Interactions with Adults and Peers

- They expect adults to be harsh or unavailable, and they provoke the reactions they expect.
- They assume their needs will be ignored so they rarely seek or accept adult help.
- They make outrageous and unrealistic demands.
- Requests that ask for compliance usually turn into power struggles.
- Ordinary social expectations threaten them so they wreck social experiences.
- Their play is aggressive or repetitive. They lack imagination and creativity.
- For some, sexual acting out has already become coupled with aggressive behaviors.

Emotional Reactivity

- Their feelings are easily triggered but confused by physical sensations that are called arousal.
- When sad, disappointed or surprised, they react with anger and aggression.
- They show low frustration tolerance so new learning is hard.
- They become easily humiliated by ordinary tasks.
- They react to others emotions with aggressive acts that quickly become out of control.

Distorted Perceptions

- They perceive danger much of the time, and assume they could be hurt.
- They carry grudges and retaliate when they have been hurt, even if the hurt is accidental.
- They misread social cues and often assume retaliatory aggression has occurred when none was intended.
- They don't remember what happened in the past, and they can't think about or explain their own experiences.
- They remember bad times and often distort good times with worries.

Inadequate Skills

- Because they have poor language skills, or don't rely on words, they resort to actions like hitting, kicking, spitting, and swearing.
- Their problem-solving skills are poor, and their solutions usually make things worse.
- They anticipate difficulties, but rarely seem to learn from new experiences.

These children are not usually identified in the community as struggling or unhappy, even though that is the case. Instead they are labeled disruptive and angry. They often defeat adults who try to help.

Because these children seem unpredictably reactive, it is hard for adults and peers to maintain engagement or positive regard. It is easy to assign negative attributions. Teachers and other community adults often describe these children as deliberately mean and manipulative, or intentionally acting badly. However, pushing them away perpetuates their emotional misery and their aggressive reactions.



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Primary Risk Factors

Children become very at risk when they experience an accumulation of serious risk factors that impair normal development and interfere with their adaptive functioning at home and in the community.

These children are described as very at risk when they begin to act out in ways that exacerbate the negative effects of accumulated risk experiences. While risk factors are inevitable in most children's lives, it is the accumulated number and severity of risk factors that put these children at such harm.

The most damaging risk factors include:

- **Disrupted primary care or inadequate care** that compromises children's abilities to become developmentally organized. Organization results from security in parental care, and positive adaptation to developmental tasks and learning. Many very at risk children have early experiences of care that suggest insecure or disorganized attachment patterns as well as ongoing relational damage due to maltreatment.
- **Violence** that shatters safety and security and promotes aggression as an adaptive response to every perceived threat (*get them before they get me*). Domestic violence and physical abuse are common experiences, as are exposures to dangerous traumas (murder, physical threat, sexual assaults). Many children lack protection from violence at home and from their dangerous neighborhoods.
- **Family experiences** that exacerbate isolation or social estrangement. Chronic homelessness or mobility, debilitating poverty, unemployment, mental or physical incapacitation, gang affiliation, drug use, and involvement with the criminal justice systems are risks that keep children and their families outside the community.
- **Sudden loss** that further disrupts fragile stability. A significant number have lost family members to death, jail or abandonment.

- **Uncertainty** about the future. Many children are actively involved with child protective services or out-of-home placements. Some return to their parents or extended kin. Others remain in placement limbo or move to adoptive families. Despite good intentions, removal from primary care can be a secondary trauma for a child.
- **Learning obstacles** that compromise children's abilities to succeed at school. Learning obstacles may result from risk experiences, learning disabilities, or both. Chronic failure and frustrations at school may exacerbate children's reactivity to other risk experiences.

Secondary Risk: Threat Of Community Exclusion

School represents a second opportunity for social and emotional learning. For most children, school builds on what they have learned with their families. For these very-at risk children, coming into school or community is where their difficulties really stand out. They want to learn, but quickly fail because they lack early pre-learning skills as well as early academic and self care skills. They struggle to explain their needs or experiences with words instead of behaviors. They often confuse or alienate teachers who try to engage with them. They come to school not knowing how to be taught, or how to be helped.

Peer interactions increase their estrangement. Most young children are interested in other children, and have both skills and motivation to be friends. Very at risk children may have desire, but they lack ability. And other children pull away. These very at risk children lose social peer partners when they act badly. Many become aggressive when they are corrected or act out in ways that make other children shun them. Others misconstrue peer overtures—as they do adults'—and alienate other children. They are excluded from the group, and miss out on opportunities for pro-social learning.

These children become increasingly isolated when they oppose rules or engage in power struggles. Many resort to behaviors that further exacerbate their social disconnection (lying, stealing, harming property, harming others). These behaviors make early onset delinquency a likely probability. Everyone becomes preoccupied with changing their behaviors. Some very at risk children have talents such as athletic abilities or artistic skills, but these skills are not nurtured when children are disruptive.

Intervention Challenges

Developmental Repair is an intervention approach for young children with aggressive and disruptive behaviors that grew out of an experiment within an intensive group treatment (day treatment) located in a community mental health center. But the conceptualizations underpinning this approach have relevance for any setting or situation where these very at risk children need help.

Working With Very At Risk Children

Given the relatively young age of these very at risk children, it is striking how hard it can be for adults to be with them. These children generally expect relational interactions to be negative, and describe their expectations.

Teachers are always mean to me and you will be, too.

I'm going to hurt you before you can hurt me.

When adults scare me, I don't care. I'll just scare them back.

Kids never like me.

Children often explain the reasons for intervention as *I'm bad* and *I'm stupid*. Even when their family problems are apparent, they protect their parents or assume they are to blame. Many have been told it is their fault. They minimize fear, hurt, sadness or actual danger and instead act angry or tough.

After a weekend shooting at his home, including one fatality, one boy angrily denied any sense of danger, instead insisting it was “no big deal.” He dismissed staff suggestion that his mom needed to protect him, and resisted our concern. When staff persisted, he got mad and made fun of us for worrying about him.

These children carry their internal or family chaos into new settings. They expect inconsistent or unpredictable care, and interpret any negative experience—a staff member’s illness, a broken toy, a missing favorite snack—as proof that their fears and assumptions are true. When adults try to intervene, they are challenged by the persistence of children’s patterns of perceived harm and behavioral reactivity.

Most challenging for adults are times when children become dysregulated. Their aggressive surface collapses, revealing intense arousal and painful agitation. What looks like fighting is actually their frantic efforts at self protection. But these behaviors, and the attending emotional storms, are exhausting for staff.

It is not surprising that most people want to leave them alone. Their dysregulation is contagious, and adults feel emotionally off balance as they instinctively recoil against being harmed, even as they try to offer help. At the same time these children can be surprised by kindness and want more.

It is especially wrenching for adults who work with these children to feel valued one moment and discarded the next. Empathy and kindness can be difficult to maintain when children are aggressive; when children do become vulnerable, their pain is wrenching.

Adults often feel confused, abused and unsettled. Yet they also can feel exhilarated when real connections are made, and they allow help to come in. They are not opposed to relationships but disorganize others when they become internally disorganized.

Working With Their Families.

Most very at risk children live in families that are also struggling. Many parents suffer their own difficulties and their life histories mirror those of their children. They continue to be hurt by others (family members, the child protection system, endangering neighborhoods) and they are stuck in decisions that make daily life difficult. Parenting a child who is aggressive in the community is yet another source of unrelenting stress.

Many have poor parenting skills, or resent their children’s needs. They deny their children’s hurts and feelings, or put blame on their child or the community. Parents describe assumptions about their children that reveal their own experiences.

*He is so much like his father; I just know he will be packing a gun soon.
Since she was a baby, she won’t do anything I say. She was born to disobey me.
He is always asking for it...he pushes until I break. I don’t deserve this.
He just better learn to take care of himself ‘cause I’m not doing it. That’s just the way it is.*

Engaging these families in interventions can also be very challenging. They feel powerless in their lives. Some remain angry in order to survive. Others have exhausted their rage and seem depressed and depleted. They are often aggressive towards their children, and can be hostile to adults who want to help.

Families are often suspicious of interventions even as they ask for help. They often protect their privacy and demand their children do the same. Keeping outsiders away is a form of control, so allowing anyone to influence their parenting means relinquishing this control, and tolerating help. They are not receptive to good advice or parenting instructions.

Many parents use physical punishment or are consistently harsh to their children. This propensity to abuse may be the hardest for staff to manage, especially when children protect their parents.

My mom says don't tell you our business. She says I can't tell anybody about what happens because our family don't trust nobody. Leave us alone, she says, or they will take me away. I don't want to be away from my mom.

Some families are a loose organization of kin who provide a home base. Definition of family must include all the people who might be available and willing to become involved. These very at risk children often rely on extended family support. *One of our children lived with his great grandmother. His mother was actively addicted to crack cocaine. His father was in jail with no possibility of parole during his childhood. His grandmother was caring for a large extended family and rejected her daughter—and by extension, this grandson. His great-grandmother was bed-ridden but became his primary emotional support. She was his family.*

As hard as these children can be for their families, they are not yet as defiant or overpowering as they might become in adolescence. Many families retain hope that their children will turn out well. This potential for good outcomes must drive work with families.

The Intervention Challenge

Early aggressive behaviors and early school difficulties are highly predictive of more serious problems in later childhood. Research has identified patterns of development that predict “life course antisocial behavior by age 5.”¹ These very at risk children represent this population and it is imperative that they have early and intensive intervention to prevent this damaging trajectory. Developmental Repair is an intervention model that recognizes their risks and deliberately introduces protective factors to improve the outcomes for these children, and when possible, for their parents and families.



¹ Rutter, M., & Sroufe, L. A. (2000). Developmental psychopathology: Concepts and challenges. *Development and Psychopathology*, 12, pp. 265-296.

3 Research Foundations

- Research Foundations
- Research About Early Developmental Learning
- Experiences That Create Risk
- Resilience: Protection Through Developmental Repair



RESEARCH FOUNDATIONS

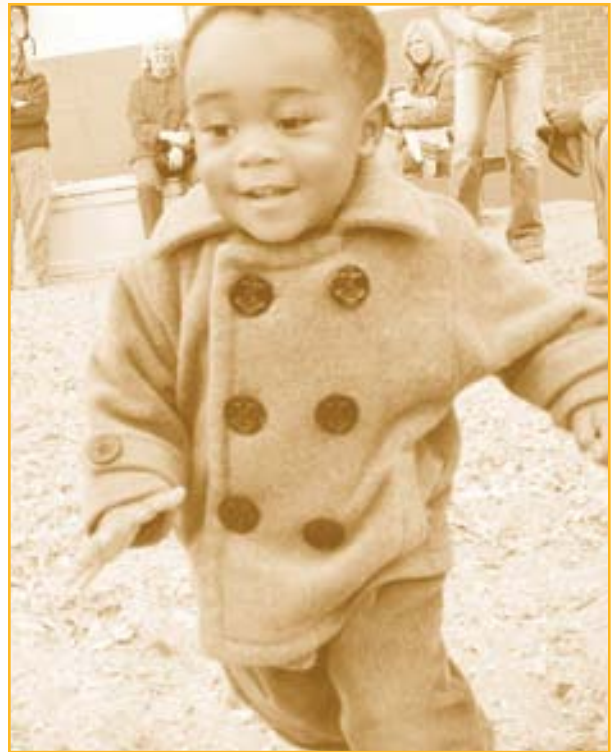
To build the Developmental Repair intervention model we selected and integrated salient ideas from a wealth of research that seeks to understand why very at risk children become aggressive and what might promote developmental change. The organizing constructs for Developmental Repair are based on research describing normal developmental processes, effects of risks, and developmental continuity and resilience. Citations and explanations are included, but this is in no way an exhaustive reference list. It does offer readers examples of how research evidence translates into practice with children and their families.

Normal Development

The foundation of Developmental Repair comes from research about normal development: how most children grow, and how parent/child interactions facilitate the emergence of internal capacities that mediate children's experiences of themselves and their larger world. Normal development always involves the transaction: many systems interact and collaborate to support adaptation and change.¹ Systems describe a combination of interacting parts organized to form a complex whole. In development, systems refer to the parent/child experience, the child's internal experiences, family involvement, and community processes.

Self regulation of emotions is particularly important to development because children learn when they can seek out new experiences and tolerate the inevitable emotional dysregulation that accompanies change. Children must learn to maintain and regain regulation in order to move ahead. But self regulation always starts with shared regulation; children need adult regulatory help. Difficulties with this capacity for self regulation result in developmental accommodations that are often maladaptive, or costly to the child's well being.

¹ Sameroff, A. & Fiese, B. (2000) Transactional regulation: The developmental ecology of early childhood intervention. In J. Shonkoff & S. Meisels (Eds.) *Handbook of early childhood interventions*. New York, Cambridge University Press.



Exposure to Risk

Research² also describes how risk experiences² trigger children's maladaptive coping. "A risk factor is anything that increments the probability of some negative outcome."³ Risks include predisposing vulnerabilities (from genetic effects), exposure to harmful experiences (such as physical or sexual abuse), and the absence of positive experiences needed for normal development (as is the case with neglect). Risks can be specific events or cumulatively negative influences. Children with predisposing vulnerabilities who are chronically exposed to interpersonal and environmental risks are especially prone to psychopathology.

² Garmezy, N. & Masten, A. et al. (1999) Competence in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology*, 11(1); Rutter, M. (1999). Psychosocial adversity and child psychopathology, *British Journal of Psychiatry*, 174. Farrington, D. (2005) Childhood origins of antisocial behavior, *Clinical Psychology and Psychotherapy*, 12.

³ Sroufe, L.A., Egeland, B., Carlson, E., and Collins, W.A. (2005) *The development of the person: The MN study of risk and adaptation from birth to adulthood*. New York: Guilford Press.

Risks do not necessarily defeat adaptation. Many children experience risks and learn to manage. What is damaging are overwhelming or accumulative risks, or too little adult help. Very at risk children have suffered multiple and extreme risk experiences: early disruptions of care, exposure to violence, maltreatment, social isolation, high mobility, and often with some combination of mental illness, substance use, or criminality in their immediate family. These children also evidence neuropsychological vulnerabilities that may be caused by risk experiences and compound risk effects.

Risk experiences threaten children's internal equilibrium, and children always need adult help to manage. When risk experiences compromise parental care, children must find alternative solutions. Their efforts to adapt to risky situations become maladaptive when they resort to behaviors that increase their emotional dysregulation rather than reduce it. Aggressive and disruptive behaviors protect them from perceived harm but disconnect them from others. Research identifies how children's difficulties achieving self regulation of emotions contribute to behavioral difficulties and social alienation.⁴

Resilience and Developmental Continuity

Resilience research examines how children maintain, "relatively good psychological functioning despite the experience of serious psychosocial adversities."⁵ Risk events that accumulate and persist are the most adverse to development, especially when adults are unable or unwilling to provide protection. Children need adult help, but risks can also be offset by children's internal developmental capacities, especially the capacity for self regulation and by children's ability to maintain inclusion in the larger social community.

Research also describes how development is continuous. Children's development keeps moving ahead, and becomes increasingly specific to new tasks. Development must manage more and more complex tasks and children become increasingly active in their own developmental efforts. There is no single pattern to developmental organization, but children find what works within a given context and then generalize what they learn to other situations. The end result of development is competent and coherent adaptation.

"Adaptation is a product of history *and* current circumstances. Current challenges and supports impact functioning and may even transform established patterns of adaptation. At the same time, the impact of new experiences is modulated by expectations and capacities based on history. Fundamental change is possible in new contexts, even though history is not erased."

 Sroufe, L.A., Egeland, B., Carlson, E., and Collins, W.A. (2005) *The development of the person: The MN study of risk and adaptation from birth to adulthood*. New York: Guilford Press.

⁴ Eisenberg, N. et al. (2001). The relations of regulation and emotionality to children's externalizing and internalizing problem behavior. *Child Development*, 72.

⁵ Rutter, M. (2002). Nature, nurture, and development: From evangelism through science toward policy and practice, *Child Development*, 73 (1).

Looking for Evidence To Support Intervention

There are evidence-based protocols for children experiencing risk. Many serve children with specific risk factors (attachment difficulties, trauma).⁶ Some serve children with multiple risks but require active parent involvement.⁷ Many are most effective for older children with similar needs⁸ or when certain developmental criteria are met,⁹ or when other community settings, such as schools, can contain the child while treatment gains take hold.¹⁰

There remains a significant need for models that can be provided by community settings with reasonable costs and staffing and serve aggressive and disruptive children whose families are not readily able to become engaged and who are already being excluded from community settings. This combination of obstacles to intervention makes these children very at risk. Developmental Repair is an intervention approach that incorporates many of the critical constructs embedded in these evidence-based protocols but adds something. The group experience supports the whole of children's development when intervention addresses the social, as well as the emotional and learning needs, of these children.

Developmental Repair takes much of its research evidence from the field of developmental psychopathology. "The field of developmental psychopathology must be viewed as the logical extension of the belief that a developmental approach can be applied to any unit of behavior, discipline or population."¹¹ It is critical that these very at risk young children be considered still developing, with potential for growth and change. Developmental psychopathology is interested in the "description of the interactive processes that lead to the emergence and guide the course of disturbed behavior."¹² It is not enough to understand risk events. Intervention must also recognize the possibility how these same interactive processes could be reversed to ameliorate disturbance.

Research About Early Developmental Learning

Because these very at risk children are young (ages 3 to 8), they are active learners with significant developmental potential. Children change when care and environmental supplies change, or when their own developmental capacities are repaired to permit better adaptation. This section identifies research about normative learning that builds a template for repair.

Early Relational Experiences

Babies are born into relationships. Much has been written about the biological propensity for attachment—how babies are prepared to recognize and use caregivers, and how parents become psychologically available to provide care that assures their babies' survival.¹³ When parenting is consistent and trustworthy, children learn to expect care, especially when they feel distressed. Attachment is not about love at first sight, but about a growing sense that, within this partnership, *I can count on you and that feels good and safe.*

⁶ For example, Circle of Security addresses attachment disruptions; Trauma Focused Cognitive Behavioral Therapy is a useful intervention for children with discrete trauma events.

⁷ For example, The Incredible Years is a family based intervention; Child-Parent Psychotherapy is effective with children exposed to violence but, as the name suggests, assumes parents are involved.

⁸ SNAP (Stop Now and Plan) is an intervention that works with older children identified as endangering the community; MFT (Multi-system Family Therapy) is most effective with older children and teens when family members commit to treatment.

⁹ The Collaborative Problem-solving Model (*Treating Explosive Kids*) provides a useful frame but assumes average level of cognition.

¹⁰ ARC (Attachment, Self-Regulation and Competency) is a promising practice model for children experiencing complex trauma; intervention is individual and individualized but assumes children can remain in their community settings.

¹¹ Cicchetti, D. (1993). Developmental psychopathology: Reactions, reflections, projections. *Developmental Review*, 13.

¹² Cicchetti, D., & Sroufe, L. A. (2000). Editorial: The past as prologue to the future: The times, they've been a-changin'. *Development and Psychopathology*, 12.

¹³ John Bowlby's books — *Attachment, Separation: anxiety and anger*, and *Loss: sadness and depression* — provide a trilogy about the attachment experience and its evolutionary benefits.



Despite the infant's relative dependence, this relationship is never one-sided. Babies actively engage their parents into this attachment partnership. They also have an innate facility for sharing inner (subjective) experiences with others, especially their mothers. Babies converse with parents, using sounds and gestures to “alternate or complement one another”¹⁴ long before they share conscious thoughts or words. This synchronizing of infant need and parent response has been described as attunement¹⁵ and the nature of their communication is intersubjective, moving between two subjects. It is from this early attending to one another that understanding and sympathy (connecting to the other's feelings) emerge.¹⁶

Parents need not be perfect in their responsivity, because moments of mis-attunement allow children to call parental attention back.¹⁷ Babies cry out, smile or use other gestures to signal *take care of me*. Children also start to replicate care—some babies learn to suck their fingers to feel soothed until their parents arrive. This illustrates the beginning of self regulation and self care.

Attachment becomes a regulatory system¹⁸ because the interactive experiences promote

important adaptations on many levels. Parents and children work together to create biological and psychological regulation that is initially shared. Babies have innate but biologically immature potential for regulating body stress activation, and parents' physical care provides needed modulation. This care happens over and over and over again so that children's bodies—and minds—learn the feeling of becoming regulated.

Young children detect patterns (contingencies)¹⁹ that organize important information about how this system works. Caretaking becomes remembered within the child's mind as expectations: *when I need help, this is what happens*, or more specifically, *when I need help, this is what you do*. When care is reliable and reciprocal, children also learn strategies to engage care when they need it. When care is interrupted or lost, children struggle to restore this 'enduring social bond.'²⁰ Gradually children maintain this bond by representing patterns of care within their minds.

Because attachment is particularly organized to assure survival, the system is quickly activated by fear-generated distress or disequilibrium.²¹ Distress comes from endangering outside events as well as internal agitation. Children are biologically programmed to panic when they lose sight of their attachment partner.²² This feeling of panic helps the child and parent maintain proximity to assure safety and manage harm. Parents provide regulatory help (soothing, reassurance, clarification, protection) to re-organize these threatening experiences. Many

¹⁴ Trevarthen, C., & Hubley, P. (1978). Secondary intersubjectivity: confidence, confiders, and acts of meaning in the first year. In A. Lock (Ed.), *Action, gesture and symbol*. New York: Academic Press.

¹⁵ Stern, D. (1985). *The interpersonal world of the infant*. New York, Basic Books.

¹⁶ Trevarthen, C., & Hubley, P. (1978).

¹⁷ Tronick, E. (1989). Emotions and emotion communication in infants, *American Psychologist*, 44, pp, 112-119.

¹⁸ Schore, A. (2000). Attachment and the regulation of the right brain. *Attachment and Human Development*, 2 (1).

¹⁹ Contingency is an interesting word, since many programs working with very at risk children rely on contingency reinforcement (with limited success). Contingency here refers to the infant's early ability detect patterns of interactions and then tolerate less than perfect replications of these patterns. In other words, they realize the other is different and can interact with these differences. Children with autism always need the same. Very at risk children also react badly to change or surprises (even good ones) because their interactions with parents are not contingent—but unpredictable. Gergely, G. (2001). The obscure object of desire: 'Nearly, but clearly not, like me.' *Bulletin of the Menninger Clinic*, 65.

²⁰ Bowlby described that attachment lasts over time, beyond the period when infants need parenting. In this way, attachment attends to both physical and social/emotional survival.

²¹ Bowlby accurately observed that the trigger for attachment behaviors is danger or distress. While children love their parents at any time, they need their parents' care when they feel vulnerable. Attachment security is trusting that help will be available in these moments of distress.

²² Panksepp, J. (2001). The long-term psychobiological consequences of infant emotions: prescriptions for the 21st century. *Infant Mental Health Journal*, 22(1-2).

developmental abilities support this connection. For example, young children learn to follow their parents' gaze and then shift their attention to what parents signal will be safe or more settling.²³

The attachment relationship supports exploration of the larger social world, and facilitates early social learning. Children take in information about the social world as it makes sense to them. Children and parents engage in “mutual mental awareness that gradually is evident with joint attention, shared intentions and shared affective states”.²⁴ Early cognition is not instruction about objective knowledge but learning from experience, through interactions. Parents are not programmers inserting data, but collaborators, designed to “provide just the right sort of information”²⁵ in the right way.

To do this, parents must recognize their children's internal sensations and interests. They read their babies minds, not because they know (impose) meaning, but because they intuit or feel what could be going on. Parents' availability, regulatory support and sensitive intuition combine to facilitate a sense of security. As children feel secure, they become interested in others and seek out social opportunities, especially when they know that they can return to the security of being with parents. Being with parents becomes a physical and emotional *safe base*.²⁶

While early experiences do not absolutely predict how subsequent relationships might work, they do influence how children learn and color what they expect to happen. Early relationship security contributes to the emergence of self regulation and other critical developmental capacities, and determines how well children are able to move into the larger social community.²⁷

²³ This is called joint attention. Joint attention is the process of sharing one's experience of observing an object or event, by following gaze or pointing gestures. Children start by sharing their parents' experiences and then asking their parents to share theirs. Joint attention is an important regulating tool when parents help to move children's attention from something (or someone) that is distressing to more soothing focus.

²⁴ Gopnik, A., Meltzoff, A., & Kuhl, P. (1999). *The scientist in the crib*. New York: Morrow.

²⁵ Ibid.

²⁶ *Safe base* is a term used frequently to describe returning to the security of being with the attachment partner.

²⁷ In this longitudinal study, the authors found that secure attachment predicted positive peer affiliations and school competence. Sroufe, L.A., Egeland, B., Carlson, E., and Collins, W.A. (2005) *The development of the person: The MN study of risk and adaptation from birth to adulthood*. New York: Guilford Press.

Regulation Starts as a Shared Experience

Regulation is about maintaining and regaining equilibrium in the face of stimulation. In the beginning, both the baby and parent are unsettled. The adult adjusts to the parenting job and learns to parent this specific baby, and the infant adapts to what the parent offers.

Being regulated (or not) starts as a shared or mutual experience, even though the adult has better regulatory potential to manage inevitable distress.²⁸ Parents support regulation with sounds or gestures that convey *it's ok*, or more accurately, *it will be ok*. Most parents learn to be effective co-regulators, and most babies regulate back by becoming sooth-able and by growing. Both benefit when other caregivers can also provide regulatory support.

Research has demonstrated how children use reliable regulatory support to modulate arousal and increases mastery.²⁹ Over time, shared regulation transfers into the child's capacity for self regulation. Children continue to imagine others' help by remembering the feeling of shared regulation within their minds.

Representations are affective mental pictures of being cared for, as well as mental interpretations about care and about interactions between *myself and an other*. Secure representations demonstrate *when I am distressed, someone will help* or *when I am ready, someone will engage with me*. The sum of these representations is *I deserve care*. But self regulation is not a one-time achievement, nor is regulation even totally without others' help. Parents must remain on duty, ready to intervene when children lose ground or move ahead to new developmental challenges.

While regulation starts with body modulation, it expands quickly to include emotions. Emotions are inside sensations that become organized within relationships. “Attachment is the dyadic

²⁸ Gianino, A. & Tronick, E. (1989). The mutual regulation model: the infant's self and interactive regulation and coping and defensive strategies. In *Stress and coping* Vol. 2. Hillsdale, NJ: Erlbaum.

²⁹ There are many resources about self regulation. One excellent resource is Gross, J., ed. (2007), *The handbook of emotion regulation*, New York: Guilford Press.

regulation of emotions.”³⁰ Parents match emotions, provide emotional expressions that correspond to what babies are feeling to create shared awareness and shared intentionality.³¹ Matching allows babies to gradually recognize similarity between others’ emotions and their own. Emotions become about someone or something.

Parents also help to modulate feelings (quiet or excite feelings to fit the experience). When children experience contradictory or conflicted emotions (*I love you, I miss you; you love me, you are mad at me, you hurt me*) they need parental help to manage this emotional turmoil. In the best of situations, even the most painful emotions can be shared and managed together. During the second year of life most children are susceptible to dysregulating tantrums as they try to tolerate confusing desires and intense emotions without falling apart or causing the relationship to fall apart. They continue to need regulatory support to manage complicated emotions and social rules.



³⁰ Sroufe, L. A. (1996). Emotional development: The organization of emotional life in the early years. New York: Basic Books.

³¹ Beebe, B. (2006). Co-constructing mother-infant distress in face-to-face interactions: Contributions of microanalysis. *Infant Observation* 9(2), pp. 151-164; Goodman, M. & Tomasello, M. (2008) Baby steps on the road to society: Shared intentionality in the second year of life. *Zero to Three*, 28 (5).

Regulation and Social Communication

Social communication involves exchanges of feelings, ideas and intentions between people. Because children need parents so much, they become interested in what their parents will do, and gradually anticipate what their parents might do. They are starting to think about their parents’ minds. Parents also anticipate what their babies are thinking, and in this way, help children know their own needs, feelings and even thoughts. Babies are born with the potential to have a mind, but need parents to show them how to use their minds³²—how to recognize others’ feelings and intentions. This is how social communication and social referencing begins.

Children gradually move into the larger social world. Exploration involves physical movement away from parents, but also mental imagination to discern how this larger world works. Children use their parents to orient to what is safe. Most children recognize social interactions as very different from curiosity with objects, and they respond with animation to facial gestures, voice tone and emotional expressions.

