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Trauma Treatment in Young Children with Developmental Disabilities: Applications of the Child-Parent Psychotherapy (CPP) Model to the Cases of "James" and "Juan"

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ABSTRACT

This case study series investigates the application of the Child-Parent Psychotherapy (CPP) model for young children with developmental disabilities who were exposed to trauma. Two Latino clients and their families were selected for systematic write-up: "James," 14 months old who, following medical trauma (surgery and stroke) showed global developmental delays; and "Juan," 6 years 2 months old with autism in the context of early exposure to domestic violence and a history of physical and emotional abuse. Utilizing the CPP model, we addressed the families' histories of traumatic events, including domestic violence, medical trauma, and attachment concerns associated with parental adjustment to diagnosis. The CPP model was selected with the goal of strengthening the relationship between each child and his caregivers; restoring the child's sense of safety, attachment, and appropriate affect; and improving the child's behavioral and social functioning. Clinical insights regarding the application of the CPP model for young children with developmental disabilities who were exposed to trauma are offered. In addition, cultural applications for Latino families are explored.

Keywords: trauma; mental health; early childhood; developmental disabilities; child-parent psychotherapy; Latino; case studies; clinical case studies

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1. CASE CONTEXT AND METHOD

Aim of the Study and Rationale for Selecting the Clients

Child-Parent Psychotherapy (CPP) is a therapeutic model for young children ages birth to five who have been exposed to at least one traumatic event (Lieberman & Van Horn, 2008). As discussed in more detail below, several randomized controlled trials have documented the effectiveness of CPP. Its goals are to strengthen the relationship between the child and his/her caregiver(s) and restore the child's sense of safety, attachment, and appropriate affect, while improving the child's cognitive, behavioral, and social functioning (Substance Abuse Mental Health Services Administration, 2012). It is now well understood that trauma can have a profound impact on young children. Young children are at disproportionate risk of experiencing traumatic events, and this risk is still greater for young children with developmental disabilities (Goldson, 2002).

In addition, some environmental risk factors (e.g., single-parent families, stress related to acculturation and discrimination) that have been linked to trauma exposure appear to be more prevalent among Latino children in the United States (Davidson, 1996; Olsen, 1997). The National Child Traumatic Stress Network (NCTSN) developed a brief to provide guidance about recommended cultural adaptations for therapists providing trauma-informed treatment to Latino families, and this case series illustrates the application of these principles (The Workgroup on Adapting Latino Services, 2008). While CPP is being widely disseminated as an evidence-based practice, little is known about the application of the CPP model for young children with developmental disabilities.

Two Latino clients who had a developmental disability and were exposed to traumatic events (e.g., domestic violence, separation from primary attachment figures, medical trauma, and attachment concerns related to parental adjustment to diagnosis) were selected, in order to test the application of CPP with children with developmental disabilities.

The Clinical Setting in Which the Treatment Took Place

The treatment was provided within a large, interdisciplinary, outpatient community mental health program, set in a children's hospital in an urban area. Clients served in the clinic are primarily low income, ethnically diverse, with treatment funded through Medicaid insurance. Trainees providing mental health services include psychology interns and psychology postdoctoral fellows, occupational therapy residents, developmental-behavioral pediatric fellows, and speech-language pathology fellows. Their training includes both evidence-based mental health models as well as interdisciplinary training in neurodevelopmental disabilities through the agency's federally-funded Leadership Education in Neurodevelopmental Disabilities (LEND) program at the University Center for Excellence in Developmental Disabilities (UCEDD).

Child-Parent Psychotherapy was introduced within the clinic's early childhood mental health program after a transformation in the mental health system in the county led to the expansion of evidence-based practices (Williams, Rogers, Carson, Sherer, & Hudson, 2012).

The early childhood program serves children aged birth to five years, with referrals coming primarily from the child welfare system, physicians, and preschools. Common presenting concerns include disruptive behavior disorders and reactions to trauma and abuse. Approximately 50% of children served in the early childhood program have a dual diagnosis of a developmental disability (intellectual disability, autism spectrum disorder, and/or language delay), in addition to their primary mental health concern. Culturally, about 70% of clients served by the program are Latino, with about 50% from monolingual Spanish-speaking families. Specialized training for staff and trainees is provided in Latino mental health and the delivery of comprehensive bilingual mental health services.

Length of Therapy

In accordance with CPP, the first case of James involved 40 sessions lasting over 13 months, with all the sessions conducted in the clients' home. The second case of Juan involved 46 sessions lasting over 14 months, conducted in the outpatient community mental health clinic mentioned above.

Methodological Strategies to Enhance Rigor

Case study design is valuable in the development of evidence-based practices (Baxter & Jack, 2008) since it provides an in-depth understanding of the potential usefulness of intervention techniques with specific populations of interest. We used a descriptive case study design (Yin, 2003) to gain insight, provide a preliminary framework, and refine specific modifications and application of the CPP model for young children with developmental disabilities. The study includes two cases that illustrate the application of and modifications to the CPP model, therapist and supervisor insights, treatment barriers, and clinical data.

Videotaping and process notes were collected throughout all phases of treatment in order to capture qualitative information, and the primary therapist participated in weekly individual and group supervision. CPP Fidelity Checklists (Ghosh Ippen, 2012), designed by the CPP model developers, focused on multiple strands of fidelity to the CPP model (i.e., reflective practice, emotional process, dyadic-relational, trauma framework, procedural, and content). Fidelity checklists were completed independently by the first three authors, based on review of videotapes of therapy sessions, in order to confirm fidelity of the model's application.

Sources of Data Concerning the Clients

A number of standardized interviews and self-report scales and questionnaires are used in the clinic as part of our intake process and standard of care, with specific measures selected depending on the child's age, presentation and treatment intervention. In this paper we are reporting the instruments used for gathering information and measuring symptoms relevant to the CPP intervention. The following interview measures were completed at the beginning of treatment as part of the assessment and engagement phase:

The Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR; Ghosh Ippen et al., 2002) is a revised 24-item version of the original TESI (Ribbe, 1996). The TESI-PRR is a clinician- administered interview, conducted with a caregiver, and designed to identify and assess the impact of a variety of potential traumatic events in young children. The types of events assessed include injuries, hospitalizations, domestic violence, community violence, disasters, accidents, physical abuse, and sexual abuse. This measure has been piloted in assessing traumatic events in young children.

The Life Stressor Checklist-Revised (Wolfe, Kimerling, Brown, Chrestman, & Levin, 1996) is a self-report instrument that measures traumatic or stressful life events in adults. For this study, the measure was administered