Exploration also allows caregivers to share children’s awareness about what they are discovering. As children feel organized (*look what you are doing*) and validated (*I see you like that*), they start to develop self awareness. They recognize internal feeling states and form emotion thoughts, which are ideas that make sense of feelings. They also discover their own intentions about what they want or desire. They look inside for information (reflection), for explanations about what is happening to them and for ideas about what might be happening inside others’ minds. They start to think about how the world works.

When desires collide—when the child wants something different than the parent wants—they learn to negotiate³³ and reconcile conflict without losing connection. They attend to

³² Slade, Arietta. (2005). Parental reflective functioning: An introduction. *Attachment and Human Development*. 7(3).

³³ Louis Sander was the first to identify negotiation as a normal process. Instead of seeing negotiation as giving in to children, he recognized how important it was to value their needs and capacity to know what they want—and to tolerate what others want as well. Nahun, J. (2000) An overview of Louis Sander’s contribution to the field of mental health. *Infant Mental Health Journal*, 21, (1-2), pp. 29-41.

others' expectations and during the second year develop the capacity to replace what they want with an action that better fits their parent's expectations. They learn to inhibit actions for the sake of connection, or for other actions that are preferred. Children choose something other than their own immediate desire because they value the relational tie.³⁴ This shows how attachment security facilitates inhibitory controls. With parental encouragement, children start to exert effort to manage impulses and behaviors. This is the beginning of effortful control.³⁵ Children's efforts are initially directed to meet parental expectations. As they grow, they also direct their effort to what they decide is important, including social compliance and peer expectations. Effortful control is likely influenced by positive attachment capacities (empathy, awareness of others, social sensitivity and competence) more than negative threats of reprisals.

Children's attention shifts to important social norms. What starts as awareness of shared intentionality (between parent and child) evolves into an implicit social contract. Children become engaged in "collective intentionality...learning not just how to do things but how one ought to do them to meet cultural expectations and norms."³⁶ Parents initiate this orientation to cultural expectations and help children learn to extend effortful control in new social situations such as school.

Capacities for self regulation, self awareness, emotional learning and effortful control emerge from early experiences of care. These capacities are initially shared or experienced cooperatively, and are the foundations for developmental mastery and learning, and for membership within the larger social community.

³⁴ Kochanska, G. & Murrey, K. (2000) Mother-child mutually responsive orientation and conscience development: From toddler to early school age. *Child Development*, 71.

³⁵ Rothbart described effortful control as the "ability to inhibit a dominant response to perform a subdominant response." Rothbart, M.K. & Bates, J. (1998) Temperament, in *Handbook of Child Psychology*, New York: Wiley.

³⁶ Goodman, M. & Tomasello, M. (2008). Baby steps on the road to society: Shared intentionality in the second year of life. *Zero to Three*, 28 (5).

Experiences That Create Risk

Research identifies how children experience acute and cumulative adversities and how adaptation becomes compromised. Despite trying to manage best as they can, very at risk children are toppled by the accumulation of risks. Aggressive and disruptive behaviors often convey both helplessness and rage. These opposing motives make their behaviors seem frantic and confusing.

The Risk of Disruptions in Primary Care Relationships

Many very at risk children have experienced disruptions in their primary care relationships. Disruptions occur when parents provide care that hurts them (physical, sexual, or emotional abuse) or is inconsistent or unresponsive to children's needs (neglect). Some children are eventually cared for by extended family members, or in out-of-home placements. In this very at risk population, many children present on a continuum of insecure/disorganized attachment patterns. Their parents' histories suggest they too struggled with attachment security and the effects are often evident in how they parent and how they think about their children's needs.³⁷ Most children remain loyal to their attachment partners, but carry the effects of disrupted attachment care into school, community, and the treatment experience.

Insecure patterns of attachment result from unreliable parenting that compromises the attachment partnership. These patterns reveal how hard children work to stay connected to their parents.³⁸ Some children provoke care by whining or clinging to interrupt parental preoccupation (resistant/ambivalent pattern). Other children become prematurely self-reliant

³⁷ The Adult Attachment Interview is a research protocol that has provided important validation that attachment experiences are lasting and influence how adults then parent their own children. Parents' state of mind with regards to attachment can be reliably assessed even before the baby is born. Main, M. & Goldwyn, R. (1998) *Adult attachment scoring and classification system*. Unpublished document, University of California, Berkeley

³⁸ Mary Ainsworth first identified three attachment patterns of styles: secure, avoidant and resistant (ambivalent). The second two are considered insecure since the child must make their strategies (attachment behaviors) accommodate to the parent's availability and desires.

when their parents dismiss their needs (avoidant pattern). These solutions cause children to feel anxious and insecure about parental care. When these interactive patterns are stable, children can become organized—learn how make these solutions work most of the time, even when they remain anxious and insecure.

Difficult circumstances disrupt these solutions. Risks such as separations, traumas and life challenges de-stabilize these insecure patterns of care and increase children's needs for adults even as they doubt regulatory help. Feelings of insecurity may become disorganizing when risks are unrelenting or overwhelming. Anxiety blocks new learning and children cling to old behavioral strategies to manage their fears. Some children remain hesitant and restricted. Others act recklessly or aggressively self reliant. Both solutions leave children feeling vulnerable in the community.

Disorganized attachment patterns constitute very serious risk. Disorganization occurs when the attachment parent is also a consistent source of harm and danger. Children experience “fright without solutions”³⁹ because they cannot look for attachment help when they feel endangered. They cannot engage the parent in providing the necessary regulatory help. This impossible combination of care and harm leaves the child distraught and disorganized. In some situations, harm results from parental powerlessness to meet the child's basic emotional and physical needs (neglect). In others, harm is aggressive and deliberate (abuse).

Disorganization starts within the parent/child relationship but contaminates children's sense of the larger world. Children struggling with disorganized patterns of attachment care show unusually high patterns of aggressive behaviors by age three, and become dangerous towards others by age five,⁴⁰ even as they remain fiercely attached to their parents. Disorganized attachment patterns predict emerging psychopathology, especially when these children are exposed to repeated traumas and community violence.



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³⁹ This term describes an impossible attachment dilemma: the child feels fear and looks to the parent for protections, but realizes that the parent is the source of danger. The child freezes; there is no solution for distress. The child becomes disorganized; the child stays confused and aroused, or recovers until the next time. Main, M. & Hesse, E. (1990) Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In *Attachment in the preschool years: Theory, research, and intervention*. Chicago.; University of Chicago Press.

⁴⁰ Lyons-Ruth, K., Easterbrooks, M., & Cibelli, C. (1997). Infant attachment strategies, infant mental lag, and maternal depressive symptoms: Predictors of internalizing and externalizing at age 7. *Developmental Psychology*, 33(4).

When children feel disorganized in their primary relationships, they become disorganized in their development. They remain confused about their own feelings and thoughts and actions, and struggle to relate to others in the community. Developmental learning is significantly compromised. Problems experienced by children with attachment disorganization include:

- **Problems with relating.** These children struggle to form and maintain normal relationships. They have abandoned expectations of help and learned to distrust what help is offered. Instead, they mimic what they have experienced with their parents. They turn internal frightened states into frightening aggression or controlling behaviors.⁴¹ In new situations, they sabotage relationships because they anticipate harm and have learned to fight first and think later. Their negative expectations are reinforced by continuing trauma or neglect at home making it hard for them to expect positive outcomes. Since they don't expect regulatory help, or know how to use to it, their disorganized needs confuse and defeat even the most well meaning adults.
- **Problems with regulating arousal and emotions.** These children's needs and feelings are also disorganized. Many use behavioral strategies to distance themselves from intolerable arousal and emotions. When fear reverses into anger, they remain susceptible to rage at the slightest triggers. Vulnerable emotions, such as sadness, disappointment or hurt, cause disorganization and humiliation. Even when they are removed from endangering (traumatic) situations, children remain volatile and internally dysregulated. Arousal persists.⁴²
- **Problems with reflective thinking and awareness.** Disorganization describes how these children relate and feel, but also how they think and act. Because early care was chaotic or unpredictable, children struggle to discern others' motives. Thinking does not mediate experiences⁴³ so they remain disorganized about their own needs and intentions. The pressure of their pre-existing perceptions and predictions defeats reflection. They misconstrue social signals and use past experiences to dictate what will happen in present situations. They struggle to take in new learning.
- **Problems with exploring the larger social world.** These children bring disorganization into the larger social community, and guard against harm by attacking first. They lack critical social and learning skills (such as tolerance or reciprocity). They are not good at engaging teachers and react badly to rules that threaten their need for control. Their behaviors appear intentionally aggressive, even though their motive is for self protection. Because they seem indiscriminately aggressive, they are quickly ostracized and restricted from pro-social opportunities.⁴⁴

Most very at risk children appear disorganized even as they maintain desire for connections. Reactive attachment disorder is the extreme of attachment danger; it is a serious and relatively rare disorder that describes how children experience caregiving relationships as threatening their survival, rather than supporting it. Children with reactive attachment disorder turn away from the possibility of attachment with anyone and must be convinced that human connections have value if they are to recover from earlier pathogenic care.

Because children do not give up on attachment partners or stop wanting care from them, they often cling to what they have. Many children have no alternative frame of reference for good care. They often

⁴¹ Hesse, E. (1996). Discourse, memory and the Adult Attachment Interview: A note with emphasis on emerging cannot classify category. *Infant Mental Health Journal*, 17.

⁴² Dozier, M. Gunner, M. et al. (2006). Foster children's diurnal production of cortisol: An exploratory study. *Child Maltreatment* 11(2).

⁴³ Peter Fonagy described how "having a mind mediates our experience of the (social) world." Mentalizing is an early form of thinking that allows us to observe what is happening and negotiate between our own perceptions and what we see the world expecting and offering. Without some mind awareness we would feel trapped by circumstances. This is exactly how many very at risk children feel; they have no ability to think their way out. Fonagy, P, et al. (2002). *Affect regulation, mentalization and the development of the self*. New York: Other Press.

⁴⁴ Dodge, K, Dishion, T. and Lansford, J. (2007), The problem of deviant peer influences in intervention programs, in *Deviant peer influences in programs for youth*, New York: The Guilford Press.



explain abuse, neglect, and other disruptions in care by blaming themselves. They resist help for several reasons: they don't expect help, they protect their parents, and they react so quickly to perceived danger that most adults quickly shift from trying to connect with them to controlling them. They inadvertently maintain their own internal disorganization.

Risks Resulting from Traumatic Experiences

Traumas are endangering events, "rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations"⁴⁵ to cause shock, surprise or sickening anticipation. Children are at risk when trauma remains overwhelming or when the effects of trauma persist as unmanaged arousal, fear and persistent helplessness.

Traumatic events are mediated by several conditions: intensity and duration of the danger, frequency of trauma exposure, strength of fear and arousal, and the availability and effectiveness of adult support.

Adult support is important because children lack sufficient internal resources to survive alone. Even when parents are overwhelmed by the same traumatic events, children are soothed by feelings of co-regulation that are represented within their minds. Young children are especially vulnerable to trauma because "the neural circuits for dealing with stress are particularly malleable (or plastic) during the fetal and early childhood period."⁴⁶ With adequate adult help, children

learn that traumas happen but are manageable; without adult help children remain susceptible to biological and psychological changes that persist.⁴⁷ Trauma effects disrupt children's developmental abilities and change their attitudes about themselves and the safety of their worlds.

Trauma research has demonstrated how the body's fear alarm activates an instinctive impulse for fight or flight, even as the child feels helpless and frozen. But both actions are insufficiently protective when stress arousal is intense or prolonged. Brain architecture is altered, exacting significant physical and emotional costs. "Toxic stress during this early period can affect developing brain circuits and hormonal systems in a way that leads to poorly controlled stress-response systems that will be overly reactive or slow to shut down when faced with threats throughout the lifespan."⁴⁸

Even though ineffective, fight or flight reactions become habitual. Children become aggressive (fight) and dissociate (flight) when surprised or endangered. Toxic stress also changes how children perceive non-traumatic events. Toxic stress causes "strong, frequent or prolonged activation of the body's stress management system...so that it responds at lower thresholds to events that might not be stressful to others."⁴⁹ Events that may seem relatively benign to others may be overwhelming and frightening to children who have been exposed to trauma.

⁴⁵ Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, 148(1).

⁴⁶ Shonkoff, J., & Phillips, D. (Eds.), (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

⁴⁷ Teicher, M. (2002, March). Scars that won't heal: the neurobiology of child abuse. *Scientific American*.

⁴⁸ Shonkoff, J., & Phillips, D. (Eds.), (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

⁴⁹ Ibid.

Research also describes how unmanaged traumas divert developmental energies and disorganize developmental momentum. Self-regulation is defeated or compromised by children's trauma reactions. Fear restricts emotional flexibility. Children become cautious and hypervigilant. Their motivation to learn and explore is replaced by a more restricting motivation to survive.

Trauma memories are often encoded in body feelings or sensations and very young children without language can only remember in this implicit way.⁵⁰ Their body responses become organized to the feeling of the event. For example, infants exposed to extreme early abuse flinch at touch, and over time may form a more patterned response to avoid physical contact, or cry in anticipation of contact. Infants exposed to intense angry sounds respond to subsequent angry noise with greater reactivity. In this way, negative sensations distort subsequent positive contact or pleasure. As children grow, they may struggle to know information about what happened to them and need verbal confirmation or re-organization. Many remain vulnerable to disturbing body triggers and associations⁵¹ that keep the feeling of trauma danger alive.

Complex trauma⁵² is a relatively new designation for children exposed to environmental and relational assaults that capture how children become extremely vulnerable when trauma-related helplessness combines with relational helplessness.

Sometimes trauma effects become constant. Post-traumatic stress disorder (PTSD) occurs when the stress system fails to turn off, keeping the brain and body chronically aroused and disrupting access to higher-level mental capacities such as orientation to time and place or cognitive organization. "The biology of PTSD is not the biology of stress but of failure to adapt and re-organize to stressful memories...The person cannot inhibit past reactions, so cannot regain

the habit of safety."⁵³ While most young children do not develop post-traumatic symptoms of this magnitude, those with histories of anxiety, repeated traumas, or family adversity are more vulnerable to the effects of repeated trauma, and more susceptible to PTSD.⁵⁴ These qualifiers are nearly universal in the very at risk population.

The Risk of Social Isolation and Alienation

Social exclusion exacerbates developmental risks.⁵⁵ Very at risk children struggle to find a secure place in the larger social community. Social interest requires nurturing and guidance that families with tenuous social connections often fail to provide. Many families (and communities) have long-standing and painful histories of social isolation, and feel defeated by social demands they cannot meet. Many children lack associations to neighborhoods, churches or other community organizations where normative social roles and rules are established and serve as a model. Some families become alienated from social norms and impose this same alienation on their children. High mobility compounds the problem by limiting the opportunities for social connections. Isolating social institutions (special education, child protection, juvenile justice) disproportionately involve children of color and poverty.

Social disadvantage exacerbates individual risk experiences. Research identifies cascading effects⁵⁶—harsh or inconsistent parenting predicts social and cognitive deficits which predicts behavior difficulties when children come to school. This cascade continues towards increasing social alienation and deviance without intervention. Poverty includes a paucity of social and emotional resources that deplete parenting and other family needs.

⁵⁰ Gaensbauer, T. (2002) Representations of trauma in infancy: Clinical and theoretical implications for the understanding of early memory. *Infant Mental Health Journal*, 23(3).

⁵¹ VanderKolk, B. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. Harvard Review of Psychiatry.

⁵² Complex trauma in children and adolescents: White Paper (2003), National Child Traumatic Stress Network, www.nctsn.org

⁵³ Yehuda, R. 15th International Trauma Conference presentation, Boston, MA, 2004.

⁵⁴ Copeland, W. et. al. (2007), Traumatic events and posttraumatic stress in childhood, *Archives of General Psychiatry*, 64.

⁵⁵ Children's Defense Fund report (2007), *America's Cradle to Prison Pipeline*; www.cdf.org This report documents how our collective systems perpetuate criminal incarceration, especially for children of color and disadvantage.

⁵⁶ Dodge, K. Greenberg, M. & Malone, P. (2008) Testing an Idealized Dynamic Cascade Model of the Development of Serious Violence in Adolescence. *Child Development*, 79 (6).

When children and families are isolated from the community, social interest is often replaced with wariness or distrust. This interferes with children's opportunities to imitate well adapting peers or to form positive identifications with adults outside of the family. Children exposed to violent and aggressive forms of social discourse often adopt these behaviors. Without social interest and identification, children become blind⁵⁷ to the experiences of others and struggle with empathy.

Very at risk children also struggle to belong to social groups. Social communities function like clubs, with implied roles, rules, and acceptable functioning. Social groups also define and organize emotions such as pride, shame and guilt. When children feel excluded they struggle to master basic constructs like negotiation and reciprocity. Reciprocity is contingent on everyone's needs and perceptions must be valued; instead these children often violate social rules because they anticipate unfairness and act accordingly.

When children are excluded from community involvement, they also lose social protection from family stress. They are drawn to anti-social associations in order to have an alternative place to belong and feel valued.⁵⁸ These associations influence the rules and roles they learn.

Risks of Developmental Discontinuities: Neurological and Environmental Deficits

Developmental adaptation requires that children consolidate what they are learning with what they already know. In normal development, children practice and sometimes move back (regression) before moving forward (mastery). Developmental discontinuities occur when children struggle to maintain mastery, or get stuck in maladaptive learning.

Neuropsychological deficits exacerbate risk.⁵⁹ Some children have genetic vulnerabilities while others acquire deficits because of early environmental assaults such as prenatal exposure to toxic substances. These neuropsychological deficits include attentional problems (impulsivity and poor executive functioning) and specific and non-specific learning difficulties (language fluency, memory and impaired processing, information organization and recall). Effects of anxiety and mood disturbances disrupt learning. Many children also struggle to recognize social cues or comprehend social exchanges and intentions. These learning difficulties are often unrecognized or ignored when children are labeled with behavior problems. Struggles with learning may be the additional risk that tips children towards dysregulation and aggressive behaviors in the community.

Research also demonstrates how adapting to risky environments causes developmental discontinuity. Trauma and maltreatment interrupt learning and children must survive in risk situations as best as they can, given their resources.⁶⁰ Learned ways of surviving result in behaviors that may not be functional in different settings. For example, children forced to take care of themselves at home are criticized as controlling, manipulative, and defiant at school. Children exposed to violence protect themselves by becoming aggressive, a behavior that puts them at risk in mainstream classrooms with zero tolerance policies.

⁵⁷ While considering a very different population, this writer provided a description that often fits these very at risk children. They cannot see into others minds, not because they are autistic but because being interested is too endangering or unfamiliar. Baron-Cohen, S. (1995). *Mindblindness: An essay on autism and theory of mind*. Cambridge, MA: MIT Press.

⁵⁸ Dodge, K. Dishion, T. & Lansford, J. (2006) *Deviant peer influences in programs for youth*. New York: The Guilford Press.

⁵⁹ Greene, Ross (1998). *The Explosive Child*. New York: HarperCollins.

⁶⁰ Perry, B., Pollard, R., Blakeley, T., Baker, W., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and use-dependent development of the brain: How states become traits. *Infant Mental Health Journal*, 16(4).



Resilience: Protection Through Developmental Repair

Very at risk children have experienced multiple and compounding risks. However, there have been “important conceptual advances that recognized the need to get away from viewing risk as an effect that took place at some discrete moment in time and, instead recognize that risk and protective processes tend to operate over time in ways that could either lead to cumulative effects, or resilience and recovery.”⁶¹ This is the intervention challenge: to organize protective resources that can temper the impact of risk experiences and promote resilience. For young children, recovery requires repair.

Organization in development assumes that parts hold together to support the whole. An organizational perspective on development recognized several critical assumptions.⁶²

- The fundamental feature of behavior is organization.
- Organization is revealed in the interplay of emotion, cognition and social behavior.
- Development is defined by changes in organization of behavior over time.
- Organization of behavior is central to defining individual differences.
- Central aspects of individual organization originate in the organization of early primary relationships.

An organizational perspective is protective because young children must be understood for their whole experience instead of targeting one part (such as behavior). Children who are already disorganized by risk experiences need help to become more organized with new experiences.

Developmental Repair starts with organizing the behaviors of very at risk children differently. Instead of assuming malice, we see behaviors as reactions to overwhelming stress. Aggressive behaviors are children’s best effort to maintain regulation, even as these same behaviors perpetuate dysregulation and disorganization. Disorganization explains the treacherous disconnection between their feelings and actions, and the persistence of these behaviors despite efforts to impose controls. These children are stuck. Establishing the importance of all developmental domains (feeling, thinking, behaving and relating) builds organization, because interventions that neglect any component fail the whole child.

These children struggle to use new relationships differently than they have learned to use primary relationships. They lack the developmental prerequisites for self regulation. It may be possible to remedy what these children have missed by re-activating interactive experiences of care because they are still

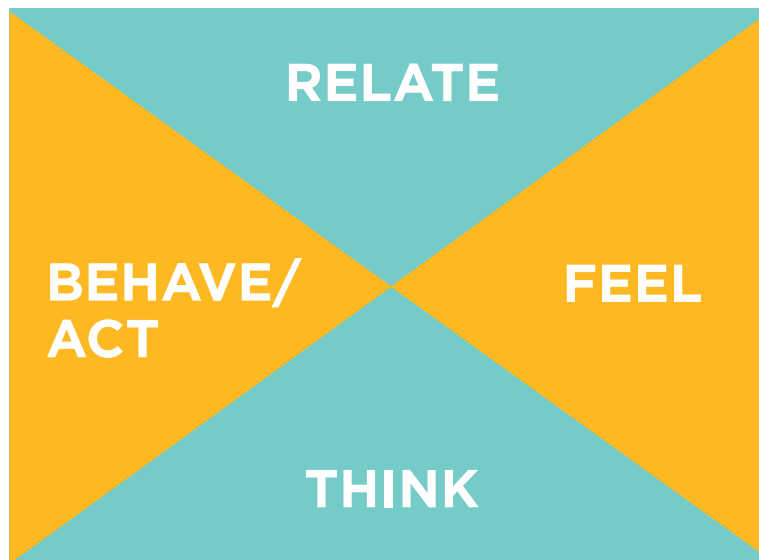
⁶¹ Rutter, M. and McGuffin, P. (2004) The social, genetic and developmental psychiatry centre: its origins, conception and initial accomplishments”, *Psychological Medicine*, 34.

⁶² Sroufe, L.A. (1979), The coherence of individual development. These ideas have been elaborated in the chapter 2, A perspective on development, in Sroufe et al, (2005). *The development of the person: The MN study of risk and adaptation from birth to adulthood*. New York: Guilford Press.

relatively young and open to new relationships and new behaviors. These new relationships must provide consistent regulatory support. Those who overcome adversity do so because of the availability of balancing support⁶³ even when that support occurs after exposure to risks.

Resilience is not a constant trait but the ability, over time, to manage adversity and bounce back to some positive adaptation. Resilience over time may be protected by personal qualities as well as relational support: one longitudinal study identifies relationship interest and engagement, a capacity for reflection, and a sense of personal agency as three characteristics that distinguished resilient from not resilient life stories.⁶⁴

Developmental Repair focuses on repairing internal capacities and restoring developmental organization and social inclusion. *Repair happens through interactions, repeated again and again.* This repetition allows children to experience different patterns than they expect, and to become familiar with new options. Change occurs over time, with practice, and through incremental steps. Any change has the potential to cause rippling effects that support the next change. The goal is to help children become more organized in their efforts to grow and adapt.



Repairing Relational Regulation

Repair starts with relational engagement because these very at risk children don't expect help and don't know how to use help. Intervention must construct a new regulatory system that can provide the right sort of emotional information that these children have missed. This is an interactive intervention, because "self regulation is taught (or more accurately, modeled) by the caregiver's regulatory activity."⁶⁵ These new relationships do not replace the tie to the primary parent, but adults must be able to engage with children in ways that replicate the intimacy and intensity of the early parenting help.

Mutual regulation provides the bridge to self regulation. In normative experience, both parent and child work together towards the common goal: the child's wellbeing. In Developmental Repair, adults and children also work together to construct a mutually regulating connection that can handle children's

⁶³ Sroufe, L.A., Egeland, B., Carlson, E., and Collins, W.A. (2005) *The development of the person: The MN study of risk and adaptation from birth to adulthood*. New York: Guilford Press.

⁶⁴ This study followed teens at risk, but many had characteristics similar to very at risk children. Longitudinal research provides clinicians with a unique opportunity to learn from the past and focus practice on protecting or supporting critical elements such as these. Hauser, S., Allen, J. 7 Golden, E. (2006). *Out of the woods: Tales of resilient teens*. Cambridge, MA: Harvard University Press.

⁶⁵ Fonagy, P. and Target, M. (2002) Early intervention and the development of self regulation, *Psychoanalytic Inquiry*, 22.

emotional and behavioral distress. Both must tolerate inevitable moments of emotional activation and dysregulation⁶⁶ so children can feel re-regulated, with adult help, and hold onto that feeling as something they can have and eventually do.

This new partnership operates in the immediate present. Children are surprised when patterns change. Arousal is triggered by past expectations but is activated within the immediate present. This arousal provides the emotional energy for repair, since help is most remembered during moments of distress. Working in the immediate present, within the group, also prevents contamination by factors beyond the control of the intervention such as family crises or neighborhood violence. These outside events cannot be fixed but feelings can be recognized and shared. When children feel more regulated, they may access an increased sense of safety, or *earned security*⁶⁷, to organize different responses to outside risks.

Repairing Emotional Learning

Disorganization intensifies arousal. Arousal must be recognized for what it is (an expression of fear and panic), rather than what it appears to be (an angry attack). Arousal reveals children's internal states more than interpersonal conflicts, even when children try to engage adults in battle. When caregivers' emotions are too highly charged or too frightening, children's emotions remain diffused with arousal noise.⁶⁸

As arousal becomes more moderated through shared regulation children can differentiate pleasurable arousal (anticipation, glee, surprise) from negative arousal (pain, fear, agitated excitement, distress) and recalibrate their reactions to tolerate reasonable stress and change.

Emotions must be recovered from arousal confusion. Discrete emotions can be named, especially when these are valued within relationships. Attention is paid to both emotions that are intensely evident, but also emotions that are missing or minimized;⁶⁹ children often express anger but deny fear or worry. Emotions then become modulated to fit the immediate experience (replacing too much or too little intensity). They become tolerated and tolerable (regulated). When emotions feel regulated, they can move to make room for new emotions and new experiences,⁷⁰ instead of becoming stuck. Emotional awareness also builds empathy and emotional reciprocity. Children must feel their own emotions to be able to feel for another (empathy). Reciprocity builds on empathy because it assumes that *I can extend care to you because someone has extended care to me*.

For most young children, behaviors are their way to send emotional messages. They transfer emotional energy into behavioral action to discover what they feel. When emotions convey coherent information, behavioral messages will make sense. When emotions are incoherent, behaviors will also seem incoherent and random and whatever messages children intended will be lost to what the child did.

⁶⁶ Many researchers describe the importance of *limbic learning*. Emotions must be recognized and included in learning experiences.

⁶⁷ Earned security is a construct from the Adult Attachment Interview research, when adults with negative childhood experiences acquire coherent understanding and reach some resolve. The term has been used more liberally in clinical literature to identify increasing security in present relationships. Children usually cannot build narrative coherence yet (given their limited cognitive capacities for analysis and historical perspective), but can experience increased internal security when they can maintain regulation.

⁶⁸ Arousal noise has also been called "background emotions." There often feel like an undertone but can add to a child's sense of emotional disequilibrium. Damasio, A. (1999) *The feeling of what happens*. New York: Harcourt Brace.

⁶⁹ Disturbance of emotions "is seen both when such reactions [fear, anxiety and anger] are chronic, misdirected, or inappropriate triggered and when they fail to appear when needed." In Sroufe, L.A., Egeland, B., Carlson, E., and Collins, W.A. (2005) *The development of the person: The MN study of risk and adaptation from birth to adulthood*. New York: Guilford Press.

⁷⁰ This is an important idea: emotions move. Regulation is not only about modulating but moving emotions to assure room for new emotions. Very at risk children hold onto emotions as permanent, rather than transient, experiences. Gross, J. and Thompson, R. (2007). *Emotion regulation: conceptual foundations*, in *Handbook of emotion regulation*. New York: The Guilford Press.



Repairing Reflective Thinking, Which Supports Both Emotional and Behavioral Regulation.

Self awareness and reflective thinking, like self regulation, are casualties of disorganized early experiences. Social cognition (interpersonal exchanges) builds a foundation for formal cognitive (facts, knowledge) and learning skills. When children interact with their caregivers, they learn the intricacies of knowing one another, and then knowing about the social world together. When interactions are compromised or parents are unavailable, children miss the necessary back and forth stimulation that supports self discovery and social interest. They don't learn how to reflect on what happens between people, or what happens within their own minds.

Repairing this early form of thinking requires that adults imagine what is going within children's minds. Just as parents offer their babies a sense that they have a mind, so must adults do that for these very at risk children. Adults must demonstrate that they can be *mind-minded*.⁷¹ They use their own minds (and mentalizing capacities) to be interested in, and attuned to, what is happening within children's minds.

This kind of reflective thinking is called mentalizing. Mentalizing⁷² is a "mostly preconscious imaginative mental activity, namely perceiving and interpreting human behavior in terms of intentional mental states (needs, desires, feelings, goals, and reasons)."⁷³ This mental activity is "imaginative because we imagine what others people might be thinking or feeling . . . and a similar kind of imaginative leap is required to understand one's own mental experience, particularly in relation to emotionally charged issues."⁷⁴

When care has been harsh or neglecting, many children stop imagining. Instead of reflecting, they shut down thinking except to stay vigilantly aware of danger. When care has been disorganizing, children struggle to find coherence in interactive exchanges, and lose a coherent sense of themselves.⁷⁵

⁷¹ This term describes caregivers who are psychologically attuned to their babies and support early understanding of social exchanges. Meins, E. Fernyhough, C., et al. (2003). Pathways to understanding mind: Construct validity and predictive validity of maternal mind-mindedness. *Child Development*, 74.

⁷² This function has several names. Fonagy called this capacity 'mentalization'. Jon Allen prefers 'mentalizing,' a verb that describes mental activity. Reflective function is a third variation that captures thinking about what you see inside yourself or within the other's mind. Earlier work on this idea used interpersonal interpretive mechanism. What is central in all these terms is the effort to intuit others' intentions, and then become aware of one's own intentions and thoughts (self awareness). See: Allen, J. & Fonagy, P [Eds]. (2006) *The handbook of mentalization-based treatment*. Hoboken, NJ: John Wiley & Sons

⁷³ Fonagy, P. Target, M. & Gergely, G. The parent-infant dyad and the construction of the subjective self. *Journal of Child Psychology and Psychiatry*, 43 (3/4).

⁷⁴ Ibid.

⁷⁵ There is interesting research about how repairing this ability to mentalize helps adults struggling with disorders of emotion regulation, including borderline personality disorder. This disorder has also been described as resulting (some of the time) from disorganized attachment experiences. Bateman, A. & Fonagy, P. (2008) Eight year follow up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry*, 165.

“Mentalization could hold the key to breaking the cycle of abuse and deprivation for that child growing up.”⁷⁶ Intergenerational patterns of maltreatment continue when actions replace thoughtful awareness of others’ feelings and needs. Without some capacity for reflection, very at risk children will grow up and treat their children as they have been treated. They will not be able to imagine different outcomes.⁷⁷

Repair must address emotion/thinking: *what does my mind tell me about how I feel and what I want to do? The instruction, think before you act*, requires an ability to also know about feelings that have triggered the need for action. This kind of reflective thinking is an essential component of behavioral control. Very at risk children must shift from their habitual *I don’t know* responses to a more coherent awareness about what they want and need.

Mentalizing supports narrative coherence. Making sense, or meaning, of difficult experiences is a critical protection against ongoing confusion. Children must be able to consider what has happened to them, and why, and how they feel, so they can trust their own perceptions. Reflective thinking also supports social involvement because it helps children tolerate and respect different points of view and understand negotiation.

Repairing Effortful Control of Behavior

These very at risk children are prone to acting out. Behaviors triggered by emotions are not obligatory; acting is usually a choice. But behaviors resulting from heightened arousal feel obligatory to these children when they misperceive danger and become activated to fight the danger away (externalizing solutions).⁷⁸

Imposing external controls interrupts behaviors but also disrupts developmental agency, which is having the sense of one’s actions as effective and having impact. For self regulation to work, activity must be a partner with organization. Children must initiate actions to know they are capable. Because very at risk children have relied on aggressive actions, it is reasonable that people want to stop them. But external controls restrict their only way to be active.

Respecting agency also protects children who are prematurely responsible for themselves in many situations. These children must be active but at the same time must become deliberate about the effectiveness of their behaviors. Even when children stay prone to externalizing distress, they can learn to fix problems instead of resorting to aggression. Children who are already prone to oppositional behaviors must learn new behaviors that draw them closer to people when they are distressed.

Effortful control describes trying to deliberately manage *my own behaviors*. If this capacity is correlated with attachment security, then repairing effortful control requires some relational connection (*I need her care*) that can then promote imitation/identification (*I’ll try it her way; she wants me to do this so I want to do it too.*) When very at risk children can replace behavioral reactivity with motivation to maintain relationship ties, they feel organized to this purpose. But they must also stay active. This is where negotiation becomes useful, to make sure that children maintain some sense of their own agency

⁷⁶ Fonagy, P. Target, M. & Gergely, G. The parent-infant dyad and the construction of the subjective self. *Journal of Child Psychology and Psychiatry*, 43 (3/4).

⁷⁷ Minding the Baby is an intervention that focuses on maternal reflective functioning. At risk mothers struggle to see and protect (vs. deny and reject) their babies’ feelings and needs, just as they struggle to know their own. The program works to “keep the baby’s mental and physical states alive for the mother, and to continually model reflective awareness in everyday caregiving and nurturing.” Slade, A. (2002). Keeping the baby in mind: A critical factor in perinatal mental health. *Zero to Three*, (June/July).

⁷⁸ These authors state that “the multisystem changes associated with emotion are rarely obligatory” but when stress arousal triggers brainstem activity, their behavioral discharge do seem obligatory to their body safety. Gross, J. and Thompson, R. (2007). Emotion regulation: conceptual foundations, in *Handbook of emotion regulation*. New York: The Guilford Press.

even as they accommodate to what they should do. Social norms must work for them, as these work for others, so children feel there are choices.

When children demonstrate increased behavior control, they begin to tolerate more normative consequences for misdeeds. If children are to return to community inclusion they must be able to abide by the rules and develop a social conscience that dictates *what I should do*. Very at risk children must learn about cause and effect in new ways.⁷⁹ Responses to behaviors that make sense to securely attached children (such as time out, natural consequences) must be learned and practiced. Adult kindness provides the necessary glue that helps these children stay regulated in response to imposed external controls as well as to exert the effort required for positive internal control.

Repairing community involvement

Developmental Repair is embedded in research that supports early prevention and intervention. Because of their young age, these very at risk children are able to make developmental shifts from maladaptive to more adaptive learning when they can access adult help. At the same time, because they are still young, they need help in other settings. Risks cannot be erased and many children face ongoing danger and stress. Developmental Repair also aims to change how the larger community perceives and understands these children.

Schools are the third partner, working with families and the treatment team. Success in school is a critical protective experience.⁸⁰ Schools give children access to other adults and well adapting peers, and provide opportunities for social and academic learning. The school community becomes another place to be (in addition to home, which may not be safe). Social inclusion in school provides the template for social inclusion in other community settings (teams, clubs, jobs).

Inclusion in schools may not be enough. These very at risk children deserve ongoing community support, yet support and understanding are often denied because their behaviors are perceived as threatening others' security.⁸¹ This vicious cycle must be interrupted. Communities must extend kindness instead of harsh rejection. Because they are already in danger of falling out of the community, it is imperative that every effort is made to support their participation in pro-social activities and experiences.

Keeping these children connected has significant economic benefit to the larger community.⁸² Early intervention is cost effective when weighed against the likely financial implications of economic alienation (school failure, poor job skills, unemployment), social deviance (criminal activity) and social dependence (incarceration, disability, welfare for children).

Developmental Repair does not assume to cure these children of the long-term effects of risk and developmental disruption. It does presume that these children can do better in their functioning and when necessary, access less intensive community help.⁸³

⁷⁹ To revisit contingency (footnote #20): Children need their regulatory partners to be predictable enough (contingent) to tolerate imposed contingencies, or social expectations that the child may not yet know. Contingency reinforcement as a behavioral tool works when children feel connected to the adult, and want to maintain this connection. 'Nearly, but clearly not, like me' leaves room for disappointment and new learning.

⁸⁰ Reynolds, A, et al., (August 2006) Effects of a school-based early childhood intervention on adult health and wellbeing: A 20 year follow up of low income families. *Early Childhood Research Collaborative*. www.earlychildhoodrc.org

⁸¹ Dodge, K. (2008). Framing public policy and prevention of chronic violence in American youths, *American Psychologist*, 63, 7.

⁸² Rolnick, A. and Grunewald, R. (March 2003), Early Childhood Development: Economic Development with a High Public Return, March 2003; Heckman, J. and Masterov, D. (October 2004) The Productivity Argument for Investing in Young Children.

⁸³ As children complete this intervention, less intense and more focused interventions may be appropriate. Better said, the children (and their families) now have the prerequisite skills to participate.



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4 Developmental Repair

- Developmental Repair As An Intervention Model
- What Is Developmental Repair?
- The Arousal Curve
- Four Developmental Domains
Relating, Feeling, Thinking And Acting
- Moving Towards Self Regulation
- This Is What Happens In
Developmental Repair



DEVELOPMENTAL REPAIR AS AN INTERVENTION MODEL

Children who are very at risk struggle with regulation. Unlike their peers, they have missed opportunities that support this developmental capacity. They don't expect adults to provide regulatory support and often push help away. They become easily dysregulated and act out their distress. Treatment must address children's inability to regulate arousal, emotions and behaviors if children are to access new and more adaptive learning. And because self regulation always starts with shared regulation— with regulation provided within a relationship with another—repair must address their ability to use adult help.

Developmental Repair is an intervention model that provides this necessary help. Intervention cannot change past experiences, but repair can help them function differently in the present. Treatment repairs the interactive and internal processes that support self regulation and allow new learning, and in the process, reduces aggressive behaviors and social alienation.

What Is Developmental Repair?

Developmental Repair is a treatment model informed by research about normal development and risk effects. Developmental Repair recognizes how most children learn and approximates the interactive learning processes these very at risk children have missed. Developmental repair also attends to the meanings these children have constructed from past experiences and provides new relationship interactions that can alter their maladaptive perceptions, beliefs and understanding about themselves and others.

When adults recognize that these children appear out of control on the outside because they feel out of control on the inside, our thinking and acting shifts. Rather than trying to extinguish or control behaviors (contingency reinforcement), intervention focuses on helping young children repair their capacity for self-regulation of arousal



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and emotions as a prerequisite for subsequent developmental mastery and behavioral control. To support self regulation, treatment must also attend to deficits in self-awareness. Developmental Repair builds shared awareness as well as shared regulation as the bridge to more age-appropriate functioning.

These ideas organize Developmental Repair:

- Self-regulation of arousal and emotions is at the core of developmental functioning. Self-regulation supports exploration, self-awareness, organization, self-control and many other complex capacities.
- Since development always occurs within relationships and presumes the availability of regulatory help, repair assumes the availability of adult partnering to supplement what earlier relationships have struggled to supply.
- Development runs on internal motivation and energy, and intersects with environmental triggers and demands. Intervention attends to environmental experiences and influences that impact children's developmental capacities.

- Development becomes strained and disorganized when there are new demands. Normal disorganization leads to re-organization. Adults provide necessary support during transitions.
- Under the right circumstances, development can shift towards more effective adaptations. This is especially true for young children, who remain malleable to new and different experiences.
- Maladaptation represents children's best efforts at coping with the resources they have. Rather than blaming young children, we must respect what they have tried to do and appreciate the costs to their development.
- Because we are targeting developmental capacities that involve mental life, this intervention relies on mental actions. But for young children, mind and body are especially intertwined, so Developmental Repair pays attention to both mind and body experiences.
- Developmental repair is not a regressive treatment. Activating the possibility of adult partnering happens in present moments. When children are engaged in new ways there is possibility that developmental capacities can be repaired and current life demands addressed with better resources.
- Resilience is the ability to bounce back in the face of risks and challenges to developmental competence. When children practice different ways of relating, feeling, thinking and behaving, over and over again, they can better bounce back from ongoing risks, but also stop exacerbating risks with their own maladaptive coping.

These are young children trying to survive difficult circumstances. Developmental Repair recognizes how current diagnostic categories imprecisely describe children's efforts to survive relational neglect, trauma and social estrangement. Interventions must understand the interactive nature of their symptoms and the developmental capacities or functions that have been compromised because of these adverse experiences. Behaviors are re-defined as important communication about children's developmental deficits, such as a difficulty maintaining and regaining self-regulation. These deficits must be repaired before behaviors can consistently improve.



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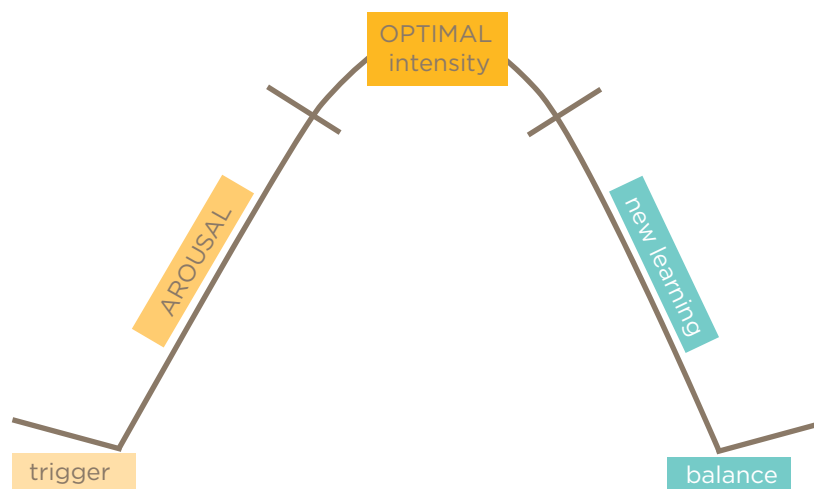
The Arousal Curve

Developmental Repair recognizes the insidious effects of chronic arousal dysregulation. To understand this intervention it is important to consider the function of arousal in normal development. When children's arousal is better regulated with adult help, then new learning is possible.

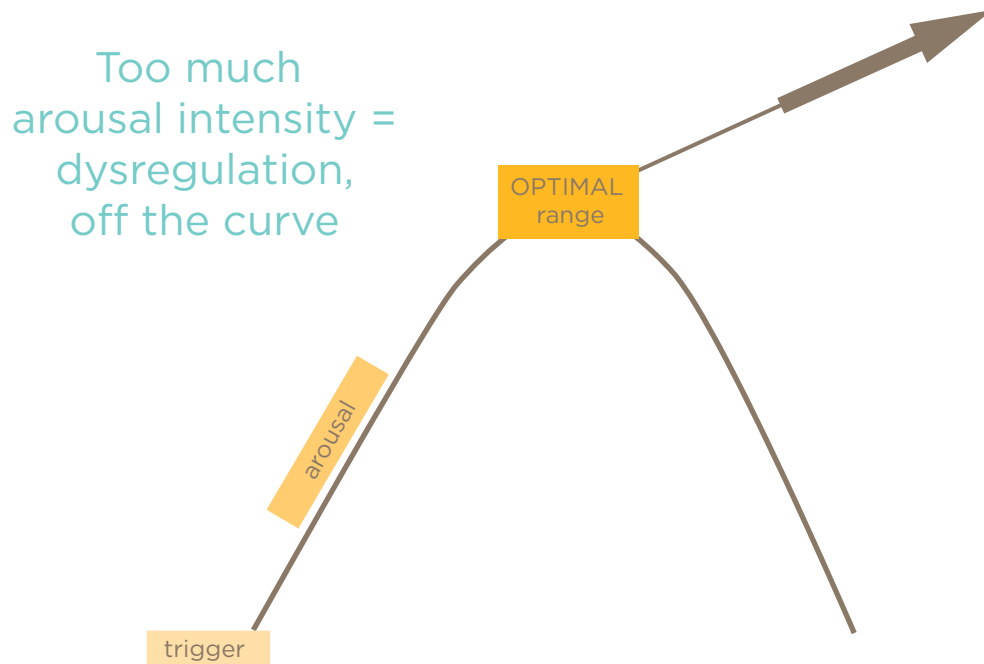
Arousal is biologically triggered when something happens, from outside (real or expected events or experiences) or from inside (physical distress or perceived associations), that signal danger. Arousal activates the body and brain to pay attention, and then to figure out what to do to manage this painful distress. Most young children turn to adults to figure out how to feel and what to do. They need their parents or caregivers to step in—to provide soothing care so that arousal can be tolerated and eventually organized into perceptions (what is safe or dangerous) and emotions (what I feel about this experience).

When care is reliable, adults help children know what to do. For example, when infants wake to hunger, they become aroused and cry out. As they learn to anticipate feeding, they may quiet to the sound of someone walking towards them, even if they cannot see this person. They are learning to realize patterns that signal care, and then to construct their own patterns of response (called strategies). Babies can regulate their hungry crying and can then relax enough to become interested in other things – their crib, the sounds in the room, the movement of their own bodies. They will also look eagerly when parents arrive to make sure the adults know they are expected. This early interactive (social) learning facilitates adaptation and a sense of security.

AROUSAL CURVE (normal)



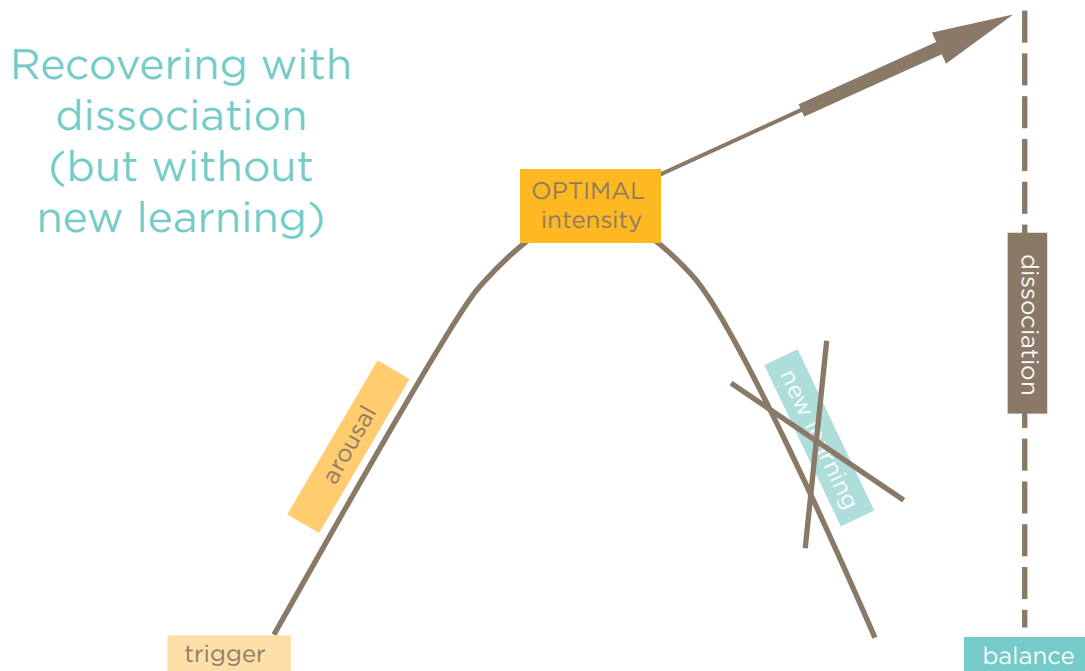
This curve illustrates how arousal promotes new learning. Optimal intensity arousal is enough to grab the child's attention, but not so much as to become overwhelming. All children experience arousal and parents provide needed support to make arousal useful. Optimal arousal represents what a child requires internally to activate *my own attention* (personal characteristics) as well as what the family expects to activate *their attention and care* (the family's emotional availability).



New learning happens when children can use this arousal attention to find solutions, or to allow adults to provide solutions that they can then adopt: *this is what I am feeling, this is what I can do, now I know*. Children regain balance (relative well being) and carry out these solutions: *I can do this, and I can do it next time*. Very young children are not consciously aware of this process of arousal and learning, but they gradually feel secure about their parents' help and then build confidence that they can do this for themselves. Managing arousal starts as shared regulation and over time becomes self regulation.

Arousal dysregulation and dissociation

When children become too intensely aroused, or when arousal activation becomes chronic or ignored, children struggle to learn. When adult help is insufficient or unavailable, children become overwhelmed because arousal without solution becomes painful and confusing. Even relatively minor distress can become exaggerated because of arousal velocity. They feel too much. When arousal activation is chronic, or there is a consistent lack of adult soothing, arousal dysregulation can become a pattern. These children fly off this arousal curve. Instead of moving towards solutions that restore regulation, their arousal takes them away from solutions and increases their perception of feeling endangered by external threat and their own internal upset. They become disorganized and dysregulated.



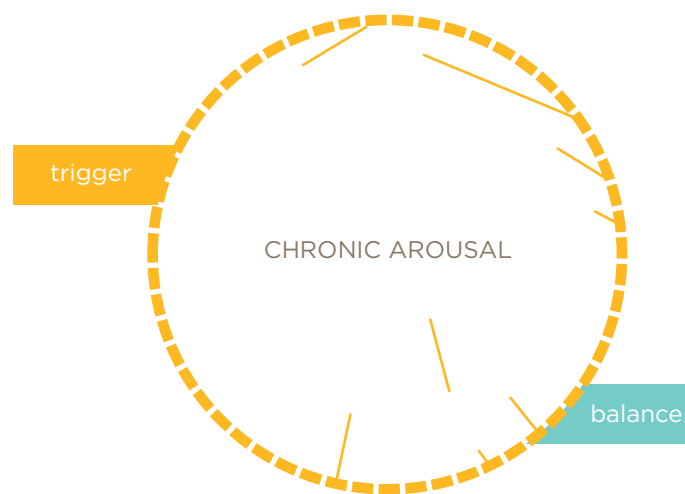
When children have experienced arousal dysregulation repeatedly, their learning becomes co-opted. Instead of looking for adult help, they perceive help as adding to harm. They have few internal resources for calming down and resort to fight or flight behaviors that are instinctual. Some children escape this painful state by dissociating from the current situation in ways that are described as *checking out*; they become quiet and disengaged. Others fight, using indiscriminate aggression against anyone or anything that is in their way. Offers of help are lost within the roar of their own arousal. They become oblivious to the triggering event and perceive imposed external control as further harm (*get away from me, leave me alone, you're hurting me*). Their behaviors can appear intentionally defiant but their motives are to escape and protect themselves from more arousal and danger.

Dissociation describes both fight and flight reactions. Dissociation is the brain's tool to manage unbearable arousal (similar to the body's shock response). When these children dissociate they leave the immediate experience of threat and their own arousal pain. They regain regulatory balance by relinquishing interest in what has happened and retreating away from relationships that have caused this harm. Dissociation quiets arousal but also interrupts *new learning in the moment*.

Behavioral interventions for aroused children don't stick; because they are overstimulated, they do not learn what to do differently. Behavioral instruction after the fact may be cognitively taken in but may not be useful in the face of subsequent heightened arousal. These children often enrage adults when they do the same thing again and again. Relational interventions are also compromised when children abandon the possibility of adult help when they are most aroused. Children may feel soothed after they calm down, but they miss learning solutions for the next time.

Some children remain chronically aroused. Their experience is better illustrated as a constant circle, with spikes of arousal activation and discharge followed by dissociative obliviousness or disinterest. The effect of this pattern is eventual lowered arousal and is the predominate characteristic of children with chronic oppositional and conduct problems.

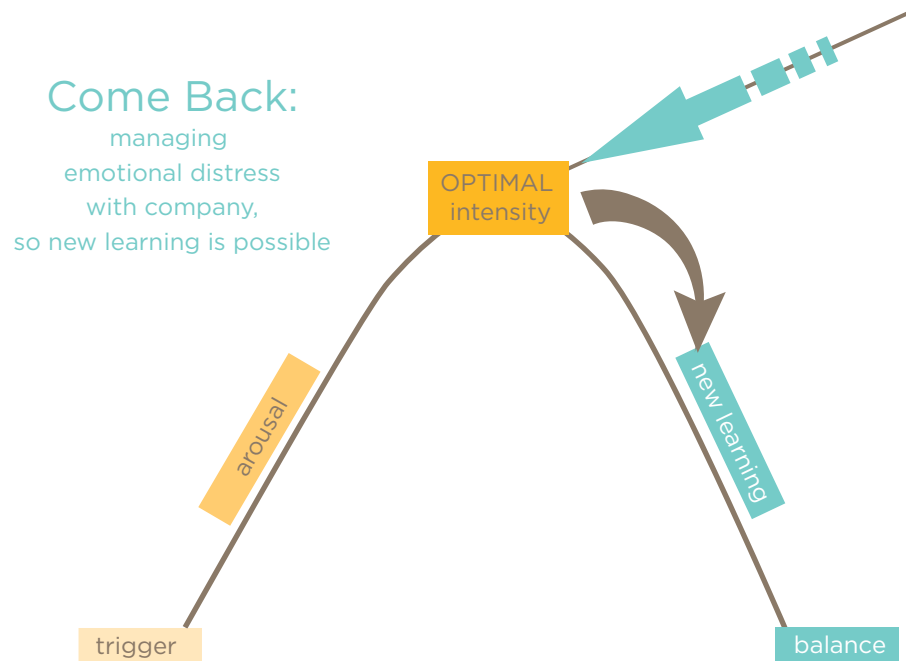
The problem of chronic arousal



Restoring Adult Help

To help young children who present with arousal dysregulation, adults must focus on returning them to an optimal level. They need to *come back*. Even the children who are chronically aroused need to find a safe mid-range of arousal intensity in order to know that arousal can subside. For very at risk children, return to optimal arousal is when they can allow adults to provide company and regulatory support even as they remain upset and distressed.

Come back happens when adults break into this dissociative cycle and help children calm. This happens not with attention to whatever triggered their arousal, but with interest to their own internal experience (*You got so worried and it turned into big feelings and you didn't know I could help*). Coming back stays with their feelings and perspective, and helps them become soothed in the moment. (*Now I know what happened to you. I see how upset you felt and how your body gets worried*). In this way, adults become co-regulators who provide messages: (*you're OK*) and (*we can make this OK, we can find solutions.*). Children need help to tolerate what had happened to them before they can comprehend how their behavioral reactions impact others. Other perspectives, or *facts*, must wait.



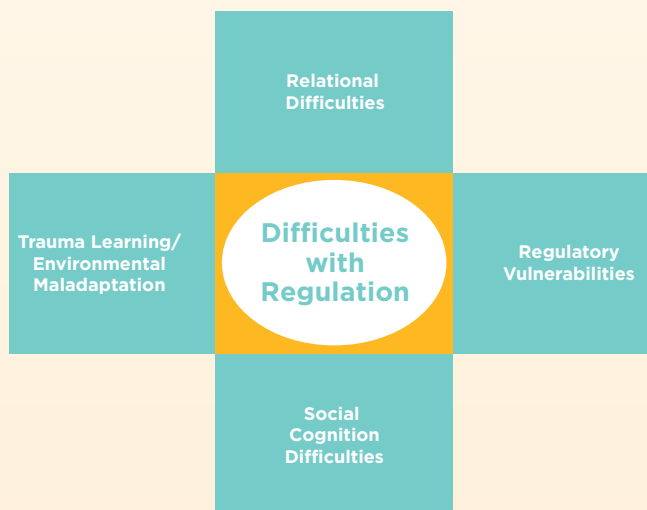
When children can emotionally *come back*, adults help them re-activate the normative arousal curve. With adult empathy for their perspective and their arousal dysregulation, they can slowly organize their experiences. They can see what happened to them and tolerate solutions that fix their distress. They can feel regulated enough to think about what to do. Coming back to arousal regulation must happen again and again and again until the child expects this is possible with adult help. When adults share their experiences, children feel more secure about help and can begin to consider new solutions. New learning happens when children realize that something different could work. In time, other perspectives are tolerable, especially when these are offered as things we can see together. (*When you're feeling calm, we could ask the other kids to share. We could see if they do. I bet they will let you and I'll help you if they don't.*) Complicated feelings are introduced—*mad/scared, mad/hurt*—that better name their internal states. And with adult support, children can begin to anticipate a next time, and practice different reactions or solutions that are remembered when prompted by supporting adults (*next time, when you get worried there won't be enough for you, tell me. Next time when you start feeling so mad, let me show you how to be mad enough and not too mad.*)

This learning involves emotional thinking and remains available as new ideas that come from inside the child and from the child/adult partnership. Developmental Repair uses moments of arousal dysregulation to work on children's developmental ability to trust that adults will help them stay regulated enough to learn.

FOUR DEVELOPMENTAL DOMAINS: Relating, Feeling, Thinking and Acting

Because these children are not infants, they have already established patterns of functioning. These patterns represent ways they have learned to survive in their environments (family, neighborhood, school setting), but are maladaptive. Very at risk young children remain vulnerable to difficulties with self regulation and with social exclusion.

Developmental Repair recognizes that these children must access more adaptive ways of functioning. Intervention attends to four intersecting domains of learning and functioning: relating, feeling, thinking, and acting. Each area contributes to children's capacity to be self regulating and socially involved.



Relating domain: Developmental Repair actively helps children seek and use adult help. This is in contrast to other interventions that ask children to accommodate to adult expectations. In Developmental Repair, we join with children and provide help, especially in moments of distress. We support children by providing adult availability and reliability, even when children expect and provoke the opposite. We soothe children from a state of uncomfortable arousal to a state that

is tolerable and allows for learning. Using adults is the first step towards learning how to feel regulated together, and gradually how to become more self-regulating.

Thinking domain: Developmental Repair actively works to repair reflective thinking and help children organize (make sense of) interpersonal expectations and associations. This is in contrast to other interventions that assume children's cognitive awareness and intentionality. Reflective thinking (mentalizing) develops within very early social interactions that support children's awareness of their own needs, feelings, intentions, beliefs, perceptions. We help children become aware of thoughts that reveal feelings and direct actions. We also help them see and understand the thoughts, feelings and intentions of others.

Feeling domain: Developmental Repair actively helps children feel and understand their emotions. This is in contrast to other interventions that confuse children's emotional and behavioral communications. As arousal becomes modulated, children's discrete emotions can be recognized and regulated. Emotion regulation always begins as shared regulation (sometimes called co-regulation or regulation shared with a caring other). As children know their emotions, they can better manage emotional distress and behavioral upset.

Acting domain: Developmental Repair actively helps children to become motivated to learn new patterns or new ways of functioning that increase internal behavior control and improve social inclusion. This is in contrast to other interventions that impose external control on children's behaviors. Behavioral disorganization is replaced with increasing organization about how children can make things work. (Work involves developmental mastery and positive social inclusion.)

All four domains contribute to children's capacity for self regulation. In describing Developmental Repair, it is necessary to present this intervention as a linear process—to identify a start point and describe next steps. In reality, these four areas are interactive and intertwined, so intervention activity is continually shifting among, and engaging with, all these domains.

RELATING: THE FIRST DOMAIN

Forming a Co-Regulating Partnership

Developmental Repair always starts with relating. Children need adults as reliable partners to re-activate the interactive learning that they needed as infants and need even more now.

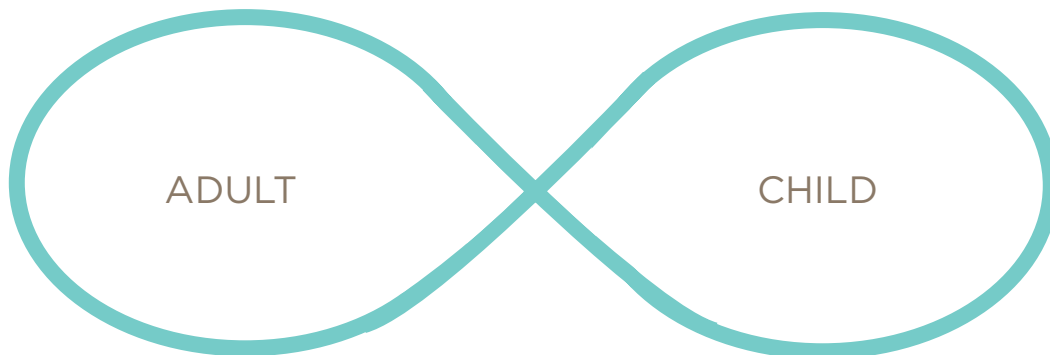
Joining Discovers Children's Needs

Treatment starts with joining the child. Joining means being available to children, and becoming interested in their experiences and perceptions. We join children to re-activate the normative process of becoming regulated, which starts with the expectation that adults can and will help. Unlike their peers, they have not had, and do not expect, consistent care or company. They expect adults to disappear, to become overwhelmed, or to be threatening at moments of distress.

We want children to feel how an adult can be a regulatory partner. We demonstrate our intention to help them. Because early regulatory learning is based on relationship reliability, we start by offering a new helping relationship. To provide this specific kind of reparative help, adults must learn to sense and engage with children's needs and feelings. They must recognize children's distress, tolerate children's disappointments, and resist seeing their behaviors as bad, or personal attacks. They must become interested in what is happening to each child and become attuned to what helps.

Children must become participants in this new relationship. They must *take in help*. They must allow adults to provide soothing support, especially during distressing experiences. Because many expect the opposite—to become more dysregulated by adult company—they need repeated opportunities to experience how this works.

The mutually regulating (dysregulating) system



Joining is a mutually regulating experience. Children initially push adults away or pull adults into their dysregulating chaos. Staff can feel threatened, confused or even provoked to retaliate. Instead we must tolerate these dysregulating encounters as necessary to know about children's painful internal experiences. By staying interested, we can regain our regulatory balance, and bring them back with us. We learn how to help individual children by engaging and watching and feeling what works, and tolerating when we struggle to find the right response. The more staff feel successful, the easier the regulating job becomes. Both adult and child start to anticipate the next time with building confidence.

Joining involves both physical availability and mental attention. Adults look at the world through the child's eyes and hold onto the child's experience, making this perspective as important as our own. We keep the child's needs in mind, even when the specific needs are not yet knowable. We do not assume to replace children's primary attachment relationship, which already exist in their families and in their minds. We build a new relationship within the clinical situation that will become a regulatory partnership.

Joining Builds New Patterns

Interest and kindness are the initial tools when joining children. We attend to their needs and look for opportunities to be helpful. There are always openings: they can't tie their shoes, they want more food, they struggle to use a toy, they get hurt. Joining a child starts with small gestures. We demonstrate our willingness to attend to their needs, even as they reject these overtures and reveal their skepticism. We establish a reliable pattern of concern and usefulness, and notice when they can accept help.

Joining becomes most important when difficulties emerge. Instead of imposing consequences for misdeeds, we act to restore their regulation (*this got really hard for you, let me help you*). We seek opportunities to interrupt children's isolation or faulty self-reliance. Small successes build security for the next inevitable disruption. We bring them into our sense of order. Joining does not preclude clear limits and expectations, but as we enforce rules and structure, we join the child's efforts to comply. We stay resolutely intent on helping them.

You got so upset and threw that car. No throwing toys. Let's breathe and get calm and then we'll figure what you really needed and how I can help you. It's OK.

This is very different from expecting compliance as a start point. Our position remains *with the child*, and with the child's experience. When they refuse to follow directions, we become interested in what they have perceived. When they act aggressively, we anticipate their fear of retaliation and avert power struggles as much as possible. They expect a disconnecting impasse. We offer concern about their feelings. Even when we stop behaviors, express disapproval and set limits we maintain a joining stance. Our interest is more on the child than on the behavior. Understanding replaces judgment and restoring regulation replaces compliance as necessary first steps.

When you start hitting, I know how upset your feel. I'm stopping you from hitting because I won't let you get hurt, and I won't let you hurt me. We'll figure it out and then I can really help you.

Notice the order of this response: *I won't let you get hurt and I won't let you hurt me*. This illustrates the important shift: we are there to take care of this child, and we want to protect the child from aggression, even when the child appears to be the cause of aggression. We want them to need us, although dependence is not our end goal. Letting us in, accepting our regulating help, is our end goal. We become dependable to them, especially when they are experiencing distress, so that they can feel helped, and count on our assistance. We build new patterns. Shared regulatory experiences become pathways to repairing their self regulatory capacities. The adult moves from doing for the child, to doing with the child, to watching and encouraging the child and then to expecting and eventually holding the child accountable for skills that are now possible.



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Helping Children Engage Adults

As children become comfortable with us, they *hire* us. *Hire* shows their activity in this partnership. They must start to actively seek our help when they become distressed. *Hiring* is not yet a secure commitment, because children will frequently forget us or *fire* us when they are angry. But when care and company is reliable, they learn to feel connected even in the face of negative emotions. *Hiring* also includes their desire to keep us involved as they manage new situations and look for our approval and admiration (positive emotions that have been strikingly absent).

Adults can never be perfect regulators of any environment. We cannot prevent upset or disappointment in the group situation, we cannot control children's experiences away from treatment, and we cannot interrupt painful memories or internal reactions. What we can do is recognize and even anticipate obstacles together, and provide regulatory support. This company is functional. Some children become upset and demand to be left alone; others immediately blame us for their miseries (*stop looking at me; you are making me scream*). Functional company is not interpersonal; it is not about us. It is about our ability to provide help.

This regulatory help must match what children can tolerate. Sitting quietly (and not expecting eye contact or verbal communication) allows many children to take in soothing company. One child described how he expected adults to walk away when he cried—as his parent did—and how humiliated and frightened he became when he was alone. Yet we also observed how he shied from eye contact, and needed quiet. This became an opportunity to plan how we would stay nearby but not talk until he was ready. In return he promised to work things out instead of shutting adults out, another form of walking away.

Children act out what they expect to happen. New interactive negotiations help them practice new patterns that allow them to feel active and engaged by choice. Children often use physical contact aggressively, or startle at touch because they expect harm. Adults need to restore touch as a normal part of relating so that children can stay in their bodies. Children need age appropriate ways to feel touch and to touch us. It is important that this communication be rehabilitated as a positive and adaptive interaction. Gym or outside time is a favorite for many children. They can run and expend energy. It is also an excellent time to touch children as they climb, jump, and push. They need to make contact, but to do this in ways that assure safety and regulation. Physical activity lets them practice getting excited and then turning that excitement down. Some children will want to be touched for comfort as well. Adults must meet this need without fostering undue regression (the child acts like a baby) or too much excitement (as can happen with children who have been physically or sexually abused).

Engaging with Multiple Partners

One benefit of group treatment is that children can learn to feel secure with multiple adults. We help children *hire* other adults within the group and the program. This generalization of help dissipates frantic neediness and intense fears of abandonment, and protects children when a staff person is absent or occupied, or when adults leave the program. Expanding partnering possibilities also helps children experience regulating styles with different adults. We vouch for unfamiliar adults (*he knows how to help kids, just like I do*), support patterns (*I told him how we do it here*) and help children accept some variety (*she does say it differently than I do but her way seems to work too*). We encourage children to show unfamiliar adults what they need from a regulating partner (*He's new, so show him what you need when you get worried. Tell him not to talk so much...He'll listen*).

Preferential relationships may emerge over time. Affection grows from feeling understood and soothed. This example illustrates how children start to notice what works: a six year old boy was consistently quiet in group, which reflected his sadness as well as his cultural style. Yet talking to him caused more isolation. One day he announced how one of the occasional adults had helped him. *"She just sat there and listened,"* even though they mostly were quiet together. This connecting experience became a strong affectional bond that carried through his treatment even when access to this adult was infrequent. He remembered and asked for her. His statement also helped regular staff to acknowledge what he needed.

Obstacles that Disrupt Joining

Joining can be difficult to sustain for both the child and the adult. These children bring established relational patterns from home, school, day care, and foster placements into the treatment setting. They work hard to make us fit into their assumptions of what they expect will happen, even when they want to let us in. Here are some examples of how children block help: they become aggressive as soon as they feel frustrated; they accept help but then become contemptuous of the helper; they anticipate disappointment regardless of what adults do; when they feel vulnerable, they become humiliated and inconsolable. Many children provoke rejection to prove their doubts. Others forget times when help is effective, so each interactions feels new.

Adults become frustrated when their overtures are rejected and get too angry or impatient in everyday interactions. Staff working with these very at risk children have described feeling as if on an improvisational stage without a script, unaware of what is going wrong until it is too late and trapped not only by the children's strategies for pushing help away, but also by our own uncertainty and emotional clumsiness.

These obstacles must be noticed and attended to, rather than excused or dismissed. Children's behavioral strategies reveal beliefs that maintain maladaptive outcomes, as well as patterns learned for protection. Adult reactions help staff decode the interpersonal dynamics from children's earlier experiences. But these same reactions also reveal how challenging it is to be with these children and can support genuine empathy for their parents as well as concern for the children. When adults continue to make efforts for joining, most children succumb. Developmental Repair assumes that young children want to feel cared for and connected to adults, even if they doubt this possibility.

Joining in Stormy Moments

Stormy moments describe episodes when children's behaviors become disruptive and intense arousal takes hold. These moments can be triggered by current realities at home or in the community. These can also occur when children feel thwarted within the treatment experience: when adults act in unexpected ways, when peers seem rejecting, when tasks spark humiliation, when needs are denied or limits imposed. Some children quietly despair, but most very at risk children project their fear and anger out,

reacting to perceived offense with disproportionate aggression. They fight as if those present are the cause of all things bad.

When these moments occur, arousal increases rapidly. Children become disorganized and then dysregulated. They lose inhibitory controls, they act mean and retaliate against perceived threats and they provoke abandonment or rejection. They expect bad outcomes.

Joining is most critical, and most challenging, at these times. Staying with children can seem like going into the eye of a storm. Adults feel tossed about and must act against instincts to run away or strike back. (Staff must be realistic about their own safety. The young age of these children does reduce the possibility of physical harm to adults). For most children, distress activates two neurobiological responses. The first is the fear response and their behaviors suggest they believe they are fighting for their lives. The second is the attachment response—*I need someone to save me*. Instead of shunning these children when they become aggressive, we seize this opportunity to provide care and regulating help when they most need it.

In these intense moments children need help containing arousal feelings. When children are not so aroused, adults match feelings to help children see what they are feeling and learn to express these feelings. But when children's arousal feelings remain painfully intense and overwhelming, they need adult help to become soothed back to a more tolerable state. Children learn something valuable when they can permit adults to join them during these stormy times. When heightened arousal and emotions are calmed with positive care, children learn something new.



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Tools for Quieting Intense Arousal

Very aroused and aggressive children assume adults are adversaries, even when we are not. The adult's task is to decelerate arousal and aggression, and to regain connection so that regulatory help is possible. These are some ways to help children *come back*.

- Be quiet. Being quiet may be the best joining gesture to counter children's internal arousal noise.
- Breathe slowly and intentionally. Children automatically copy this rhythm. Breathing interrupts hyperventilation, and makes children aware of the adult as present but not threatening.
- Use eye contact—or not. Some children need to feel seen. Others will scream “*don't look at me*”—so don't. Joint eye contact can signal a return to connection.
- Verbally match. Verbal sounds (similar to cooing towards infants) signal our presence and attentiveness. Words that match the child's own words (*I hear you, you're telling me that wasn't OK*) or provide a reassuring message (*I can stay right here and be still, don't worry*) can also be useful. The point of words is to quiet arousal fury and panic, rather than to explain a situation.
- Stay in the present experience. When children are highly aroused, explanations about what happened or directions about what they should have done assault the child's already fragile equilibrium. Be patient that opportunity for this learning will come in time.
- Remain physically nearby as the storm passes through. When children become certain the adult will remain available, their panic lessens, as does their fury. Arousal becomes like riding a wave instead of drowning. Close enough can be next to, across the room, or outside the room so children don't feel captured or controlled.
- Find distractions that can be shared. Distractions are not avoiding conflict but interrupting painful arousal energy. Shifting attention, repetitive play (like tossing a ball), physical movement, introducing a positive idea can dissipate arousal and restore connection.
- Recognize when the child *comes back* to a less aroused state. This recovery deserves to be admired as an accomplishment. Positive emotional support at this moment helps children tolerate their fear and shame.

Co-regulation describes how adults provide regulatory action even when the action is being still or supportive. Children need to regain regulation again and again. It is through these repetitions that children begin to *feel* the sensation of arousal disruption and arousal repair. Developmental Repair helps children become attached to our regulatory help, and remember these memories of being helped to improve their capacity for self regulation.

THINKING: THE SECOND DOMAIN

Helping Children Use Their Minds

As children regain and maintain regulatory balance they learn something new. This is not yet insight. Insight presumes some awareness of what is happening within *your mind*. Very at risk children struggle with deficits in self awareness as well as self regulation. They can appear intentional and manipulative but often act before they have thought about what is happening. They have missed out on early relational experiences that support the emergence of a socially active and aware mind that organizes appraisal and reactions. They have not learned to think about themselves or others, except to assume repetition of what has already occurred.

When we join children, we also join with their minds. We help them learn about reflection and mental states. We *read* what they may be thinking or could be thinking if they could organize the multiple sources of information necessary to make sense of experiences. We also help them access our minds so they can understand interactions without collapsing into disorganization. This early thinking is called reflective thinking (mentalizing). Developmental Repair uses mentalizing as a staff tool to facilitate regulation, and recognizes how shared awareness leads to reflection and self awareness.

The Importance of Early Social Communication

To understand reflective thinking, we must understand something about minds. The social mind holds each person's subjective experiences about how my mind represents experiences that happen in a certain way, or are intended to happen; the social mind also takes in some sense of what others' want and intend. Social awareness starts in infancy as babies take in, or represent, care. Representations are mental pictures or sensory collages of experiences with others that gradually include experiences of myself.

Parents provide more than represented experiences. They also imagine their baby within their own minds, and propose what their babies' feel and think and even intend. Then they offer these thoughts to the baby (Are you hungry? I see you're feeling hungry. You're telling me such a sad story today. Are you mad from waiting?) Parents read their babies' minds; they describe why things happen (when you get so tired, you must go to sleep. I'll rock you so you can relax). Children gradually represent these attributed feelings and thoughts as coming from their parents' minds but also belonging to their own minds. So begins shared awareness.

Children are born with this capacity for mind awareness but need adult company to learn how to activate this social exchange and use their own minds. Very at risk children struggle when social exchanges include negative sensations that obliterate their desire to know what is going on. They struggle to protect themselves from attributes in their parents' minds, or feel responsible as if their own thoughts and needs are cause of their miseries. Without help, they struggle to know about their own feelings, intentions and ideas and remain confused about what is happening in others' minds. They lack experiences with social communication that support reflection and sharing.

Learning to Reflect

Developmental Repair addresses this gap in social communication and reflective thinking. We intuit their thoughts, feelings and intentions, and *read aloud*, what we assume could be going on. Before we can address feelings, we have to help them find their minds. We offer shared awareness—we take their perspective as what is important. But we also add to their perspective—we *read* their faces and bodies and behaviors and imagine what is happening inside them. Reading is not mind-reading but

social communication that recognizes the importance of *what is on your mind*, and tries to discern mind messages. Within these shared exchanges, children recognize that they do have thoughts and ideas and feelings within their minds that can be shared and explained.

Shared awareness often starts with our intentions towards them as different from what they assume.

You are thinking that I wanted to hurt you, but I don't. It was an accident that you got hurt and I'm sorry that happened. I didn't want it to happen to you.

We *read* our interactions with children. We use our own perceptions to see their needs and responses and then we imagine what is going on within their mind. We put into words what we see.

There was too much noise and you got so wound up and didn't know what to do. When you feel that yucky excited feeling, you get scared inside.

I want you to have the toy and I'm looking for it. You think no one will help you but I am thinking I will.

We *read* emotional undercurrents which likely trigger behaviors. We start with relational behaviors because this affords some certainty—we know what we were thinking and we can guess the child's side of the exchange. This often helps children realize that misunderstandings can exist without malice.

You thought I wouldn't listen to you, so you got really mad and knocked that over. But I wanted to listen. You didn't believe me when I said that. You believed your worry instead. We had a misunderstanding. Next time listen and see if it works.

We also address perceptual differences because children are primed for confusion and betrayal. They protect their own perceptions rigidly and make others wrong (and fear we will make them wrong).

Wait...wait...you think I am mad. But my mind is saying that I'm not mad. I think this is a mix-up in your mind. You worry all the time that people will get mad and you won't know why. But I don't do that. I tell you when I have a feeling and you can know about it.

When I was gone, you thought I didn't want to be with you. I was gone because I had to go to a meeting. You felt mad and I felt sad to miss you. We were feeling different things but really it was the same. We both wanted me to be here.

You think I wanted to hurt you, but I don't. When you were upset and hitting, you may have thought to hurt me. But you were just thinking. You don't want to hurt me anymore so it's OK.

Shared awareness allows adults to propose what has happened, and then to join children in reflecting what that was like. We construct possibilities that allow for different meanings and different outcomes. Children must learn how to understand and interpret what happens between people, and to be aware of their own experiences within these exchanges. This permits beginning self awareness.

When children can reflect about their own experiences and feel organized by their own thoughts, then they can start to address worries and agitation from home or school. We always acknowledge these events, but *thinking about* these hard times is often too painful until children can sort out their own emotional thoughts. When they talk about these stories, we help them tolerate their feelings and sort out what happened to them first, before we address the reasons that may reduce their confusion and protect them from perpetual disorganization.

Supporting Self Care and Self- Sense

Self is a construct that is assumed and taken for granted: *do it yourself, you know what you want*. But relational experiences validate *I am*, and relational representations hold *this is who I am*. When earlier representations have not been supportive to children's *self-sense*, this must be repaired. We help children see themselves as they exist in our minds, so they can imagine themselves.

I can see what you want and that helps me to know about you. You tell me.

When you are home, think about how I play with you, and then remember how you like to play.

Self care builds this sense of self. *Take good care of yourself* must be prefaced by a message that others' care for you (*you belong to me*). Many children have missed out on the experience of someone having such caring thoughts about them. This concern then transfers into positive self care. *I'm thinking about your teeth, and I want you to have good teeth, so brush your teeth really well to take care of yourself* is a very different message than an angry directive. Especially with maltreated children, promoting self care must be activated as a shared desire to repair earlier relational neglect.

Take good care of your own ideas is also an important message. Developmental Repair works with similarities and differences to build awareness of what children like and don't like. Not surprisingly, very at risk children often start out not liking anything. We share ideas and find similarities that help them to trust their own minds again, or for a first time. We protect their right to know their own ideas or needs without feeling blamed.

Some kids like apples but it is OK if you don't. You can tell me what you do like and maybe we can get that someday.

I think you wanted to say no to math. You can tell me what you want, even if it is different than what I want. You can tell me instead of throwing stuff.

Skills for Self Awareness

Children can learn skills that help them use their own minds and support self regulation. One example is self talk. Self talk starts as relational conversations or interactions that are taken into the child's mind and remembered for future use. Self talk start simply: *don't hit, hot stove*. These useful instructions help children protect themselves. Self talk expands as situations become more complex, but the purpose remains the same: *remind me what to do and how to be so I am OK*.

For very at risk children, self talk is not positively instructive. Usually their self talk is a litany of negative self descriptions—*stupid baby liar*—or swearing, angry words that are the background noise of their environments or mimic attacks against them. Instead of supporting regulation, their self talk threatens their internal balance or is used as a projected weapon against others.

To build this skill, we talk with children. We share how we think and feel about situations, and encourage them to use these ideas. We look for easy words and phrases that address their needs. Self talk is not just for rules and prohibitions but also speaks to their worth and desires. Self talk helps children maintain their own well being and regulation by knowing what to do to protect themselves.

When you get upset here, you know what we do. When you are at school, try to remember what I say, and then you can say the same thing to your mind—calm down, I can figure it out, it will be OK. You can do that instead of yelling. Talk to yourself.

Another skill we repair is conversation. Very at risk children struggle to use words; swearing often dominates their vocabulary because they lack other ways of expressing needs and thoughts. Children practice talking about what is on their minds. We exchange ideas. We help them engage in conversations so they can hear what they think, and give them opportunity to say what they know. Conversation does not impose ideas but helps them discover their own thoughts, especially thoughts that evoke feelings.

You're getting so mad but use your words. Tell me and I will listen, and then we can talk about what to do. I used to guess, but you can tell me now.

Children learn they can know about things, not in reactive and behavioral ways, but through imaging thoughts that stay safe. They also learn that thoughts are different than actions—they can think about what they feel and would like to do without carrying out a plan.

Intervention starts with experiences within the treatment partnership, instead of moving too quickly to address out-of-treatment experiences or relationships. In the treatment setting children can have thoughts and feelings that can be contained. These thoughts and feelings need space to exist aloud without being squashed or acted out. Without the mental place to think reflectively about how they feel, they cannot absorb or comprehend more organized cognitive explanations. They cannot re-frame when they lack the original ability to frame their own thoughts.

Introducing Shared Problem Solving

Think before you act, or think about what you did, requires a capacity to be reflective. Many very at risk children are extremely impulsive and struggle to delay actions. Instead of allowing them to continually fail, we introduce shared problem solving. When children are aroused and connected, they respond to help that sees what happened and then what could happen next. *Could*, not *should*, organizes this shared effort to identify possibilities for fixing situations. Shared problem solving alleviates too intense shame and substitutes desire to feel re-connected and secure.

Negotiation presumes that, in conflict, both sides are important. These children are surprised when adults value their needs and support their ideas. Shared problem solving helps children retain their sense of agency—that they can take care of themselves—and still accommodate to others' needs and expectations. We make *deals* that clearly demonstrate that both sides can come out of the deal OK. They need practice feeling effective so they can eventually tolerate that some deals include not winning, or not getting their way. Negotiation as a state of mind extends to peers and helps children tolerate and appreciate the other's point of view.

As children feel more organized about their own intentions and needs, and feel secure that they can discern ours, they can discover their emotions from the rubble of arousal. They have felt assaulted by their own emotions, and have been told what emotions they feel, but they have struggled to use these emotions for their own well being and regulation.

Here are some ways to help children think about better solutions.

- Offer a way out. Children need permission to be done with arousal rigidity. *It can be over, we know why you got upset so you can be OK now.*
- Agree to work together. *We can figure this out* is more helpful than *you know what you did*. Arousal alters perception and confuses intention. Children need company to discover facts—to enter objective data into their subjective experience and make both true.
- Recognize what is on their minds. When their perceptions are validated as real, children can then hear another’s point of view. Shared awareness means that both perceptions count.
- Introduce *feeling/thoughts*—ideas about what they feel. Because children have so little experience with useful emotions, feeling/thoughts help them think about what they could feel—or could be feeling. Feeling/thoughts emerge from shared awareness and provide a pathway to children’s own awareness.
- Consider intention as well as action. *What you meant...and what happened* allows them to see differences between what they were thinking about and how their actions are perceived by others.
- Unpack situations together. Children need help figuring out situations. Offering interest is more important than assigning blame. *Let’s see what happened* replaces *why did you do that?* Because children want to keep connections, they are usually more honest about what occurred.

FEELING: THE THIRD DOMAIN Regulating and Using Emotions

Self regulation of arousal quickly includes emotions. Emotions are innate responses that are activated by stimulation. Emotions orient us to our own needs and help us understand others’ reactions to shared experiences. Children first discover *feelings-with-someone*, and regulation of these feelings is also learned through interactions with others.

Emotions Need Relational Activation

Children feel emotions when they are interacting with caregivers. Parents serve as mirrors—they express emotions and respond to children’s facial and body actions in ways that name these internal states. Babies look frightened and parents recognize fear and act; babies smile and parents increase this pleasure with their own positive animation. Parents match feelings to signal the safety—or danger—of the environment, and children follow their parents’ lead.

When parent care is reliable, children learn to trust their emotions. Feelings become named (recognized). Feelings also contribute to personal attributes: *she is such a happy baby*. When care has not been reliable, or attributions reveal parental fears, then emotions become contaminated: *she keeps expecting too much from me; he has always been an angry child since the moment he was born*. Parental mirroring is distorted and children's representations of their own emotions become confused and confusing. Emotions become disorienting, instead of orienting.

Children also need adult help to modulate emotions. Emotional intensity must fit each new situation or experience. Depending on circumstances, emotional expression increases in intensity, or becomes quietly contained. Young children show emotions through behaviors because emotional energy moves them. Emotion regulation involves knowing *what I feel*, and *how I can express this feeling*. But emotion regulation also includes *how this feeling will impact my connection with others*. Feelings that threaten relational connection become dangerous or disorganizing. Children often abandon their own emotional awareness.

Emotional Confusion and Disorganization

For these at risk children, early care difficulties and trauma often compromise access to reliable interpersonal companionship. Without adult help they struggle to know how to express their emotions and fear their emotions will cause disconnection. Their emotional states are exaggerated by too much arousal or too disorganized delivery. They have limited awareness of a usual range of emotions, and they have little ability to allow adults to help them when they feel emotionally overwhelmed.

When emotions cause disorganization (*I'm feeling something but I don't know what?*) instead of organization (*I know what I feel and why I feel this*), children remain stuck in arousal activation. They struggle to stay in that optimal range and can rarely access new learning. Detecting others' emotions adds to their perception of danger, especially when adults' emotions are too intense or confusing. For example, infants exposed to domestic violence become primed to react to sounds of anger, but the emotional communication is not directed towards them. Their own feelings are confused with the emotional energy they have absorbed from situations.

Very at risk children display anger to manage fear, hurt and sadness. These other emotions cause children to feel exposed and passive, especially when adults react by becoming more angry and attacking. Vulnerability is managed by aggressive behaviors, which further disorganizes their awareness of internal feelings. These children often become agitated by any mention of emotions and deny obvious feeling states: *I am not sad/hurt/scared—you're stupid, you're *^!#*, you don't know nothing about me*. They feel endangered by their own emotions as much as they feel endangered by others' emotions.

When negative emotions dominate in their environments, children will match what they see and feel. In addition to anger, disgust and fear are most evident. Positive emotions become distrusted or are quickly converted to something negative when they suspect these feelings will end. They disorganize interactions.

Recognizing Discrete Emotions

For these very at risk children, aggression has already become their way of managing emotional disorganization. Aggression is also their way of communicating feelings in a disorganized way. Without swear words or threatening behaviors, they are emotionally speechless. They need help recovering their feelings from arousal, allowing these feelings to be named (recognition) and experiencing these feelings in amounts that assure reasonable safety (modulation). Then they can start to feel emotion regulation and re-organization.

Emotions are recovered from arousal with adult help. As children can allow us to quiet their internal storms, we begin to name feelings. But naming requires shared awareness—they need to see our feelings as organized and reliable first. When *feelings-with-someone* becomes safe and tolerable, children can start to see their own emotions as good and useful.

Recognition involves finding discrete feelings. When they allow adults to be regulating partners who can read their experiences, we can introduce how feelings are at the core of their distress. Many have felt shamed and overwhelmed by their own feelings so this is initially careful work. Allowing that feelings are universal reduces their humiliation and also supports recognition: *I get sad, everybody feels sad when their mom is gone*. We must still be prepared for a defensive retort: *I never get sad*; and then push this conversation further—*Really? Well, I sure get sad about that and when I'm sad I tell someone so I won't feel too alone*. This addresses two major obstacles: that emotions will cause children to feel overwhelmed (disorganized), and that if they are too alone, they will feel bad (be bad).

Emotions must be felt, not just talked about. Adults demonstrate how feelings exist within children's bodies: *your body is telling us about a feeling*. Most children can start with *worried*. Adults show children how to stay with a feeling (instead of escaping): *I'm really worried today and I may be worried tomorrow because my dog is sick*. They need practice to discover different feelings, and complex feelings (mad/sad; mad/hurt). These complex emotions are often why children become so aroused and unable to stay organized, especially when the feelings are contradictory (love/anger). Complex emotions are also confusing when children's feelings do not match their parents or caregivers—when they feel differently but cannot activate adult help to resolve these differences.

My mama gets mad all the time and she acts mean, and that makes me really sad and I want to cry even though she says I'm being mean. I'm not, but she makes fun of me when I cry and then I feel mad and she won't stop.

Intervention helps children know what they are feeling with adult help so they can name what is occurring inside them. We name emotions for and with individual children when they have been aroused and are becoming calm. We can also name feelings to help children not become so aroused. As feelings become identified and recognized, children are better able to accept that feelings other than anger are responsible for their distress. We also help them recognize and understand intensely painful social emotions such as disappointment, jealousy and embarrassment.

This is called disappointment. It's mad and sad mixed together. I am so sorry you got disappointed when I couldn't spend more time with you. Disappointment doesn't mean that you have to push me away. It's just a feeling and we can figure something out.

When Developmental Repair is used within a group structure, conversations about feelings occur with many children, or within earshot of children observing a struggling peer. Often children mock one another when feelings other than anger are exposed: *he's just a stupid crybaby*. One child's emotional distress activates others, so they try to block their own feelings. Adults use these moments to introduce sympathy (empathy), another aspect of recognition. Many children have similar life difficulties, and to be empathic towards others they must feel empathy towards their feelings. With adult help, they learn to tolerate shared feelings and express concern.

She's crying because her dad is gone. She's sad. We all get sad when someone is gone. I think you feel sad when I'm gone, and when your grandma goes back home. Sad is a way to let us know.

This intervention uses shared regulation and shared awareness to facilitate increasing self capacities. As we help children recognize their own feelings, it is a mistake to keep feelings shared. It becomes

important to validate children's emotions as their own because *how I feel* becomes central to one's sense of self, to *who I am*. Our goal is to provide relationship support so that children can recognize their own experiences. So, *we're sad today* must transition to *you are sad and I recognize that*. Using the *we* can also be useful shorthand for *you are sad and I am sad too*.

Learning Modulation

As children find their emotions, they often feel overwhelmed with the force of these feelings. They need help with modulation. Modulation is about having the sensation of emotions with enough strength to capture attention, but not too much to feel overwhelmed. Modulation also keeps emotions from slipping into arousal storms.

You look really upset but this feels like a frustrating feeling, not a terrible mad feeling. When you drop legos, you can make that frustrating and save really, really mad for something that can't be fixed.

We show children how to move feelings to fit the context: up in intensity (often necessary for more tender emotions like sadness or hurt) or down in intensity (necessary for the habitual anger/rage). Many children become too activated when their stress arousal system mistakes danger, and they must learn to become aware of what is actually happening (different from what they expect or project). Often children have been restrained or punished because of their intense emotional outbursts and rely too much on outside control. They must find ways to check the size of their feelings as a step towards emotion regulation. They often need to see modulation: one technique is to use our extended hands to demonstrate amount.

You're getting really mad for a little thing. This is a small upset and you can remember how small it is and feel a small amount of mad. How much mad feeling do you think will work?

Engaging them in this visual negotiation does not refute their need to feel, but does help them feel so it works. Emotional regulation requires that feelings activate cognitive appraisal so children can consider *what to do*. Modulation also introduces time and the persistence of feelings. Children need help realizing that feelings move, and they can decide not to stay in a feeling state. This is a critical shift for children who are so habituated to feeling angry. We don't take children's feelings away but help them reduce—or expand—emotional endurance.

That is a gigantic mad about having to stop playing outside. But you can remember tomorrow when you can be outside again. You can practice being disappointed and patient at the same time.

It's OK to be a lot sad right now. I don't think sad will be forever, but it is a big feeling right now.

It's been five minutes, and you are still so sad. Can you let me help you think about other things so the sadness can move along. There are other things you can do today besides staying sad.

Very at risk children need to know about adult emotions, and experience these as not too intense or confusing. They are used to fighting off others' emotional barrages. For adult feelings to be useful, these need to be clear and regulated. Professionals working with children sometimes speak in third person: *adults are very mad at children today*. This neutralizing form may work for most children, but not for very at risk children. It is better when adults express *live* emotions, and then demonstrate how emotions move to something else—to solutions. *I'm really, really mad right now and I need a minute to calm down so I can think better, and then I will know what to do* requires children to tolerate our emotions without

becoming reactive (as they have done in other relationships) but also demonstrates that feelings need not stay unbearable.

As children tolerate the feeling of emotional states, they are better able to describe what could be happening inside. Sometimes an immediate emotion is a stand-in for hidden content or circumstances they cannot manage. We help children make links between what they feel, what they show and what could be going on. This sharing of emotional possibilities promotes regulation even when resolving the trigger situation is not possible.

You are really mad right now, and I see that. But you got mad about crayons, and usually that is not such a big thing. But ever since your dad has been coming to your house, your mad and sad feelings are much bigger. Maybe that is why you feel so mad now. Let me help you.

Practicing Emotion Regulation

As children become more tolerant of emotions, they shift from arousal activation to arousal and emotion regulation. Emotions are never regulated in one effort. Interactions that help children recognize and modulate their feelings must happen over and over and over. Children practice staying regulated when they feel emotions. When feelings are unsettling, they practice losing and regaining regulation. Adults coach their practice and support their efforts to know what to do with their feelings. This is the core of the necessary new learning.

Many children continue to minimize their own feelings. This is in keeping with their developmental ages, when most children are shifting from self awareness to greater interest in the larger world of facts and knowledge. But unlike their same aged peers, these very at risk children have difficulty containing feelings. Regulation also includes how to shift out of difficult feelings. Adults organize children's feelings with the related experiences so they can learn what to do. *When someone is away, I feel worried when I don't know what happened but reading can help me think about something else* becomes a model for a child who denies feelings about a lost relative but remains disorganized. *I'm so sorry you got hit, and I know it makes you really scared and sad when that happens* helps a child admit to family abuse and know his feelings. Acknowledging feelings within a caring relationship provides protection when children can feel regulated and organized instead of disorganized and dysregulated.

Increasing emotion regulation also permits room for positive feelings. Because surprise has activated arousal in the past, emotions that are usually pleasurable have become contaminated. *This is a great day for you because you've been having fun* seems so innocuous, but for some children, positive emotions such as pleasure or response to praise become unsettling enough to be avoided.

When I say good job, you can just smile. Nothing bad will happen. You just smile for one second and see how that feels.

Emotion regulation unlocks behaviors: *When you got surprised, you used to hit. Now when you have that feeling, you don't hit. You just let me know how you feel.* We can also anticipate how emotions will trigger behaviors: *the other day you were so sad that you stopped doing your work. Remember? You and I will watch for that same sad feeling and see if working might actually help.* Knowing their feelings actually gives them more power to decide what to do. Emotions often move children to action—aggression must be replaced with movement that is not so destructive. Increasing capacity for regulation permits children to consider how to act purposefully, instead of reactively. Some children become skilled at verbally naming and sharing feelings. Others recognize feelings but need physical or kinesthetic activity to manage emotional energy.

Even when emotion regulation is not supported within their primary relationships, children can learn to

be more in charge of their own feelings. On the other hand, when children are more regulated, problems in these primary relationships may decrease and parents may also regain some capacity for emotion regulation with their children. When children can manage their emotions, it becomes more possible for them to be part of a social community and to address specific concerns at home, school or neighborhood.

Activating Empathy and Remorse

Empathy is about understanding the emotional experiences of another. Empathy is learned and returned: as you feel understood, you can then understand others. Developmental Repair provides kindness and empathy towards children's emotional experiences. As children can tolerate and understand their emotions, and take in our validation of what they feel, they become more secure and kind towards others. It is cruel to blame them for lacking empathy until it has been provided to them. It is possible to repair empathy as children have feelings and can tolerate concern.

The same is true about remorse. Remorse is an extension of empathy—children see how their actions or emotional expressions have injured others and then feel badly about their impact. Very at risk often resist accepting blame because they have felt blamed in many situations. When adults remain kind even as they express criticism, then children can experience their own actions as unkind and learn to make amends.

Empathy and remorse are necessary actions for improved social attachment. Positive social connections are a primary motivation for behavior change. When children can manage their own arousal and emotions, they can better participate in social exchanges and negotiate social expectations and behavioral norms.

Making Sense of Stories

Children must be able to tolerate *emotion thoughts* before they can make sense of their stories. Narrative coherence is an important part of recovery from abuse and trauma. But facts cannot be absorbed or organized until children have the ability to infuse memories with feelings that are no longer unbearable because these now make sense or because adult company helps manage emotional pain.

Stories must always be adapted to the abilities of children to cognitively take in information and organize the distress that goes with the story. Most children do not want to abandon their parents emotionally, even if these parents have abandoned them. They need these stories to respect their parents' roles, or efforts. And they need stories to have some message about how to move ahead.

You remember that your mom really wanted to help you but it was so hard for her to do the mom job when she so depressed. I hope she gets better so she can take care of you again. Maybe we can teach her the mom job.

There is too much violence when your dad comes home. He needs to take his violent guns and violent friends and violent words away. It's hard to miss him and be afraid of him at the same time, but you and your family have to be safe.

One boy completed this intervention and moved to a relative placement. As he left he lamented about his mother "she loved crack more than she loves her kids. I wish it was different but that's the way it is." This was not resignation but conviction that he could move ahead.

ACTING: THE FOURTH DOMAIN

Using Effort to Manage Behaviors

These very at risk children present with serious behavior problems and behavior control has been the customary focus of intervention. Developmental Repair does not ignore behaviors, but we are realistic that demanding behavioral changes activates power struggles and forces imposition of external controls. This intervention repairs capacities necessary for internal control. Internal control includes reasonable self regulation, self awareness and personal responsibility. This is a developmental ideal: that children learn, as much as is developmentally possible, to own their own actions and the impact these actions have.

Being active is also a critical protective factor for children who must manage with limited or compromised parental support. They must become their own agents—they have to look out for themselves and find ways to make their lives work as much as they can. Their behaviors must support their developmental potential and social inclusion. Until now, their behaviors (actions) have done the opposite. Most of their behaviors have been in the service of survival against perceived dangers and their own emotions. These children appear controlling when they must expend enormous energy trying to control their environments—but they often lack rudimentary controls like toileting, appetite, and body boundaries. *You can be the boss of how your words come out, you can tell your body to slow down* are difficult expectations. They need help learning behaviors that are effective, instead of defensive. Because of their early experiences, they may always tend to externalize problems—to see difficulties as coming from the outside—but their behavioral solutions must accommodate social rule and norms.

Connecting Emotions and Behaviors

As children can tolerate knowing about their own emotions, adults then help them see how emotions trigger behaviors. Instead of acting randomly, we help children see their actions as having purpose that can be understood. When behaviors become connected to what children need (and feel) then changing behaviors can also be tied to what will work. This is an important first step in asking children to exert control over what they do. They must realize that we are supportive of getting their needs met, and also helpful in making sure they know how to do this.

We re-organize behaviors; these are emotional communication and learned actions. When children act, we look for what their behaviors are telling us—and them—about what they need. This restores the relational function that early behaviors have, and also inserts relational learning back into behavior management. As children are able to manage arousal, they can learn new solutions and new behaviors that are more adaptive and effective.

When children are successful at behaving in new ways, this triggers new feelings. They feel connected to adults, eliciting both approval (admiration) and pride. They become more motivated to think about what to do when they see benefit beyond compliance. With adult support, they can make efforts to try new behavioral strategies. Behavior repair does not result from consequences (done to them) but from intentional effort (done with them). Children start to build on behavioral achievements, and when difficult emotions or new circumstances trigger behaviors that do not work, adults help them remember how they managed before so they can do it again.

Effortful Control

Learning to control behavior requires effort. Effortful control is a natural outcome of secure attachment, because children look to their parents for guidance about how to act and then try hard to maintain that connection. Very at risk children need reliable adult attention and connection to repair their motivation to act in accordance with others' norms. They also need kindness because they have come to expect harsh and hostile engagement.

Effortful control becomes possible when children experience reliable regulatory support and adult help to know what is happening and what they feel (awareness). This support then permits them to recognize how emotional triggers activate behaviors. Their effort is activated when they trust their needs are important and will be met, even if some necessary modification or inhibition is required. It takes effort as well as adult encouragement to try out new behaviors, especially when negative behaviors are accepted or necessary in other settings. It also takes social motivation to amend behaviors that have maintained some degree of personal power (oppositional control) so that these children can better fit into the positive peer group.

Effortful control means inhibiting some behaviors (and needs) and replacing these with more effective or socially appropriate actions. Many of these children struggle with impulsivity and anxiety that they will not get what they need. Children's behaviors reflect their despair. *For example, one boy hurled a Rice Krispie bar when he was angry and then panicked that he would never get enough food. While a traditional intervention would have responded to his action, the adult instead recognized his need to be fed and replaced the bar. He reacted again—throwing it at the adult as if she was the cause of his panic. Instead of abandoning him to his negative behaviors she persisted in helping him recognize what was going on (emotions that were about past neglect) and changing how he behaved so he could regain control and believe her kindness. They ate together.*

As much as is possible, behaving differently must be their choice, to counteract children's fears of losing control and feeling helpless. Our interest remains on them, rather than making them behave. This relational commitment serves as an antidote to earlier learned behavioral patterns.

Adults must also show effort, to understand what children need, and to demonstrate their willingness to help. These very at risk children have experienced a paucity of positive adult help for many reasons (neglect, negative reactivity to bad behaviors, social estrangement) and so feel desperate to take care of themselves. It is important that they know we are interested in taking care of them first and then helping them fix situations with others

When you hit her that was mean. What was happening to you? I think you got worried no one would listen. So let me know when you want me to listen, and let other kids know. Say it, instead of hitting, and we'll listen. And if you want, we can go together to apologize. I can coach you about what to say.

These are some ways adults support children's efforts to change behaviors.

- Consider together what children want. Behavior change must start with appreciating the legitimacy of their needs.
- Support children's motivation to get what they need and to stay connected to others. This is at the core of behavior accommodation.
- Suggest solutions. Children's problem solving abilities are extremely impaired, especially when they fear that their needs will be neglected or that they have wrecked relationships. Help must be active.
- Anticipate a next time. *Next time* allows children to practice alternative behaviors ahead of time so they can manage shame and humiliation.
- Make sure that the child is able to act willingly. Solutions backfire if the child feels coerced. *I think you'll feel better when you want to apologize* works better than saying *you need to apologize now*.

Protecting Their Control

The goals of intervention have been to help children realize adult intentions to be helpful, and to attend to their developmental capacities. As this intervention alliance is strengthened, it becomes possible to more actively address behaviors, even when children resist. When we do need to impose order, we announce a rule or expectation clearly. These very at risk children experience ambiguity as endangering. We simultaneously act as enforcers and facilitators. We ask them to use their own control to manage rules. At the same time we appreciate that they need to feel active and engaged. Collaboration and negotiation have a place in this intervention.

This is how it works here. You can't climb on furniture. I know rules are hard. I can help you with that rule so you and I can read or play a game. You choose.

Let's make a deal. You stop swearing, because that's our rule, and I'll think of what else we can do instead when you get so mad. Swearing makes the other kids stay away from you and that feels lousy.

It is important to protect children's ability to feel some control while maintaining the larger social order and social norms. Many children use behaviors that are unacceptable in one setting but necessary for survival in another setting. The intervention challenge is to help them realize their options.

I get it that you need to act tough in your neighborhood. But when you act tough and mean here, adults get on you and kids are mean back. Do you want to see if here can be different from the neighborhood? You don't have to be mean here.

In this example, we equate *tough* and *mean*. *Tough* is a behavioral stance that involves posturing and actions; *mean* involves emotional engagement that is hurtful. Most children want to feel safe and have friends. *You're not a mean kid* tells this child how we know him, and that he has choices. His

behaviors communicate a real and frightening reality, that he must act tough to be safe. But these also communicate that he doesn't have other ways of being with people when he is not in danger. What this child really needed was skills to manage within the treatment group and at school so the neighborhood held less power. He could then practice alternative behaviors that were not tough and mean; *that's your goal, when you're mad or hurt, to not turn into tough and mean. You can tell yourself to do this because you said it was really important to you.*

Reliable Structure vs. Imposed External Control

Developmental Repair relies on external structure instead of external controls. Predictable structure and clear expectations support children's efforts. Schedules and consistent activities reduce uncertainty. In a group of children, there is ample potential for chaos, but much of this can be dissipated when the group structure works. With imposed external control, children lose the adults as partners; when external structure supports and maintains group cohesion, adults remain available and involved.

Reliable group structure helps children anticipate and practice difficult times. Oppositional behaviors are often triggered by untoward events. Surprises activate too much uncertainty and reactivity, even when the surprise is benign or positive. We provide advance warning about changes when possible, and we help children *pre-live* new situations. Pre-living is a way of practicing what will happen, or what could happen. *In a little while we'll be cleaning up. I want you to get ready so you won't be surprised.* We also help them anticipate transitions that they cannot control. *When you start at the new school, there may be things you don't know. Let's practice what to do if teachers surprise you with new rules.*

Practice is a structured form of experiential role playing. We rehearse the situation again and again, with variations of what might occur. This is not about making a predictable script, but imagining possibilities so children learn about flexibility and behavioral options.

Interrupting Oppositional Behaviors

Oppositional behaviors sometimes reveal children's frantic efforts to maintain a connection. Fighting has become a relationship habit for many of these children. When new adults battle back, we inadvertently reinforce the need for negative behaviors that maintain this painful status quo. *You wanted my help but then you started saying no. Why are we fighting? You have that habit of no, no, no, but fighting isn't what you need.*

The best way to interrupt oppositional behaviors is to insist on connecting even when the child initially resists. We maintain our intention to be helpful, and look for reasons why oppositional behaviors become activated. We do not presume children want to oppose our help; rather we assume children substitute fighting when they don't know how to engage about their real worries and needs.

You're telling me that you won't do anything. This happens mostly on Mondays, when it has been a long time since we saw each other. How long until you let me help you remember how to say yes so we don't have to fight.

Distractions are useful when children feel stuck in oppositional relating. Distractions are reminiscent of the younger child's ability to engage in what is called joint attention—following the parent's gaze to what is safe or important. We replicate this: we shift our mental gaze and thoughts, bringing children with us, because we know opposing is not useful. Rather than becoming stuck in the child's rigid oppositional stance, we shift our interest to something that can restore the relational trust and collaboration. *For example, one boy was aggressive towards peers and adults, and asking him to stop intensified his behaviors. Alone with him, it was easier to ignore his provocations but he remained stuck. Noticing his sports pants allowed us to talk about his favorite team and how he wanted to be a winner. It was less*

important to focus on why he got stuck (a familiar pattern) than how he could get unstuck. Admitting he wanted to be a winner became a very useful, and pro-social metaphor that easily translated into team rules.

As children become more behaviorally organized, we can introduce age typical contingency options (*if you choose this, then . . .*), including negative consequences. We assume that, by the end of this intervention, children will be developmentally ready to accommodate to more normative expectations. When children can feel secure in our relational reliability and their own regulatory capacities, they are better able to tolerate disapproval when they misbehave. They can see what they have done that is not acceptable, and can activate their own motivation to *get it right*. This example illustrates the shift: three weeks before he was to graduate from treatment, a boy swore at the adult, and was angrily told to leave the group room. He did, fuming. Another adult joined him and after a few minutes, he could admit that *I blew it, I was acting like a jerk and started swearing because I was mad*. He then worked out how to apologize and get back into the group. He tolerated one adult's anger, and used the other adult's coaching to repair his mistake. He finished the rest of treatment without incident and transferred successfully back to school. What was most impressive was his desire to stay connected with this second adult, seeking her out to say *I'm OK*.

Repairing Play

The play behaviors of very at risk children are strikingly compromised. Many children don't know how to play imaginatively, and have little ability engaging peers in reciprocal play activities. Play often becomes overly charged with aggressive energy, even when there is no intended malice. Children struggle to stay interested in play, wandering about from one toy to another, or one activity to another, with little enjoyment except to engage adults or initiate conflicts with peers. When they do pretend the content is often dangerous or overpowering (monsters, superheroes who kill everyone). Play, and play behaviors, must be restored as a regulating activity to engage children's minds and promote reciprocal peer interactions.

When you get wound up, playing with Legos can make you feel better. Just keep building.

Playing lets you think about what happens. Try to make a story that isn't so scary and mean. See what the cars do when they work together.

We'll play this game first and maybe then you can remember how to play it with a friend.

When these children play, they have difficulties using their own content productively. Their imaginations are contaminated with real danger and remembered traumas. But their play does not resolve these experiences because they get too aroused. As they can use adults to stay regulated, it is possible to re-organize their play skills towards exploration that includes feelings and new ideas. When they play out difficult or threatening situations (domestic fights, abusing adults, depressed parent), adults intervene with solutions. This is a necessary precursor to their using play for therapeutic work (play therapy).

Some children must learn how to escape into play activities as a safety plan at home. This kind of play serves a protective dissociative function to manage danger or frightening situations. Often very at risk children have not known how to retreat—more often they have acted out. Helping them learn to use play as a soothing and protecting activity quiets their impulse to join in the fight and gives them something to do when they need to be alone.

Engaging in Mental Activity

Developmental Repair addresses children's abilities to engage in social activities. To manage in school or community settings, children must learn how to engage in mental activity when physical activity is not possible. This challenges many children, especially those with attentional difficulties (common in maltreated children). While this intervention does not directly remediate educational skills, we do help children practice having mental activity.

Mental activity includes motivation to make something work. Whether this is homework or a new puzzle or a shared project, children need support to stick with a challenge and tolerate the inevitable frustration that precedes mastery. Many children give up, assuming they cannot succeed or blaming the environment for making them *feel stupid*. Many children struggle with intense humiliation when they fail at tasks, or shame when they realize their cognitive limitations. We work on adding behavior that can sustain learning effort. This means identifying what the child wants to learn and helping the child make this important. Accessing mental activity helps them become determined instead of defeated.

Changing Social Patterns

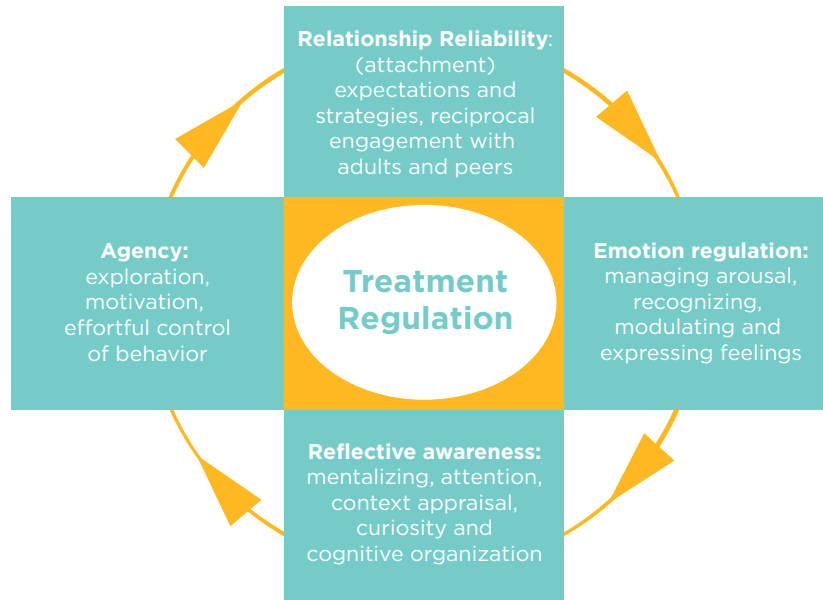
While intervention focuses on children's individual behaviors, we must also address social behaviors that place these children in serious jeopardy. Many children act in ways that are supported by their families, even though these behaviors alienate them from the larger community.

These *anti-social* behaviors confound children's abilities to participate in pro-social groups. For example, one four year old boy struggled with normal fine motor skills (holding a cup, picking up pencils) but when aroused, would posture and make complicated gang signs with his fingers. His behaviors altered him—he became threatening and determined to fight. Staff realized how much the gang signs were triggers to this transformation, and substituted a new sign that was specific to our setting—thumbs up. He accepted this substitution with surprising relief and then learned an accompanying nursery rhyme song (*where is thumpkins?*), which he taught to his mother. Both he and his mother were able to use treatment to shift significantly to safer associations.

Moving Towards Self Regulation

Developmental Repair is a continual process. Work in the four domains suggests progressive steps but change happens with back and forth movement (similar to development). Children make gains and lose ground and spin in frustrating impasses for awhile. When they seem stuck in one area, we can shift our focus to another. For example, when a child cannot tolerate knowing about emotions, we can shift to behavioral coaching that permits personal achievement and elicits positive regard from adults. We don't abandon emotions, but quiet our awareness to respect for the child's irritability (fragility) at that moment. We trust that this treatment is an integrating process and gains on one area will facilitate access to others. What remains constant is our reliable availability as regulating partners.

We provide children with the workspace to learn more effective and pro-social ways of feeling regulated. When children trust adult help, then dysregulating moments become inevitable jolts that can be tolerated, instead of endangering experiences that must be fought off. Children may never escape dysregulating times, especially when the child's outside relationships remain disrupted. The goal of intervention is to help children maintain, and regain self regulation within the group, at school and in the larger social community.



Developmental Repair is also a circular process. Children remain in treatment long enough to permit revisiting these challenges over and over. *We cycle through together* to expand their developmental mastery and confidence. As they can maintain regulation, developmental learning that is age typical is possible. Many children continue to have developmental challenges and may need help to address specific obstacles and difficulties, but subsequent interventions can affix to repaired foundations.

This Is What Happens in Developmental Repair

Children who are aggressive and disruptive come to an environment where their arousal is understood.

Adults offer help; they *join* with children's needs and perceptions to provide necessary co-regulation of arousal because these children cannot do that alone.

As children can partner in their own repair, we move forward. We help them access their minds to observe social exchanges and build self awareness.

We help them recognize feelings. As emotions are named and modulated, these become more regulated and connected to actions or solutions.

Because they feel more secure in adult help, children can change disruptive behaviors and learn new behavior patterns that work in the community.

This effort is possible when home is also more secure, but even when families continue to struggle, children are able to use this intervention to become more competent at school and in the community.

5 Supporting Families

- Engaging And Supporting Families
- Engaging Families
- Shift To Partnering
- Organizing Work With Families
- Working With Other Parents
- Obstacles To Parent Engagement



ENGAGING AND SUPPORTING FAMILIES

Most parents want to raise their children well, and do not intentionally neglect their children's need for protection and care. Especially when children are young, parents remain hopeful, and children always look to their parents for care. Still, many adults struggle as parents, for lack of knowledge, available energy or consistent concern. Many families are disadvantaged by the effects of intergenerational trauma and ongoing environmental and relational crises and do not know how to correct the course of their children's lives when serious behavioral issues occur.

When young children are disruptive in the community, interventions have traditionally engaged families with support and parent education. It is in children's best interests for parents to provide reliable and competent care, and when life situations of parents improve, children have fewer behavior problems.

For very at risk children, this premise can be a significant obstacle. Family change may not happen quickly enough to protect their developmental potential. Many parents remain powerless in their own lives. Some families struggle to understand their children's needs and lack the resources to rescue their children from difficult situations. Others do not see the danger, having been raised in similarly difficult circumstances. In some situations (adoption, foster care), families are caught in problems not of their making.

Developmental repair places attention and action on the children and asks families to do the same. We make the developmental functioning of these children our focus of change, and use this focus to address relationship difficulties. Through Developmental Repair, some children make significant gains even when their families stay the same. Working with the children—helping them to become more self regulating and developmentally competent—interrupts stressors,

which may facilitate change in other areas of their lives, such as in the family life.

Engaging Families

Developmental Repair does not ignore families or abandon the possibility of more effective parenting, especially when the parent/child relationship triggers children's behavior difficulties. Focusing on children's change is a practical decision. Families of very at risk children have been difficult to engage in community services and remain so even as their children require this intensive intervention. Many parents minimize their children's difficulties (*she never acts that way with me*) or control



behavioral difficulties with harsh punishments that cannot be replicated in the larger community. Some avoid bad news (*don't tell me he's having a hard time, there's nothing I can do*) or are preoccupied with their own needs (*I know he is having a bad time with those bullies but that is the least of my problems. I got a lot on my mind*). Some demonstrate competing loyalties (*My cousin stole my son's video*

game but hey, that is MY cousin and I'm not going to go against my family.) Parents resist engagement when intervention inadvertently adds to their stress by demanding solutions they don't have or imposing solutions that they cannot understand or accept.

Our initial point of contact with parents is when they enroll their children in this program. At this time, parents and caregivers are told about the family component: the program expects and encourages weekly contacts. Some parents come to the agency site but many families lack resources such as transportation so staff travel to them—to their homes or places of work, to neighborhood community centers, to schools that their children attend. Contact outside of the agency has significant benefits but is not

necessarily easy or initially effective. Larger family dynamics threaten the parent/child focus when adults are distracted or disorganized. Staff must assess parental awareness about their children's difficulties and also determine their willingness to participate in their children's care. In these meetings staff and parents/caregivers establish a reasonable intervention *contract* and also observe and discuss parent/child interactions. The contract is a deal, a plan about how the families will become active with us.

Many parents need pursuing. Because of aforementioned risk factors, engaging parents in this work can take extensive effort and time. Because children are transported daily to the group treatment program, parents can treat this intervention like respite and resist family involvement. Many have no positive model for working with outsiders. One immediate goal is to repair parents' abilities to engage with others who are involved with their children. Developmental Repair is most effective when parents can become partners and also feel involved and included in the social communities that know their children.

Just as we must be patient with the children, we are patient with the families. Some families become engaged gradually, as they see their children change. Others fight our overtures until we force them into meetings. For many, resistance is about fear more than refusal. As long as the child is attending the group and making progress in the school community, we can tolerate family ambivalence.

This example illustrates the dilemma of family engagement:

One young boy had been suspended 17 times by November of his kindergarten year before he was referred to our program. His school was very invested in his well being and provided an excellent complement to our group intervention. His mother resisted engaging overtures beyond permitting medication, and would regularly move, change phone numbers and disappear from contact with us and the school. Yet when he finished treatment because he could consistently and successfully manage at school, eight members of his family attended his graduation party and demonstrated their intense pride in his achievement. They apparently maintained a mental commitment to his success even though they had not overtly participated in this intervention.



Shift to Partnering

Developmental Repair shifts the lens of family engagement. Rather than making family change the logical start point, we ask parents and caregivers to join us, to become partners in Developmental Repair. We ask the adults who live with and care for these children to understand their needs differently and respond in ways that support their growth and positive adaptation.

Many of these families have resisted, or failed at, earlier intervention efforts. Partnering seeks to focus on what is most important—helping their children to succeed in school. It is helpful to consider why other approaches have not worked.

Parent education fails for this population. Many families do not see their parenting as ineffective and those that do are usually not able to learn new skills from instruction. Parent education presumes reasonable commonality about the needs of children and the role of parenting. Many parents reveal how their own histories and subsequent assumptions color their parenting attitudes and actions. Parent education can make them feel ignorant or judged (even when this is unintentional) and they often reject the ideas as not relevant to their experiences or situations. Even when they feel interested they often lack the mental resources (such as self regulation) to be more consistent or attuned to their children's experiences, or their children defeat their efforts because of long-standing behavioral patterns.

Many interventions offer family therapy when difficulties involve children's place within the family system and rules. But this approach is often unfamiliar and threatening to many parents who already feel powerless and suspicious of help. They do not have a tradition of talking about their emotions and thoughts, or allowing outsiders into their personal lives. Some have felt assaulted by child protection investigations or school complaints and assume that the system—the larger community—is harshly judgmental. Family therapy is perceived as an extension of this oppression.

A third approach has been to directly address the parent's contribution to this relational difficulty through individual therapy or parent/child therapy. Many parents are unaware of how

their parenting impacts their children or reveals something about their own mental distress. They often use therapy to confirm their perceptions of powerlessness or blame others (including their own child). Some parents eventually can use support to recognize both their children's needs and their own suffering and seek out individual help.

Partnering builds on the recognition that these parents are struggling to accomplish a primary parental task: helping their child move into the larger community. The reasons for this difficulty are many, so parents are not blamed for the causes but asked to participate in their child's solutions.

Partnering allows us to enter into the adult's experience through their parenting of this child. The parallels between their lives and their child's experiences are often startling, but these must be discovered gradually, instead of being identified in ways that suggests they are responsible for their child's problems. Partnering is a variation of joining; we ask them to work with us to see their child's difficulties within the group and in the community. Parents often cannot understand these behaviors or needs, but many will then see similar behaviors at home. Even if parents deny difficulties at home (some children do manage very differently away from parents), we address together their child's struggles in the community.

Partnering makes two critical shifts from other intervention approaches. The first is that we assert that we know their child well. We bring expertise about their child in our program. Our knowledge does not compete with their knowledge but allows us to talk about how their child acts and what children need to learn to manage in the community. The second shift is that we focus on the child's adaptation within the community (day care or school) instead of immediately attending to home difficulties or the parent-child relationship. Partnering looks for solutions about how their children can succeed outside of home.

Once parents can partner with us to see their child's behaviors and needs, the next step is to ask them to relate to their child in new ways. These requests complement the treatment intervention with their child, and promote negotiation between them and us, and them and their child.

We name these requests *experiments* and model reciprocity (back and forth talking about how these experiments worked for them, and for their child), although some parenting actions are so harmful that direction is required. We explain how experiences at home color children's abilities to be regulated and competent at school or in community settings, and how community inclusion may support better functioning at home. When children do better at treatment and in the community, this evidence often supports more experimentation, including changes that address parent/child difficulties.

Partnering does not ignore family difficulties. It is challenging for parents to stay focused on their children when families are struggling with crises and chaos. But learning to help their children can increase parents' internal resources. Partnering asks parents to balance their own needs with their child's needs, and to think about how, with our help, how they can parent in new ways to address these needs. Because parenting triggers recall of when they were children and being cared for, these parents often struggle with painful associations and memories. Present parenting may thinly disguise the way they experienced care that is now repeated with their children. When parents did not experience reliable care in their own childhoods, it is common that they feel confused or dismissive about their children's needs or preoccupied about their needs. Some resist awareness of their own histories to protect their parents and the more positive relationships they have forged as adults.

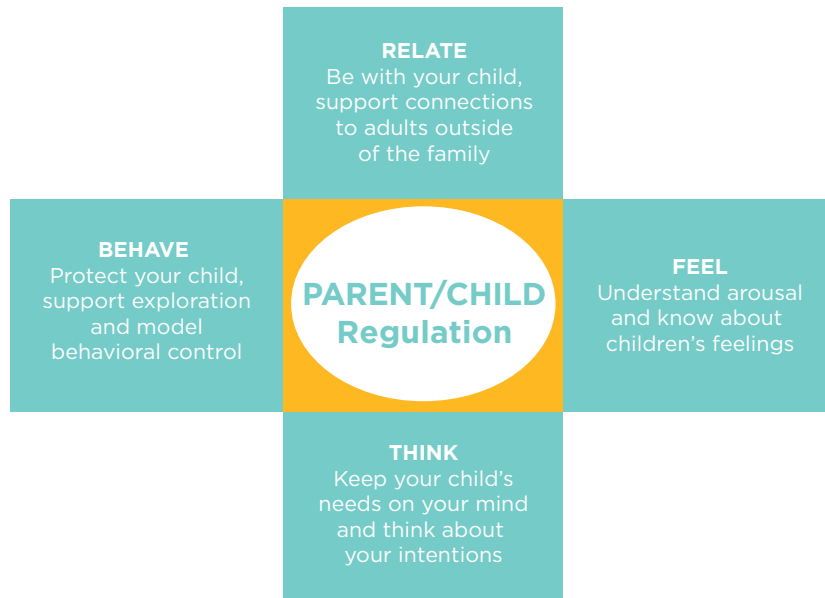
Partnering stays in the present, and in the parent/child experiences, as much as possible. Just as children need relationship support to repair developmental needs, their parents also need understanding company to change. By identifying patterns we are able to bridge the present to the past and interrupt repetitions that cause harm. Most important is how parents relate to their children now. They may feel less anger, futility and isolation when they have partners who also care about their children. As parents see and effectively meet their children's needs, they may be able to see and meet their own needs better as well, and start to build a more emotionally reliable family.



Organizing Work with Families

Partnering offers parents a plan: *we will work with your child and address the difficulties that caused your child's identification in the community and we need you to work with us.* This approach presumes that staff working with families have training and experience, and will be able to use specific tools to promote this contract and plan. Just as when we work with their children, parent work must attend to joining as a start point. We must model relational reliability and trust, and may need to prove our effectiveness and convince them that this process will benefit them as well as their children.

Family work always starts with identifying patterns. Patterns are the repetitive ways that family members relate, feel about experiences, think and believe, and behave in response to triggers. We help parents see patterns in their children's feelings and actions. We work with them to identify how their emotional reactions and actions contribute to these patterns, and how other responses would be more effective. We offer our help and ask them to experiment, with new ways of acting. Experimenting takes away the pressure of complying with directions and supports the feeling of a partnership. We observe together if these changes in responses and actions make a difference in how their child relates in the community and home. When parents see change or feel their effectiveness, they are more inclined to engage with specific advice or parenting instruction.



These experiments correspond to the interventions constructs in Developmental Repair. We think of how parents also relate, feel, think and act. The following ideas are examples that are not presented in a necessarily sequential order. Work with parents is opportunistic; we start where they will allow.

Experiments with Relationship Partnering

Engage with us about your child. Despite their children's needs, these parents are often wary of help, or don't see how they are part of their children's solutions. We encourage them to *hire* us, to allow us to come into their lives and tell them what we know about their children. It often takes a great deal of time and effort to solidify this engagement.

Attend to your child. We help parents see their children's needs. Parents complain about behavioral difficulties and don't often recognize their children's underlying distress. We remind them that their children are struggling in the community and ask them to pay attention to their child's safety and well being. Attending engages them in what is happening right now, rather than in the unfixable past.

Paying attention is a variation of attachment availability. We can observe the attitudes and beliefs that are at the core of their relationship with their child, and modify these attitudes by showing what we learn when we attend to their child in the group.

Become interested in parenting. We ask parents to be interested in their children: why they think their child is struggling and what they believe will help. The next important step is to consider how they might help. Interest is an active process of sharing about their hopes, beliefs and fears about how they want to parent and see their children grow up.

Many parents have little understanding about what is required to parent well and they need help to become interested. Many do not understand the reciprocal nature of this relationship; they impose their own feelings onto their children, and are not used to considering what their children need from them. Providing a developmental context (*what most children this age can manage; what most children this age feel*) also asks them to become realistic about these needs.

Let others help. Trust is often difficult for these families. Because they don't expect help, they don't readily accept help. They struggle to partner with us, especially when they anticipate being blamed. It is important that our intentions be clear: we want to help their child manage better in the community and believe they do too. We exchange perceptions about their child, balancing positive and critical observations, and recognize their fears (*my child is bad, I am bad, there is no hope*). Help must include talking about family interactions that are destructive and contribute to the child's distress, but these must wait until the partnership is grounded in reasonable agreement.

Maintain hope about your child and your parenting. Unlike families of older at-risk children who often feel defeated in parenting, most of these families still expect their children can succeed. It is important to use this as motivation for parents to try new ideas. We encourage them so they know how to encourage their child. Hope also moderates their anger and hostility. Family work protects this hope when parents struggle to achieve tangible changes in their children, or in their own parenting.

Experiments That Support Thinking Awareness

Learn about thinking (and intentions). Parents need to realize that their children have minds—thoughts, ideas, intentions, beliefs. When provided with evidence of their child's thoughts, they seem surprised or doubtful; some are disinterested. They (mis)interpret their child's needs and behaviors as intending to defy or take from them, and impose similar (mis)interpretation of others' intentions. When asked what is on their minds about their children, this question defeats many parents. They describe thinking in reaction to what their children do (behave) and seem confused about their own intentions or ideas.

Many parents presume children don't remember difficult times and minimize effects of negative events or interpersonal conflicts. To repair their ability to see others' minds, we explain how children try to understand what parents are thinking (*when you're upset, your son is wondering what is going on and he gets scared when he can't know*) and how parents can mis-read children's intentions (*everything your son does feels mean to you, even when he isn't trying to be mean*). Parents also confuse our intentions in ways that defeat help (*you're expecting me to be the same as that other person who disrespected your family. I'm not doing that*).

Clarifying intentions is especially important when there has been a history of maltreatment. Children shut down their minds to avoid knowing parental intentions to harm, but then remain vigilant in anticipation. *For example, a young boy described that "my mother is always thinking mean about me, even when she isn't acting mean." His mother dismissed his concern, but gradually acknowledged that her chronic sadness and futility seeped out through her hostile assumptions about others, including her son.*

Start to notice what happens. Parents have to think about what happens to their children (and to them). Many families lack any capacity for reflective thinking. They shut out thoughts that cause distress and in the process shut out solutions. Without some awareness, patterns don't change. Awareness and reflection about what happened starts within the partnering relationship. When clinicians engage with parents, they must be reflectively thoughtful about their interactions. *"This idea was on my mind today when I was coming to see you..."* asks the parents to realize they are thought about. This exchange may then move to *"What are you thinking about what happened?"* Reflection includes ideas about what happened and what this means. Thinking together permits a shared awareness. Parents who can think and reflect are much more likely to appreciate their children's thoughts and worries.

Decide what you want to give your child. *Decide* is a calculated word; we ask parents to consider what they are willing to do for their child. Parents will often report that their children are ungrateful, or difficult to care for, while children experience needing as fraught with danger and disappointment. Deciding is more about intention than about actual action. We must first help parents realize how to think about this relationship, how to think about their child's needs, and how to transfer this thinking about their child

into expressions of caring. This gives children evidence that their parents intend to do the parenting job, and allows parents to engage in *experiments*, even when they can provide limited care. *Here's a deal: your mom decided to help you brush your teeth. You need to let her and we can practice that here (at treatment). And when I come to your house, you and she can talk about how it's working and if she is remembering to do what she said.*

Parents and children use these *experiments* to interrupt negative patterns and build new interactive strategies. Locating effort in the present creates distance from past experiences and disappointments and allows us to commiserate with children when parents fail. Children may become realistically self-reliant, instead of angrily demanding what is impossible or assuming blame for what doesn't work.

Talk about things that happen. Many families are not used to talking about hard times. Talking is difficult when families are used to denying painful experiences or managing hard times with rage. When parents do describe experiences they often expect contempt or criticism. What they need is respect and interest.

Many families conceal information. Family codes prevent disclosure, even though their children may be acting out the secrets. While we respect family boundaries, it is important to know what their children know. *For example, one mother refused to talk about her brother who had been killed in a gang related incident, even though her six-year-old son (named for her brother) was gang posturing and getting kicked out of school. When she could finally talk to him about his uncle, the child's agitation shifted to sadness and curiosity.*

Talking includes conversations about parent/child interactions that negatively impact the child's functioning. Introducing these conversations can feel confrontational to staff but often permit a more genuine partnership when criticism is combined with respect. Neither child nor parent is helped if we are also unable to talk. *To illustrate this point: a clinician anxiously anticipated talking to a parent about reports of punishments that may not have been abusive but seemed cruel. She worried about betraying the child's confidence but also realized how this secret was disrupting the child's ability to manage at school and in group. When they spoke, his mother admitted that her boyfriend had gotten harsh. She accepted that she had to protect her child and used this encounter to rely on the clinician to think about her son's needs.*

Experiments That Support Feelings and Regulation

Understand arousal reactivity. Many families describe their children as angry, defiant, mean, aggressive. Schools and communities often describe children with similar words. It is critical that parents learn about arousal and difficulties with regulation. We introduce these ideas to parents: that behaviors are reactions to stress and need, and arousal can appear aggressive, especially when adults become power-struggling adversaries. We explain how arousal can be triggered by past events or feelings/fears. We use examples from the treatment setting to show how arousal is different than bad behavior.

We build a common ground about arousal. We help them recognize arousal (in their own bodies) and recall times when they feel aroused. Many parents also struggle with regulation, and need help feeling soothed and learning regulation skills. Since parents become dysregulated by their children, we share our own dysregulated moments, and show how we were able to then regain balance and help children do the same. Parents often become upset and aroused with us, and when we can help them stay connected and *come back* (just as we help their child), then arousal makes sense. Parents need to *feel*/regulated to understand what they need to do for their children.

Learn to be a better co-regulator. Some parents remember positive experiences when their children were infants; others have no sense of this co-regulating role. *One mother, when asked about her soon-to-*

be-born second baby, said, "I don't do that attaching stuff," pushing her hands away from her own body. She described how her first child had cried inconsolably, and she felt alone and trapped. Her reaction about that attaching stuff revealed her difficulty providing this early regulatory care.

When the partnership is established, it is possible to help parents learn about shared regulation; we use simple examples from our interactions, or from observed interactions between parent and child, to introduce this as a part of every relationship. The term *co-regulation* recognizes how truly mutual this effort is, when both parent and child must work together, and helps them think about their children as able to participate (instead of needy and confusing infants).

Co-regulating introduces a different model of parenting. Most parents increase their children's arousal reactivity with their own emotional intensity, and then force their children to comply with anger and coercion. Children don't expect regulatory help, but through the treatment experiences they become primed to try again. We coach parents about regulatory prerequisites (reliability, attention, interest, empathic concern), teach them how to *move arousal down* by staying calm instead of reactive, and practice new patterns that increase the possibility of both parents and children staying regulated.

Let emotions be OK. Many families experience chronic fear, anger that is threatening and hostile, and profound and pervasive sadness that blocks action. Emotions seem confusing and overwhelming. Happiness, joy, and pleasure are often absent or fleeting.

We help parents rediscover a range of emotions and emotional expressions that are not endangering. Emotions must become knowable and useful. Positive emotions have potential to forge connections and temper the pain of a difficult past. Positive experiences from the group help parents admire their children. We look for opportunities to notice positive attributes in their parenting, even though many parents initially push away compliments or positive regard.

Negative emotions (rage, despair, humiliation, contempt) that contribute to parenting difficulties are more challenging to address and accept. Negative emotions are often intense and poorly regulated. These families can be frightening in their hostility and potential for abuse. But they must learn to tolerate negative emotions without allowing these to be hurtful. Emotions must be OK, to help their children have feelings. Just as we decode the messages in children's emotions, we must also work to decode parents' emotion messages.

Be honest about feelings. These families often act out feelings, with their children and with others in their lives. They need to learn to know and be honest about their feelings. Some are more aware than they let on to us, blocking our work. It is important that they can admit to feelings even if these are negative and painful. Many times negative feelings about their child contain intense negative self loathing, but it comes out as harsh care. Unacknowledged sadness, shame and guilt become obstacles to sustained regulation and new parenting patterns.

Experiments That Support Effortful Control

Resist reacting harshly. Many parents rely on harsh treatment because that was how they were raised or because they lack skills to parent differently. Harsh force can perpetuate aggression as a learned or copied behavior. Some children actively provoke punishment as a perverse form of imitation and connection. Harsh force can become habitual and when unchecked, leads to abuse especially when adults are prone to dysregulation.

Asking parents to relinquish the use of harsh force is difficult if they have no alternatives, or they feel criticized by the larger community because of their children's disruptive actions. When young children are already identified at risk for aggressive behaviors, it is critical to interrupt ongoing harsh treatment

and prevent the vicious cycle of intergenerational abuse. Harsh force and power struggles tend to generate more imposed force that thwarts children's capacity for internal controls, which are necessary for community success.

Parent work must identify alternative methods for control. We do not want to erode family authority or cause parents to feel incapable. We also need children's *buy in* for change. Eliminating harsh treatment is rarely the starting point of treatment but becomes more possible as treatment progresses. Group treatment allows us to experiment with alternative approaches for each child that can be transferred to home. Most parents are relieved to find strategies that work better. When parents continue to use harsh force, we are forced to help children learn to follow rules and avoid causes for punishment at home.

Make rules that work. Children adapt to the lack of effective parenting. Some become fiercely self-reliant, while others stay manipulative and helpless. Changing these patterns requires better ways of *being together*. When parents feel reliable and active (instead of helpless or inconsistent), they can organize rules that support family life and children's well being. Given the cumulative risks, there is protection in supporting both clear and consistent rules and collaboration. Collaboration builds a sense of *being in this together*, that offsets earlier parental ineffectiveness.

What works is pragmatic; as parents feel and display more positive authority, their children must relinquish maladaptive behaviors or strategies. While it is tempting to impose or advise limits and rules at the beginning of parent work, to counter family chaos, we find this is rarely effective. Rules and limits must emerge when parents are able to understand and feel committed to the benefits. Rules are also useful to re-establish the parenting job, as a way to reassure children that parents will be predictable. This illustrates this transition: it took effort for one girl to stop bossing her mother around (her way of coping with mother's depression), and allow her mother to set limits and follow through. The first time her mother imposed a rule, she felt humiliated since she had always been in charge. She gradually could see her mother's authority as positive although she also called her mother out when mother forgot rules and slipped back into neglecting care.

Tolerate play—and playfulness. Play is natural activity for children at these ages, but is often absent within these families' dynamics, or is dysregulated and reckless. Themes of danger, aggression and mayhem dominate play, perpetuating chaos. Many families are so impoverished that children have few play objects and parents rarely play with their children. Playing becomes a valuable metaphor in work with families. Playing can be about having fun. Playing together creates relational pleasure. Playing can also illustrate children's developmental capacities, because many parents don't know what is typical play. Many parents are impatient with playful activities that are usual for children or fail to supervise play so it stays pleasurable. *(Having a video game is a good way for him to play sometimes, but too much is making him irritable. That's why bedtime is so hard. He needs a different kind of play at night, maybe time with you.)*

Just playing as a practicing stance permits mistakes and repair. Parents can play with new ideas or other ways of reacting to their children, just as children *play at not being so mad*, or *play at helping*. Playing relieves the pressure of doing things right, and instead introduces the idea that learning takes practice. *Let's play this out* suggests options and flexibility, and may diffuse parents' rigidity and impatience.

Consider your child when making decisions. Many families make decisions that negatively impact their children. For example, family members leave or return without warning, or new people become *family* for a period of time (boyfriends, transient company). Some families are highly mobile, necessitating sudden school changes and other disruptions. Children are rarely helped to know about or manage these changes. Preventing changes is usually unrealistic, but we can ask parents to address how these events impact their children.

This requires thinking about children's needs and how they will feel about changes. It also requires

parents to make active decisions, even when their options are limited or non-existent. Choosing a safer neighborhood, keeping an abusive partner out of the home, spending money on food instead of alcohol, or staying home at night are examples of decisions that benefit their children. When children feel attended to and acknowledged (instead of cast aside), their coping abilities are enhanced instead of constantly overtaxed.

Next Step for Families

Developmental Repair cannot address all the needs of these families. They may continue to struggle even if their children become less challenging. There is ample evidence how parents' own attachment experiences are exposed by their parenting, but also influence their other relationships. Similarly, intergenerational effects of trauma and risks persist.

As child functioning improves, some parents can address other parts of their life difficulties, including past experiences. Some cannot change but do not interfere when their children use other adults, and the larger community, to grow up. Or parents realize that they need individual help to parent effectively. **This example highlights such realization: *after years of acting tough and being tough to her young son, one mother realized how little care she had received from her own parents and from her many (abusive) boyfriends. She admitted to serious depression that she had managed with street drugs and gang involvement. Getting help activated a different loss and grief as she recognized the harm she caused her child.***

Just as many of their children will complete Developmental Repair treatment and then access community resources, many parents use this intervention as the avenue to their own help. A goal of intervention is to help parents disrupt their own isolation and allow their children to provide access to the larger community. At very least we want them to experience our help as a possibility of something more.

Working With Other Parents

Absent Parents and Extended Families

Many children are cared for by one parent; it is not uncommon for parents to live apart. It is always beneficial when both parents are available for a child, even if they parent differently. Fathers are often absent when there has been domestic violence, abuse, or gang involvement; sometimes it is mothers who are unavailable. Children remain aware of the importance of both parents and often adopt real (or imagined) behaviors that are like the absent parent.

Sometimes the missing parent is a grandparent or other family member who is doing the parent job. Some children are parenting by a *family community*—with multiple adults in charge. In these situations we negotiate with the caregiving adults to clarify whom the child can turn to, and work with that person(s) to support treatment and useful parental care. When parenting is provided by a family member, it is important to provide the child with explanation about the missing parent that is congruent with the child's experiences and also coherent—makes sense. Helping families tell the story honestly is an important part of our work. *(One grandparent found this helpful: "You love your mom and I do too because she is my daughter. We are both so sad that she keeps using drugs. At least she knew to bring you to me.")*

Some primary parents lose contact with their children (foster placements, custody conflicts, absences due to illness, incarceration, work, etc.). When these parents return to their children, they must accept what has happened in their absences. They need help to understand and incorporate their child's experiences as different from their own, and tolerate feelings that many not be congruent with their

intentions (abandonment anger).

We strive for as much parenting availability and consistency as possible. When possible and safe, we try to engage these *other* parents.



Parent Substitutes

Some children are parented in foster care. They want to be parented by their own parents but this primary relationship has been too compromised or endangering. Foster parents must provide support for ongoing development as well as immediate care.

When children live in foster care in temporary situations, our approach to family work is similar. We attend to the developmental needs of children, and to adult/child interactions. Even when care is temporary, the caregiver must be willing to be a regulating partner and provide more than physical attention. Each new relationship has the potential to further reinforce children's isolation and faulty expectations, or support new possibilities. We hope for the second.

Children suffer grief when their parents cannot parent, even when substitute care protects them from harm. This primary relational tie is profoundly strong and enduring. Substitute care always requires explanation. Without explanation, children assume blame or resent the situation that keeps their parents away. They resist new care unless they are helped with the grief related to parental loss. When children know why their parent(s) are not providing care (*can't do the parent job, working on getting off drugs, can't stop being mean*), they regain some control and are more able to accept support from other adults.

Children benefit when parent substitutes participate in the treatment process. When parent substitutes provide reliable care, this care becomes a positive alternative to what children have known. When parent substitutes act in ways that too closely replicate earlier difficulties (harsh treatment, lack of attention, unreasonable expectations), children are in more risk and family work becomes crisis intervention.

Parents Who Must Overcome Their Children's Past

Some families come together through adoption. These parents have different histories than their new children. Adopted children bring memories of pre-adoption events or disruptions with them and often confuse their new parents. To make sense of their child's behaviors and feelings, adoptive parents must use imagination and empathy to appreciate the past. At the same time, getting stuck in the past defeats a family's ability to create new experiences and provide good care.

Adoptive parents need help understanding why their children's injuries persist, in spite of their parenting efforts. They also need support when skills (especially ones that worked for other children in the family) fail with this child. Some parents feel defeated and blame the child when they have no other explanation.

Family work must help these *second* parents become effective regulatory partners to their children, to repair what the first parents were unable to provide. These second parents need support to understand the lingering effects of attachment loss and to be patient during the time it takes for their parenting care to be taken in and replace what was earlier learned.

Obstacles to Parent Engagement

We have offered ideas that support parent *experimenting*, as a complement to Developmental Repair. Ideally, as the child comes to treatment, the family comes too. But because we have identified children who are at highest risk, family involvement is often a struggle.

Some families are wary that we will fail as other interventions have. They doubt our competence or they resent our advice. Many have no template for letting others in, except through forced involvement.

Other parents don't understand why relationship experiences are important. They want us to make their child stop causing trouble but they don't understand their role in their child's behaviors or how they are part of the solution. Some even approve of their children's behaviors because they too fight and feel excluded.

In reviewing our experiences over the past decade, we notice that even when families are not fully involved, this approach has efficacy. While children with involved families made the most gains, children with compromised family involvement also made reasonable developmental gains, especially when they experienced strong community support (school). As described earlier in this manual, children made and maintained progress with the help of a supportive school environment, even when families remained stuck or underinvolved.

This possibility is promising because very at risk children come from families who have historically remained outside of most evidence driven interventions. We then asked: is there a minimal level of family involvement for children to make gains? In thinking about families we have known, we could describe five descriptions of parent involvement.

Parents who are concerned partner with us. Even

when there are unconscious or historical obstacles to parenting, they engage in helping their children.

Parents who are confused or minimizing suggest patterns (preoccupied, dismissive) identified in the adult attachment research. Parents who seem confused have difficulty understanding their children's needs but seem able with help to support their children's changes. Their confusion is embedded in current life challenges, and they lose attention to their children's needs. They often seem preoccupied with their own needs but as their children get better, they feel less conflict. They allow their children to access other relationships (school, other family members, treatment staff). Minimizing parents ignore the severity of their children's needs and problems. Even when they admit to their children's difficulties, they minimize or dismiss their involvement and may resent when others see their children differently than they do. They usually don't block their children's involvement with others but do expect their children to fix things without much help.

We did observe significant treatment progress even when there was no evident family involvement. This may be a unique characteristic of this age group, different from infants or toddlers. Many children have already learned to care for themselves, but still remain open to positive outside relationships. These families did allow school and treatment to be meaningful by sending children each day. Even as they remained passively disengaged, they provided reasonable environmental safety. Their un-involvement leaves room for others to provide help.

Sabotaging families are the most challenging—and the most defeating. These families can appear willing to engage and seem interested. But their actions or lack of actions confound treatment efforts. Their children cannot sustain or generalize changes. Some of these families had strong anti-social identifications and loyalties that take precedence over our efforts to pull their children into the larger pro-social group. Gang affiliation is one example of a sabotaging *double bind*; children defeat their own desires for a peer group when their parents teach them to signal gang affiliation. Parents' actions may provide the sabotaging message.

We did observe significant treatment progress
even when there was no evident family involvement.

This example illustrates the conflict:

By age seven, this boy has been repeatedly suspended and struggled with severe attention and impulse difficulties. He wanted to succeed at school and was academically above average when he could concentrate. But he regularly came to the group, and to school, wearing pants that were several sizes too large for his waist and no belt. This was a style of dress common among teen gang members. Losing his pants exacerbated his aggression and sexual excitement. His mother indicated she wanted him to get better but despite many requests she refused to help him dress differently, resulting in an impasse that defeated treatment.

These descriptions afford clinicians some guidance about parent engagement styles. But each parent/child relationship remains unique because children change, and that always has the potential to help parents change.

A second kind of sabotaging is when families do not directly resist treatment, but offer contradictory messages that make it impossible for the child to move ahead. Often these are caregivers who blame others for the child's difficulties, or create ambivalent loyalties that strangle the child's gains. Children feel forced to choose between what they are told and what they feel to be true.

For example, a seven year old girl lived with her grandmother because of maternal maltreatment, including drug use. This girl remained agitated and combative despite periods of treatment efficacy. Family engagement seemed positive as her grandmother lamented her granddaughter's suffering. After several months, we learned the grandmother and her partner were frequent drug users, leaving this girl to her own care. She could not tolerate telling on her grandmother so instead attacked her new relational partners, the treatment staff.

Sabotaging is a strong adjective and contradicts our earlier statement that most parents do not intend to harm their children. In these cases, Developmental Repair could not be effective when children had to remain aggressive to manage family wishes and conflicts. What is sabotaged are relationships with others (adults and peers) outside of the family experience.

6 Staff Support

- Staff Consultation
- Supervision
- Training To The Model



SUPPORTING STAFF

Being with dysregulated children is challenging for staff. They know very at risk children are vulnerable. At times staff will find it hard to feel anything but intense sadness for these children, and at other times they will feel enraged or defeated. Their personal safety can be threatened by children's behaviors, and their emotional stability is similarly rocked when they cannot change these children's circumstances. They become susceptible to stresses and strains at work and at home, if protections are not in place. Generous staff support must be an integral part of this model.

Staff Support: The Glue for Developmental Repair

Developmental Repair is a relationship-based intervention. Staff support is the glue that binds this model. These children are challenging to work with, and Developmental Repair requires that adults involved in intervention provide children with very personal attention. Adults who use Developmental Repair must understand the theoretical premises of this intervention. But emotional stamina and support are valuable antidotes to inevitable intervention fatigue. Consultation, supervision and training help staff maintain their own regulation and assure their availability to children as regulating partners.

Staff Challenges

Young children can't easily explain or relieve their distress. They act out their miseries and confusions with aggressive and disruptive behaviors. They need adult help, but at the same time they often fight against help. They are not good at being in relationships, so they are not easy children to join, especially in the prolonged way that this model requires.

These children come at you quickly, and adults have little time for measured responses. Staff must be able to tolerate their own emotional



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arousal and reactivity without undue shame or defense. They also have to be able to fix interactions with children and assume responsibility when things go badly, without losing confidence.

Being with the families of these children is also challenging. Many parents struggle with similar difficulties and years of negative experiences that make their symptoms more impenetrable. Some families are profoundly sad and defeated; many now manage in their own lives by defeating their children or those who try to help.

Recognizing Staff Needs

Developmental Repair is a relationship-based intervention that requires staff to engage with these children and their families in an intense and sensitive manner that is often exhausting and frustrating to achieve. To be effective, staff members need permission to know their own feelings and tolerate discouragement and dysregulation. Making self regulation the target symptom requires that staff maintain, and regain, their own equilibrium in the face of powerful onslaughts of emotions, so they can be co-regulating partners for these children (and parents, when possible). They need protection against feeling overwhelmed. They also need intellectual encouragement to stay the course of this intervention model. Staff members who stay

intellectually passionate about why these children struggle and how repair interrupts these struggles are much more protected than staff who rely solely on emotional commitment.

To do this work, staff must be willing to reflect on their own feelings and needs. Just as parents must psychologically think about their children, staff must also foster a “state of mind with regard to attachment,”¹ to be available as regulating partners. State of mind includes knowing the child’s experience, but also tolerating awareness about *our own* experiences of, and attitudes about, care.

Consultation, supervision and training provide necessary supports for staff who are engaging with these challenging children. It is critical for staff to be given help when the work gets overwhelming, and permission for self care. This is challenging work, and not everyone who cares about children can be effective in this program.

Staff Consultation

Consultation is a designated time each week for staff to meet to discuss their work, to solicit advice from one another, and to restore their own emotional regulation. It is an active process of looking at and understanding experiences of being with these children, and becomes a parallel process to what is happening within the treatment group. Staff bring the group experiences to consultation, and then bring the consultation ideas back into the group.

Consultation is a shared time when staff members can recognize and tolerate how children become dysregulated, and how they bring adults into this state. Instead of becoming afraid or angry at children when we lose our balance, we must become interested in this as an inevitable and even useful shared experience. We have to metabolize children’s distress in ways that permit reliable engagement, instead of disconnection. But interest is not enough; adults must feel confident that their own regulation can be restored. Consultation provides a safe and supportive opportunity to realize our own tensions and fears, and feel reassured that we can regain regulation as we help children do the same. Consultation helps staff discover children’s emotional messages embedded within behaviors, so that treatment can always be focused on what children need vs. how they act. This helps staff be responsive to children, instead of reactive. Staff must also examine what responses are helpful, and what are not, and have the courage to keep trying.

Consultation must protect and support the emotions of staff. This can be emotionally activating work, and staff who can tolerate and value their own emotions will be most effective. Consultation also holds staff ambivalence when it becomes hard to like these children or the work, and grief when children’s lives change in ways we cannot control or when staff members leave. Consultation assures staff time to support one another. Developmental Repair is an intimate model because staff must trust and rely on each other (especially when they are together in a group), so feelings of every kind are acceptable and worked through. Sharing positive emotions is as important as allowing the negative. Celebrating small steps of progress or endearing interactions relieves tension and focuses attention on what is working. Humor is a natural antidote to frustration. Change happens gradually and staff must cultivate patience.

It is natural to try to make consultation everything: training, supervision, administrative support. This is a mistake. For Developmental Repair to work, consultation must be protected as an opportunity to discharge regulatory tensions and to provide the space to play out how it feels to be with these children. When staff cannot address their own distress and confusion, their abilities to provide regulatory support for children is compromised. While consultation inevitably identifies outside issues that impact

¹ Main, M. & Goldwyn, R. and Hesse, E. (1998) *Adult attachment scoring and classification system*. Unpublished document, University of California, Berkeley

children, or workplace issues that impact the program setting, it is critical to keep the focus on repairing children's developmental capacities and supporting staff who are providing this repair.

How Is Consultation Organized?

- Consultation must be frequent and not rushed. Weekly meetings should be about an hour and a half. Shorter duration rushes staff; much longer leaves staff too fatigued.
- The consultation group size is important. When there are more than eight staff members, the interactive nature of the experience is compromised and it becomes easy to slip into didactic instruction or case facts. Consultation is best when it is an experiential group process.
- Experiment with meeting at the beginning, middle and end of the day, and the beginning, middle and end of the week. End of the day at the end of the week is often effective because staff can unload the week, leave for the weekend and return ready to implement what has now been digested into their minds. But there is no magic formula. What is *magic* is making sure there is time to meet and reflect.
- Use caution about including interns and visitors into consultation. It is a good opportunity to show the program model, but letting too many people in has the same effect as letting too many adults into the children's groups: the group loses its intimacy and purpose.

How Does Consultation Happen?

- It is valuable to have a designated consultant—someone who is most experienced with the model and can support fidelity to the model's intentions, including staff support. The consultant should know the children as much as possible and have the staff's trust. The consultant should also be experienced with working in a group setting. This is very hands-on work.
- While the consultant is the convener, consultation is an interactive process. Just as the model is not formulaic, the group process is best when it can be spontaneous and organic (occurring naturally). *What's happening?* is a good beginning; another can be *what's hard this week?* We have observed positive benefit from starting with good news—stories that have been positive or encouraging—but sometimes getting to difficulties is more pressing.
- Consultation shifts from doing it right to being interested. There is rarely one way to work with a child, or a wrong action. Interest focuses on observing what is happening between the adult and child, and assessing what the child might need within the group.
- Consultation also helps staff tolerate the inevitable family or environmental crises that take staff attention away from the children. Consultation helps staff stay in the intervention frame, instead of focusing on what cannot be fixed.

What Makes Consultation Work?

- The best preparation for consultation is the clinicians' spontaneous reflections and recollections. This stance of interest is possible when each staff is open to discovery and is comfortable with the program model. Staff who are most effective at Developmental Repair can access real experiences and historical data simultaneously. Burdening consultation with too much prepared information compromises the *spontaneous combustion* that permits genuine regulatory support.

- Keep the focus on developmental repair. Tracking children's needs or progress using the four domains (relate, feel, think and act) is a useful consultation tool for both individuals and the overall group assessment. This tool helps staff maintain a whole picture of each child, but also keeps staff thinking about developmental growth, more than specific events of content.
- Use role-playing. When children remain a puzzle, it is useful to act out an exchange or interaction in consultation. It is amazing how easily staff can become the child—mimicking words, gestures, tone, movement. This attests to how well these children are known, even when adults can't quite make this knowing logical. Acting allows primary staff to imagine the child's position, and asks others to then imagine a helpful response.
- Multiple perspectives add such richness to consultation. Children impact staff members differently, and everyone's experience reveals something about that child's reality. Consultation is like piecing together a puzzle to finally get a whole picture.
- Staff members will feel overwhelmed and frustrated. Ideas are welcome, but more helpful is group reassurance that these difficult times are inevitable and will change. New staff are especially vulnerable to the inevitable ups and downs of treatment progress, and most staff are not confident of their ability to do this work until they have seen a case through.
- Consultation creates program cohesion (when there are multiple groups) when there is space for conflict and resolution. However, it is important to protect treatment as the primary task, and to use other meetings for agency/organizational issues.

In the Washburn program, the primary consultant has not been a full time member of the staff, but comes into the program. Staff members have been gracious in allowing the consultant to move freely in the groups, and to observe (and participate in) staff interactions with children. Unlike usual clinical settings, group treatment permits a great deal of treatment transparency so there is minimal discrepancy between what actually happens and how treatment interactions are remembered in consultation.

Supervision

Clinical supervision complements consultation and provides one-to-one review of a staff person's experience of working with the Developmental Repair model. In most settings, supervision also supports individual professional growth, attends to case crises, and tracks administrative requirements. It is best when the clinical supervisor is also involved in, or very familiar with, the Developmental Repair model. Supervision helps staff learn the model. Staff observations within the group become useful tools because supervision help is directed to real interactions.

Supervision with such challenging children and families must support staff reflection. Reflective practice assumes that there is a relationship, and that attending to the experiences of being in this relationship will support the staff person and increase effectiveness. Especially when the consultation group is necessarily large, supervision provides regulatory support for individual clinicians. It is easy to feel overwhelmed and ineffective with this very at risk population. Individual supervision helps staff stay on even keel and know their own vulnerabilities and anxieties.

Supervision also provides direction for work with challenging families: engagement, clinical assessment, and ongoing intervention planning. Because many families are involved with other services (including child protection services) supervision helps staff negotiate these collaborations while keeping the child in mind.

Supervision also serves as a place where staff can address self care issues, including their personal worries and reactions. It can be hard for staff to accept their own inevitable ambivalence about these children and families, and they need support with these feelings. At the same time, experiencing our own vulnerability to emotional distress or dysregulation can build genuine empathy and understanding of the children and families, and real appreciation of how good it feels to have kind company.

One caution is necessary: group issues should be addressed within the group, in consultation. When a staff person identifies a group issue (conflict with another staff, disagreements about the model), solving this in individual supervision does not address the ripple effects within the group of this tension. When Developmental Repair is used within a group treatment model, supervision must be cognizant and respectful of staff cohesion and trust.

Training To The Model

Training for Developmental Repair must be more than reading this manual. New staff must become oriented to Developmental Repair and all staff benefit from quarterly reviews of both the model's organizing principles and the specific intervention ideas. Training to the model must happen again and again. Developmental Repair relies on ideas that can seem common sense, but maintaining these ideas when staff are with children or families can be challenging.

Training builds on natural learning habits. Many staff working with these very at risk children are new in their fields (mental health, education, youth work) and have a steep learning curve. Even more experienced staff are often surprised by the complexity of these children's lives and risks. Many find the intervention *paradigm shift* interesting but the intervention ideas become more credible, but also challenging, as staff work with children. They see it, feel it and then find words for what they experience. Training about the research and theories that support Developmental Repair builds staff confidence that they can explain what they do and why.

Periodic review of normal development is critical. Staff members need basic knowledge about normal early development. Developmental Repair uses normal developmental knowledge to frame children's needs and track movement towards more age-typical functioning. In evaluating progress, staff must not underrate or exaggerate these children's abilities. Exaggerating progress is often more likely; in our internal rating process adults often over-valued children's abilities when their frame of reference was the treatment group.

Training maintains program fidelity (assuring that delivery of care continually matches model principles). Often staff members are asked to conduct trainings for community colleagues, which further consolidate their expertise. While Developmental Repair is delivered with relationship intuition, intellectual competence and confidence about the theoretical premises serve as a life jacket for staff members when the work becomes emotionally intense and exhausting.

Training can address subjects that impact this population. For example, it is critical that staff be well versed on the ongoing effects of trauma. However trainings that introduce other intervention approaches have the potential to confuse staff members who are trying to become proficient in Developmental Repair. Other approaches may become complementary but it is imperative that the clinician feel secure in one model first.

Finally, this is an innovative model so trainings must support this feeling of innovation. One of Washburn's most useful training experiences involved work with an actor who helped staff learn and practice improvisational techniques. Trainings are beneficial when staff feel emotionally refreshed and renewed as well as intellectually enriched.

7 Implementation

- Group Treatment
- Restructuring Time Out
- Diagnosis And
Pyschopharmacological Support
- Documentation
- Generalizing Treatment Into The Community
- Funding
- Insights from Our Experience



GROUP TREATMENT

The Day Treatment Model

Developmental Repair is an intervention model that emerged from clinical practice with very at risk young children. There were no evidence based protocols that addressed the accumulation of risks and provided intensive care within a community setting that relied on community funding. The day treatment program at the Washburn Center for Children had both intensity and structure that was then adapted to become the setting for Developmental Repair. This approach can be applied to other settings, but here we present practical directions for a group treatment setting.

Day treatment as a model of intervention was developed in the mid-1960's as a community mental health alternative to residential treatment. The thought then, as now, was that taking children from their communities added to risk. Traditionally day treatment has meant full day participation for school aged children, removing them from their schools and classrooms.

Washburn provides half-day (three hours) group experiences, four days weekly. Younger children come to morning sessions and then go to day care or preschool settings; older children come from their primary schools in the afternoon, and are returned to home or day care. On the fifth day, children remain in their community setting for the entire day.

We use half day programming so that the children remain involved for the other half day in their community schools or settings. This prevents community settings from disowning these children. Out of sight can become out of mind, especially for schools burdened by large class numbers and academic performance demands. By keeping them in school, we make sure these children stay connected to their community, maintain peer contact, and have a place to practice new abilities—in both social/emotional and cognitive areas. Generalization starts as soon as they come to treatment. One full day in their community setting (Friday) tests their gains,



and permits staff to work with children and their teachers in the classroom.

Group Composition and Staffing

Each group has six to seven children, with two staff members. One staff person is responsible for knowing the individual child's history and assessment information and for engaging the child's family. Within the group, this person is watching over the individual children, helping them to manage the group demands, and supporting them when they can't. The second staff person organizes and maintains the group experience, designing group activities and tracking themes. This person is responsible for helping the group stay cohesive and functional. In practice, these designated job descriptions are fluid. Both know the children as individuals, and work with each child's needs and goals.

When a child is struggling and needs individual help; one staff person attends to the distressed child, while the other staff must hold the rest of the group together. In reality, this division of labor is decided less on job descriptions and

more on whom the individual children first *hires* coming into the group, or which staff person is most psychologically available to *be useful*.

The program also has interns from mental health graduate programs (psychology, social work, marriage and family therapy). Children benefit from including new people, and managing healthy goodbyes. At the same time, it is important that this be a working group, rather than a collection of children in a room with many attending adults.

Not all staff who work with children will be successful using Developmental Repair. This model requires flexibility, creativity, patience and tolerance for dysregulation. Day treatment often attracts newly graduated clinicians, and this model is excellent training. But it is also challenging: working in a group is as emotionally challenging as it is intellectually engaging. Staff who can accept moments when they don't know what is happening are best suited to this model. Professionals who cannot accept mistakes or tolerate feeling emotionally unsettled will not do well.



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Constructing a Pro-Social Group

The primary challenge of group treatment is aggregating children with behavior disorders. In the community, children with behavior disorders are excluded from normative social groups, perpetuating their identification with similarly behaving peers. Without pro-social peers they have no models to imitate, so a vicious cycle starts: the more they are left out, the more they behave in ways that will leave them out.

To counter this risk of further social estrangement, Developmental Repair constructs a protective, pro-social replacement peer group. Adults influence the group process, helping children feel included. They monitor group patterns, interrupt destructive interactions and actively model how children can engage with one another. Adults model and support social skills such as group cooperation and tolerance, negotiation and social repair (helping children make things right with one another).

In time, children learn to be a group. Activities help children find common ground—things they all experience, rules they make together, ideas that become projects. Children are not rejected or ejected from group membership. Staff respond with empathy and kindness when children struggle with behaviors, and often the other children do the same.

In this way, group treatment builds a community where children can securely belong. They also become part of a larger community. Because we have multiple groups, children meet other children, they

overlap at outdoor activities, and they know one another from the bus rides to and from the program. Supervisors and other staff regularly come into the groups. We build a community that has common aims and experiences. For many, belonging to Washburn serves as their first positive community experience. ***One child was anticipating discharge but objected that he did not want to leave Washburn. While he had met his goals and was doing very well at school, his family life remained chaotic, and he knew he would miss the treatment community. He worked really hard scanning the adults coming to and from the agency, in search of “Mr. Washburn” so he could make his case for staying forever. After discharge he was comforted when he saw any of the Washburn staff at his school, greeting them with confident expectation that they would remain interested in him.***

Group Cohesion

Our groups are continuous: children arrive and leave according to their own needs and progress, so there is always change within the group membership. Children already in the groups often treat new children as threats. Graduating children are celebrated but also missed. Staff changes also impact group cohesion, and interns are always coming and then going. Initially we tried to reduce disruptions, but we realized how these mirror the children’s real lives.

Losses constitute risk if they are ignored or minimized, but become protection when children learn about good goodbyes. Leave-takings become opportunity to acknowledge emotional reactions to loss and to find resources to manage without the missing person. It becomes most important to identify reasons why people arrive and leave. ***She is coming to our group for help, just like you did. Remember how he was here and going to college—now has to be at college all of the time. He’s graduating from our group because he knows how to be at school all day.*** This helps children think about others and builds group cohesion. Children also create group memories. One intern was very skilled at drawing superheroes that were then copied for coloring. One day, a year after he had left, he brought new ones. The children responded with delight—*B. made us new pictures*—even though none of them had actually known him. He was remembered as having been a part of the group.

Group cohesion is especially disrupted when children leave unexpectedly, or when a valued staff person leaves. As much as possible, providing real explanations offsets children’s proclivity to blame themselves (*she didn’t like me*). Group cohesion is protected by the meanings the group constructs about these inevitable changes.

Program Routine

Treatment must have reliable routines and structure. Positive regard and kindness cannot overcome chaos. But these routines cannot be so rigid that children feel controlled; rather, it is about helping children gradually learn more organized ways of managing time and space and being with each other. To get there, we organize the group to approximate the usual structures of school and community. We start with what they can expect: schedules, rules, *ways we do things*. When children know what to expect, they feel more competent and secure. But this is a lived experience so there must also be accommodations to what children need to succeed. When a group is relatively new, the routine must be steady but flexible enough that they can learn to comply. When individual children are struggling, the daily plan may include less group time and more opportunity for individual access to adults within playtime. When a group is well established, staff may re-arrange activities to address a specific group issue. ***The group has been successful until one boy experienced a family disruption. He became loud and aggressive and these behaviors were contagious. Five of the six slid back to old ways of acting. The routine that week shifted—staff used the group rules to help children remember their responsibility to one another. They had to inhibit the mean talk, and instead construct group talk. While the routine was not punitive, there was more focus on deliberately fixing mistakes than just adhering to the usual routine. When the group returned to even keel, the familiar routine also returned.***

The group rules become a social safety net. When adults assert control and children react negatively, the routine becomes the reality (this is how it works here). Adults interrupt power struggles and instead help the child accommodate to this group reality: *these are the rules, and you can know about them and we will help you so these feel OK*. Shifting from imposed order to adult help to fit in is an effective antidote to children's oppositional behaviors.

Adults who use Developmental Repair must be comfortable with organizing the group, as well as with joining (empathy). We are not controlling children but we are using our own control to be firm and consistent when necessary. Adults must be effective leaders in creating routine and order. Children know what to expect from us, and what we expect from them.

What Happens For Three Hours Each Day?

Group structure borrows from what children do normatively. But we also allow that these children are delayed, so many of the activities that their same age peers can manage without supervision, or have mastered, are still difficult for these very at risk children. We approximate activities that they should be able to enjoy and use. The group structure is predictable, but not rigid. We use the schedule to support children's experience of success and accomplishment. *I did it!* can involve different achievements: getting through group time without falling apart, having a great day or managing to leave without getting angry.

During the three hours, we help children be in the group and are always doing treatment. We don't formally separate therapy from social experiences from skill building. Instead we integrate all of these tasks, because that is how young children learn, especially young children who are disorganized. We are constantly thinking about what this child needs in every interaction and experience.



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These are specific activities that are used for each group. The age of the children determine how long and how structured these activities will be.

Play: Time for free play and unstructured group interactions are necessary, because this is what children of this age do. Often staff must help children manage relatively unstructured time. Many children lack imagination and play abilities. They don't have play ideas and don't know how to engage cooperatively. For some, toys are just aggressive objects. Some children start playing alone. Others want to play with others but struggle when play doesn't happen as they expect. They need adult help to learn to play, and play together.

Play time also provides time for staff to be with children individually, and to use play themes to address individual needs. Free play allows children to be with each other; at the beginning, this is hard but as children feel more secure, they build their *normal* abilities.

Art Projects. Art projects foster creative expression, skill development, attention and focus, group cooperation and patience. But art also causes disruption, frustration, and messes. Many children cannot describe their own ideas or needs, but can use materials to engage in some beginning awareness and agency. Coloring already drawn objects is often a first project. Art projects often reveal children's impatience for their own mistakes, and allow adults to reassure them about their efforts. Humiliation can be soothed by compliments and eventual pride.

Art projects also provide practice for fine motor control and hand/eye coordination, which are often under-developed because of children's lack of experience.

Snack. Snack time is about food, but also about eating together. Many children arrive hungry and remain hungry throughout the day. Some do not have enough food; others cannot regulate their appetite. Eating (and feeding) trigger regressive fears (*will there be enough? will I get my share?*), and **frantic responses (hoarding, fighting over supplies)**. Snack time allows the children to practice trust, eating regulation, social manners, and table conversation.



Large Motor Play. Because these children are so physically active, large motor play is often the best time for positive physical contact. Many children are more adept at large motor play (being in their bodies) than imaginative play (being in their minds). Activities focus on balance, body awareness in space, and body regulation, as well as social reciprocity and fair play. Tensions are discharged with physical exercise (and intentional breathing). Large motor play also encourages achievement, and activates positive approval seeking (*watch me do this!*) and positive competition with peers.

Structured Learning Activities. Books, puzzles, and games support literacy and non-verbal learning. Word acquisition is a startling discrepancy for these children. They have a paucity of vocabulary and word building. Many struggle with beginning reading skills, and even being read to is surprisingly difficult when they must be quiet and passive. They are not used to relaxing and taking something in. Being read to helps them imagine that they can someday read to themselves.

School Work. We use homework and additional academic exercises to assess cognitive abilities, remediate skills and repair motivation. We call this activity *smart time*, encouraging the children to feel hopeful of their own capacities to learn and perform. Smart time focuses on helping children to use adults for learning (supporting positive attitudes about teachers), to be motivated to try new things, and to build a work ethic about doing school work, even when it is hard. Tenacity and determination are important qualities for school success that they often lack.

Many of the older children are phobic about academic work. They are unlike their peers who are becoming more interested and accomplished in academic tasks. They already assume, and then avoid, failure. Helping children with homework or with learning that is being introduced in school builds their confidence. Doing homework also assures they have work to hand into their teachers the next day and can relieve parents of this task. We ask their teachers to provide appropriate learning projects so children can continue academic effort.

With younger children, smart time anticipates academic work. They need pre-learning practice that supports school readiness. We are making school work familiar to them and try to prevent the avoidance we see in their older peers. We help them get excited about learning.

Transitions. Transitions are part of any day. But transitions become more than just moving from one activity to another when children struggle with loss and control. Many children panic when leaving (losing) one activity for another, or shifting their attention to something new. They react when they perceive adults making them do things (which we are).

Practicing transition ahead of time (pre-living) is often the most helpful; adults and children practice together how transitions will happen and how the child can respond. Anticipatory alerts become helpful (*it's 5 minutes until clean-up*) for children with attentional difficulties, but this must be practiced together as well. Children must trust that if they stop an activity one day, it will be available again on subsequent days. Their lack of trust in the continuity of experiences interferes with their ability to remember. Some children may be able to use transitional objects to move to and from school (or to and from activities) but many act out their fears of deprivation and loss by losing these objects. They need to trust adult reliability before they can transfer this feeling into an object of their own making.

Regulation Skills Practice. Staff have developed a regulation toolbox, which includes different activities that help children to practice regulation skills. Children are always feeling dysregulated in small ways. The toolbox activities help them practice getting their balance back. These skills include biofeedback exercises, physical movements to discharge tension, activities to do when upset or surprised, and ways to shift from one feeling to another. These skills are not initially effective during moments of intense arousal, but they become familiar and useful over time as children begin to remember what they can do to get back to a more calm state.

Focused Exchanges and Check-in. Some children can engage in therapeutic group activities such as check-in or group discussions. Others find this extremely hard. We start with things children can easily know (*say one thing about today you like, which goal are you working on the most today?*), and expect participation that is tied to their developmental abilities. For example, while most pre-schoolers can easily report on personal news, these children struggle to report on something that happened minutes before.

Groups use themes (things that change, what makes a family, feelings that are hard to talk about, big and little, private and public) as a way to facilitate verbal discussions. These themes are useful in building skills, but also help children learn to reflect together about ideas and their own experiences. Because these conversations can trigger feelings that are not yet easy to share, these activities can be comforting or disastrous on any given day.



Individuals and Group Goals

Each child has individual and group goals, based on observations within the group, their histories and their coping at school and home. Goals must be in language that is concise and can be easily remembered and help children practice something new. These become the contract between the child and the adult to work on things together. Goals change as the child changes, and must be incremental, so the child can experience both the challenge and the change. For example, one child could not tolerate any positive encouragement or praise. While the staff wanted to make a goal about being proud, it became clear that she needed attention to the small steps leading up to this achievement: *notice when you do something good—let me notice too—let me be proud of you when it is good—try being happy with me—practice feeling proud.*

Children start with goals about participating within the group; they need orientation. (*Learn the names of adults and children. Let adults show you how to be at Washburn. Try eating slowly.*) Because goals are public—referenced within the group—children can actually help one another (*watch what other kids are doing*) and learn together about group participation (*try being together in a new way, not a mean way*). Group goals help the child be in the group, even when it is hard. Some children have little group capacity or tolerance. (*Be part of the group at snack for a few minutes and then watch the group while you color.*) They need transitional activities that allow them to move closer to participation, and to find acceptable ways to maintain space. (*Tell kids when you are feeling too crowded.*)

Individual goals are more personal and specific to the child's current functioning. (*Remember that people aren't trying to be mean to you. Let adults help when you think there won't be enough.*) These goals are personal, but remain about the child with the adult, or in the group, for a long time before including school or family. Children need to feel they can effect change within this group experience before they can tackle change in settings where they really don't have much control.

Goals should never exceed three or four at a time. The purpose of goals is to keep children active and engaged with their own treatment experience—their own new learning. Goals must make sense to the children, but also push them to greater regulatory competence. For example, a relatively new child's individual goals might be *let adults help*. This goal assumes children will resist adult help when they need it most. Another goal might be *watch what I do when you get worried*, which promotes shared awareness. As children start to address regulation difficulties, goals might progress to *when you get too worried, remember to listen to me* (co-regulation); *do regular play, not too big play* (arousal modulation), and *at snack, watch what others kids do* (group identification).

Engaging with peers is a rich source for both individual and group goals. Many children act provocatively towards one another. (*Let kids be your friends, so don't become a bully. Be mad, not mean because mean makes kids go away.*) Terms such as *bully* or *mean* become defined within the group culture, and

can gradually be used for situations outside of the group. Children can also practice pro-social actions and emotions. (*Say kind things. Let sad stay sad and not become mad.*)

Different groups of children require specific goals. For example, girls bring more relational conflicts to treatment. (*Be disappointed with me a little bit when it is a little thing. Instead of teasing, tell me what you want.*) Because the girls are often a minority within any group, we protect their experience with group goals such as *it's okay for girls to have different ideas than boys.*

As treatment progresses, goals serve as bridges to other settings. (*Let teachers help like you let adults at Washburn help. Practice doing math at school like you do here.*) When school staff are able to collaborate, the goals can more specifically address school difficulties. Goals can also address differences and find accommodations that work. (*At school you have to listen to teachers and not ask why. Here you can ask why so you know how things work, and then we can practice what to do at school.*) Family concerns can be similarly addressed, when the family is engaged and supportive of change. For some children, these bridging goals help them generalize their abilities. For example, fear invaded one boy's every action. His mother was extremely unpredictable, sometimes indifferent but often rageful. Within the group any request—doing jumping jacks, trying school work—made him freeze. His goal became *remember, at Washburn, it is OK to try things out.* It then moved to *at home you need to be really careful, but here it is OK to just try it out. Even if it doesn't work, we'll say good for trying.*

RESTRUCTURING TIME OUT

Community practice has long relied on *time out* as an imposed period away from the peer group in response to unacceptable behaviors. For most children time out can be both a break from activity and an imposed interruption from activity. The prerequisites for effective time out include a reasonably positive relationship with the adult, some cognitive understanding about what happened and how behavior impacts others, and sufficient emotion regulation to withstand the evoked feelings and tolerate imposed control.

Very at risk children lack these prerequisites. They assume adult hostility, they act from impulse and arousal, and they lose regulatory control. And they rarely accept this imposed consequence willingly. Time out has often required physically and forcefully removing a child to isolation. Time out protects the involved adult, as well as the better functioning peer group, from the aggressing child's fury. But time out also places the burden of restitution on the child, assuming that when separated from the group the child will realize wrongdoing and self-correct. But very at risk children usually lack alternative ways of behaving and are bereft of better solutions when they are left alone.

When children come from community settings to the group they often expect and provoke this forced exclusion. They have become habituated to leaving the group because disconnecting from painful stimulation is their best solution. Time out perpetuates this cycle of aggressive arousal and escape, by confirming children's expectations of being shunned and abandoned. Time out may inadvertently reinforce humiliation and maladaptive behaviors before children cannot correct what they do not know.

Developmental Repair replaces time out with *time with children*. As much as possible children remain in the group and work through difficulties. When children see adults being helpful, they start to expect, and hope for, help. One adult can focus on (join) the child while the other adults attends to the other children. Assisting one child in distress usually has relevance for all group members as they watch this process of being helped. When problems get fixed within the group, children often become one another's cheering partners as behavior turns around.

Sometimes children become so aroused or agitated that they cannot remain within the group. They *need a break*—they need to be alone, without the stimulation of the group, in a space where they can

decelerate (come back) to more tolerable arousal. This is a time away from the group, but not away from adults or active treatment. We do not punish children for bad behavior, but respect how arousal overwhelms their coping and reduces their behavioral options. Needing a break recognizes that they cannot manage within the group, so we help them leave with us, to regroup and minimize harm. *Taking a break* illustrates a gradual and important shift: when children start to recognize when they feel stressed they can decide to take care of themselves by choosing to leave. Whenever the child leaves the group, the adult follows and focuses on helping the child regain regulation, instead of what the child did.

When children are aroused, they can become aggressive and even assaultive. It is sometimes necessary to remove children to keep staff and other children safe. Even when we force a separation from the group, our treatment intention is to help the aggressive child. When physical holding or restraint is necessary, we try to make this contact brief. It is important to state our intentions—*I'm not trying to hurt you, I want you to be OK*. Children need to regain internal control instead of using external control (our restraints). When the child seems determined to hurt, we may impose separation with a closed door, but the adult remains in visual and verbal contact and joins the child as soon as it is safe.

The less afraid the adult is, the more effective they will be in providing needed company. Many children must explode to discharge intense feelings, and in time these feelings will become less intense. Adult company is often wordless because talking can feel assaultive and trigger more arousal. As the child feels more settled, we can introduce the question: *what happened?* This is a genuine inquiry to the child, *what happened to you?* Starting with the child's perception allows us to *read back* their experience and offer empathy and when it is possible, offer another point of view. At this point most children are so grateful that adults remain available and kind that they are open to new ways of handling the problem the next time. They are able to learn.

By recognizing how painful heightened arousal can feel, adults are truly joining the child. Taking a break is a tool to remediate their arousal and behavioral stuckness. Children come back to the group activities as soon as they are able. There is no re-entry obligation, but it is helpful when children can announce their plans to the other children and adults. Announcing often happens together, with the adult assuming the speaking role: *we figured out that he got worried kids were taking his stuff. Next time he'll ask me to help and then he won't need to get so mad*. In this way the work of treatment keeps happening within the group.

These times away from the group are often the moments of inevitable disruption and repair that eventually build into increasing self regulation. Protecting time out as a therapeutic experience allows children the opportunity to experience arousal and regulatory help. Some children continue to use breaks from group work to address individual concerns. These become intimate moments when children report worries or confide about anxieties to the adult.

DIAGNOSIS AND PSYCHOPHARMACOLOGICAL SUPPORT

For this population, current symptom classifications offer an “unhelpful reification of diagnostic categories.”¹ The most useful DSM-IV initial diagnosis is often disruptive behavior disorder NOS, because it permits us to acknowledge that behaviors (what is apparent) are caused by other factors. The common and shared symptoms are chronic regulatory distress. Some children show evidence of somatic complaints and body regulation problems (enuresis, encopresis, eating difficulties, sleeping difficulties). Many seem constantly aroused (body tension, pressured voice tone, hyper-vigilance), and most become extremely aroused when stressed and struggle to regain regulatory balance.

¹ Rutter, M., & Sroufe, L. A. (2000). Developmental psychopathology: Concepts and challenges. *Development and Psychopathology*, 12, pp. 265-296

There are not adequate categories for symptoms that are the result of disrupted or poor care, or of maltreatment. Most children have not turned away from the possibility of attachment care (a criteria for reactive attachment disorder). They desire adult connections but disorganize themselves and the attending adult when they become dysregulated. Many children have characteristics of post trauma stress. Many are labeled with attention deficit hyperactivity disorder, with etiology linked to effects of trauma or early disruptions of care. Most children do not meet criteria for conduct disorder, although some have already engaged in property damage and most are at high risk for this over time. Oppositional defiant disorder describes how many children have learned to interact with their environment, primarily their relational environment. However, these children remain more aroused when they act oppositional (not less aroused, as is the usual description of children with ODD).

These children mask internalizing symptoms with aggressive behaviors. When in relationships that feel safe, many show intense anxiety, depression and mood instability. Because these symptoms are ignored, or concealed, children often feel aroused by external triggers and by their own inside distress. It is possible that externalizing behaviors manage more painful internal miseries.

Medication can be a helpful, and sometimes essential, adjunct to Developmental Repair. New learning cannot be absorbed unless there is neurological quieting of arousal and agitation. Washburn is fortunate to have psychiatry services on site. Family reporting is supplemented with day treatment data and at times our psychiatric evaluations have included observation of a child within the group.

Not all families welcome or accept medication recommendations. Many families are strongly opposed for understandable reasons: family history of drug use, distrust of psychiatric medications, fears about effects for such young children. We work to help them understand their children's difficulties as involving body (brain) distress, but we must also respect their concerns and find alternative ways to achieve this relief (including asking them to become more consistent and reliable in their parenting). Some families will agree, but then fail to give medications to their children regularly. Families have abused their children's prescriptions. For some children, taking medications when they are at school has been an effective alternative.

DOCUMENTATION

Documenting progress follows the format of the host setting. Washburn is a community mental health center so documentation follows usual agency and funding requirements. Goals and objectives should be consistent with the program logic model. We have developed a 12-item rating scale to describe activities that represent our treatment focus (included at the end of this section). This form prevents program drift from these core components and help staff attend to and track incremental change.

It is very useful to devise ways to daily note children's experiences. Staff learn to discern patterns in behaviors that seemed erratic or impulsive or confusing. Progress moves forward and back, so frequent assessment of *where are we now?* helps staff understand children's changes and periods of difficulty as they learn new ways to adapt.

We've also integrated the principles of the treatment model into documentation and ongoing program evaluation. The following 12-point rating scale, based on the foundations of the model and key developmental milestones, was created and implemented as a monthly rating tool to track treatment change and provide continual data for program evaluation.

How has the child functioned in the past MONTH?

Rating guide: 0=could not do this even with help; to 6=did this without help most/all the time

Consider the child's current level of functioning compared to general (ideal) treatment aims.
Consider behavior you observe at Washburn, home or school

1. Used adults—formed and maintained connections with adults: sought adult help appropriately.
 0 1 2 3 4 5 6
2. Managed arousal—brought extreme emotional reactions back into a moderate range.
 0 1 2 3 4 5 6
3. Understood emotions—distinguished among emotional states and could label them.
 0 1 2 3 4 5 6
4. Interpreted situations accurately—read social cues/interpreted the intentions of other accurately.
 0 1 2 3 4 5 6
5. Mentalized—appeared to be thinking about his/her experiences; thought about what happened and why.
 0 1 2 3 4 5 6
6. Managed behavior—reacted to emotional distress or provocation in functional age-appropriate ways.
 0 1 2 3 4 5 6
7. Group membership—participated in groups activities in functional age-appropriate ways.
 0 1 2 3 4 5 6
8. Interpersonal skills—played, shared, negotiated solutions with individual peers in age-appropriate ways.
 0 1 2 3 4 5 6
9. Motivation to learn—displayed a motivation and tenacity about learning even when feeling frustrated.
 0 1 2 3 4 5 6
10. Attention flexibility and focus -- able to shift attention and focus to support better outcomes
 0 1 2 3 4 5 6
11. Ability to play—in organized and imaginative ways vs. repetitive enactment or teasing.
 0 1 2 3 4 5 6
12. Sense of agency—recognized/owned his/her acts, and felt responsible for whatever made those acts happen.
 0 1 2 3 4 5 6
13. Integrated experiences and generalized skills across settings (family, school, community).
 0 1 2 3 4 5 6

Generalizing Treatment Into the Community

Day treatment must address functioning beyond the group. The best way to generalize treatment is to help children anticipate difficult interactions and then practice new coping. Generalizing treatment gains is continual. The benefit of half-day intervention is that they return to schools or day care and can practice what they are learning. Progress in the beginning of treatment is often inconsistent, but as children settle into the group they are better able to manage the community setting. Teachers are relieved to have help and can become more patient with the difficult child.

The bus ride becomes an immediate opportunity to transfer learning. Children are transported to and from treatment by special education transportation (small buses) or vans contracted through medical insurance. The ride usually involves interactions with other children, as well as with adult drivers who are often not predisposed to be patient. Making the bus ride work is a group effort and an early goal for a new child. Adults track how the child manages the experience (feeling frightened, becoming a bully or taunting, acting defiant to the driver's rules, reacting to the seat belt restraints.) We then identify triggers and rehearse alternative coping. Part of that coping is thinking about how we would help the child—what we might say and do. *(If I were on that bus, I would say it's OK, you don't have to get too big. Nobody on the bus will be mean to you.)*

Children can't change without help. We provide bus driver consultation and orientations at critical times each year to build working alliances, offering general information about day treatment and effective management of difficult behaviors. We try to elicit their empathy so they will see these children as struggling instead of bad. For many of the drivers, this information significantly reduces their animosity and increases their interest in helping these children ride their buses successfully.

Bringing Family Experiences and Information Into the Group

Bringing family information into the group must wait until children are secure within the group and allow staff to be helpful. Children must trust both the adults and the other children not to humiliate them or mock their families. Family experiences first come into treatment through the children's actions and reactions. For example, children may expect the adult to act as the parent does at home. Children may act more aggressively towards peers within the group when dynamics at home have become endangering. Initially, it is not helpful to make causal links; what is important is to help children with their arousal. Shifting prematurely to the issues at home misses the chance to work on the child's dysregulation and resulting behavioral reactivity.

As children can maintain regulation, they can use our hunches *(I think this is not about our snack. I think it is really about having no food at home last night when mom was so mad.)* to make sense of children's feelings. When possible we bring treatment to home. *We can tell your mom how you solve that here, and maybe it would work at home, too.* Hopefully their caregivers are similarly ready.

Engaging with Community Collaborators

Constructing community partnerships is challenging when silos of care (education, mental health, child welfare, physical health) offer few incentives for active collaboration. Yet the community must protect these children and services must be intentional and coordinated.

When schools function as the third critical partner, then staff must have a working alliance with teachers. This is not to burden teachers but to provide support and common language and goals. Because these children expect rejection and even abuse, teachers' frustrations can be a source of intense distress and provocation. The more the teacher can appreciate the child's struggles and respond with

kindness and interest rather than impatience or contempt, the easier the child can transfer treatment learning to school. Many children show behavioral improvement at school as they become less aroused and reactive. Overlooked learning difficulties can then be addressed. Start of a new school year, change of teacher, and imminent discharge all require close treatment/school collaboration so gains can be protected during these transitions.

Collaboration with other service providers, such as child protective services, is as critical but often harder to effect. For children in out-of-home care, a reliable residence is critical. We lose children when the child protection worker is unable to maintain a placement or guarantee foster care support. When children are uncertain about permanent care (parental termination of rights), they need to know what is happening to reasonably manage this life crisis.

Families of very at risk children are often involved with multiple service providers. Perhaps because they need so much, and bring so little to a service alliance, interventions tend to be fragmented at best and can often become divisive. Collaborating agencies often want to manage and control, and there is too little coordination of care. Coordination is a hallmark of effective intervention with these families. But with few incentives and many obstacles to better service organization, these children are often abandoned when they need help. A coordinated case formulation for the duration of treatment assures needed organization and protection. Anything less can become a treatment impediment and add to these children's risk.



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This illustrates the problem of community collaboration: soon after a five year old boy started in the group, his mother was suddenly arrested for a probation violation and returned to another state. He was left with a neighbor who delivered him to his father, who was on probation for crimes related to drug use but still lived with very active drug users. Most of the time, this boy could not get to group because no one in the house was awake to put him on the van. We taught him to use an alarm clock, and for awhile he managed to get himself up and out of the house. Neither Child Protective Services nor his father's probation officer was willing to intervene on this boy's behalf. He became invisible to everyone, except us.

Referrals and Length of Treatment

Children are referred to this program by families, schools, mental health agencies and providers, community organizations, child welfare and child protective services, and courts.

Referred children may need to wait for an available treatment space, or for financial and technical arrangements. This is an opportunity for what we call *before care*: evaluating the child's needs, and providing help to the family and the child's school or day care setting. Once in awhile a child's disruptive presentation is situational and assessment with guidance averts day treatment placement.

The average length for treatment has been one year. Many children make gains and then slide back when there are disruptions such as vacations or family changes. One child angrily started most Mondays saying

“why isn’t Washburn on Fridays and on the weekends. Tell me why again. It is too hard to wait.” Longer inclusion is usually related to interrupted family living, such as out-of-home placement, reunification with biological parent or kin, change in foster care, or adoption placement.

Mis-placements

Occasionally children who are aggressive or disruptive are referred but may not benefit enough from our model to stay for the usual length of care. Children with autistic spectrum functioning may initially be helped by the structure and adult co-regulation but cannot use the group. They need social skills, but among these peers, they are actually confused more than organized. Children with significant cognitive deficits, especially fetal alcohol effects, may struggle to generalize learning or hold onto even the most basic self-regulation constructs. They need a more predictable environment than is possible with our population. We find we can be effective in clarifying cause (etiology) and identifying patterns of arousal that allow referrals to more appropriate settings.

Criteria for Discharge

Discharge may be decided because of sense that treatment has been enough. Keeping children in the group for too long, even if family situations remain conflicted, has been a mistake. Their behaviors may start to deteriorate within the group, especially if they are doing well at school. When children have gained regulation abilities, they are ready to be with more adaptive peers. They are now like normal children who are pulled down by disruptive peers. This is a signal that it is time for the child to move on. The period before children actually graduate (usually about three weeks) is important because staff can practice more age typical responses to support the child’s better functioning. These include behavioral interventions that earlier would have been mis-interpreted or ineffective.

Many children graduate to moderate levels of intervention. Discharge is an opportunity to determine what community-based interventions are necessary and recommended. For many children, an outcome of day treatment is their amenability to these less intense resources (outpatient treatment, school tutoring, community mentors, sports programs). It is best when these can be in place prior to discharge so day treatment staff can vouch for these new providers.

Graduation is a very important part of discharge. At graduation, the last day of group attendance, children invite anyone who has been helpful to them. Often this includes family members, teachers, and community providers. Graduation signifies that treatment goals have been met and has a consolidating effect on the child’s progress. Evaluation data support that graduating increases the child’s chances of maintaining gains, even when treatment goals have not been fully achieved.



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Discharge is determined by four factors:

- The child is able to demonstrate increasing capacity for self-regulation in stressful situations and shows consistent progress on specific areas of developmental remediation over time. Self-regulation for children assumes some reliance on, or acceptance of, outside support.
- The child is able to engage in group participation and can obey rules and directions. This includes accepting usual directions and corrections without becoming aggressive and dangerous.
- The child is sustaining these gains at school and seems able to transfer learning to new situations.
- The child's family situation is relatively stable, or the child is able to manage the family status quo and maintain at school and in the community.

Aftercare

Aftercare is a critical component of this intensive treatment, but because of funding challenges, it is often neglected. Ideally children can be followed for at least two years following treatment to integrate gains into new situations. Aftercare also supports children's ability to seek out and use adult help in the community.

The most critical aspect of aftercare is ongoing contact with schools and with the children in schools. Aftercare is psychologically and financially cost effective because school was the original location of disruption, and many of the children remain vulnerable to peer group pressure and learning difficulties. Staff can monitor progress and identify problems immediately before new negative patterns take hold. Aftercare also helps the teachers retain an empathic appreciation of these children. Negative teacher attitudes or attributions are especially devastating for these children, especially when their family situations are untenable.

Aftercare is also useful for the children who cannot maintain treatment gains, or who experience subsequent life blows that again overwhelm their coping. Continued and sustained interest is protective. Some children have required more restrictive or more intense interventions (full day treatment, hospitalization, residential treatment) after day treatment. While it is hard not to see this as a failure of day treatment effectiveness, a better assessment may be that many children will continue to need support to sustain developmental gains over time.

FUNDING

Funding this intervention can be challenging. Funding prevention and early intervention continues to face opposition despite substantial and repeated documentation of overall benefits.² Services for the hardest children continue to be funded by the softest money (grants or supplemental funds) that disappears with economic shifts and policy changes. At Washburn, funding has come primarily from medical insurance, agency endowment and grant funding. The school district contributed transportation services. Similar programs in other communities have been creative in obtaining other funding sources. Services like aftercare or school consultations are the hardest to fund, even though these are likely the most cost effective.

² These citations were already identified in the research section but deserve repeating: Rolnick, A. and Grunewald, R.(March 2003), *Early Childhood Development: Economic Development with a High Public Return*, March 2003; Heckman, J. and Masterov, D. (October 2004) *The Productivity Argument for Investing in Young Children*

Insights from Experience

Over the past ten years we have realized many things about Developmental Repair. This intervention can improve the child's internal resources, but it cannot erase historical events or undo the effects of chronic neglect and relationship damage. These children remain at risk, but may have gained sufficient protective buffering to stay on a course of development that does not get worse. For this population, with these clearly identified risk factors, stabilization with expected ups and downs may constitute sufficient progress. Over the course of this project, there have been many sustained successes. Many are doing well and are able to access moderate levels of intervention. Peers with similar risk experiences are likely to have an accelerated course of difficulty. Longitudinal outcomes will be the most telling: can these children keep developing, despite ongoing or new risks?

Developmental Repair is applicable to settings other than mental health group treatment. While this manual has described very at risk young children, many of the constructs in this model are applicable to children with more moderate difficulties, for older children and adolescents, and for parent guidance to families struggling to understand challenging behaviors. At the core of this approach is the possibility that addressing difficulties as developmental can facilitate new learning. These ideas are also useful for schools interested in social/ emotional remediation and child protective services, to reduce the inevitable effects of disruption and placement.

Children describe most clearly what this intervention is about. One eight year old girl said, *"my heart, my whole heart was broken"* when she described her grief at the loss of her father and how her life had changed. These children have suffered terribly. Loss and grief colors their perceptions of the world, and will become the reality of their future without help.

A second child pleaded: *"I don't want it to be all my fault."*

Behavioral interventions too often silence these children and push aside their efforts to adapt to difficult, and sometimes impossible, circumstances. They are trying so hard, and deserve help.

“my heart, my whole heart was broken”



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They are trying so hard, and deserve help.



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Agency Description

Washburn Center for Children is a 125 year old children's agency that is now recognized as the leader in helping children with social, emotional and behavioral problems and their families. As a community mental health center with an experienced clinical staff, Washburn provides the highest quality assessment and treatment services for children from birth through adolescence. Washburn partners with national experts to implement and develop services and evaluate its programs, and trains the next generation of therapists with over 50 undergraduate through postdoctoral internships annually. Washburn served 1,840 children in 2008, about 60% of them from low-income families living in the Twin Cities and its surrounding suburbs.

In 2008 Washburn Center for Children received the Nonprofit Excellence Award from the Minnesota Council of Nonprofits and MAP for Nonprofits and was included by the Minnesota Historical Society in the "Minnesota 150," 150 people, places, things and events that have shaped Minnesota during the past 150 years.

About the Author: Dr. Anne Gearity



Anne Gearity, Ph.D., LICSW, is a leading therapist, educator and trainer in the fields of social work, child development and children's mental health treatment. Her numerous certifications and awards include: National Alliance for the Mentally Ill (NAMI) MN Chapter, Mental Health Professional of the Year (2005) for work done on this project; National Association of Social Workers, MN, Social Worker of the Year (1996), and Distinguished Practitioner, National Academies of Practice. Dr. Gearity has provided extensive training and consultation at Washburn Center for Children over the last decade. In addition, Dr. Gearity has a mental health practice with children, adolescents and adults; provides consultation to schools and other agencies; teaches at the University of Minnesota, Graduate School of Social Work, and Harris Center Program for

Infant and Early Childhood Mental Health. She has presented locally and nationally on a variety of issues including child development and treatment, self regulation, attachment difficulties, trauma and aggression, and the treatment model described in this manual.

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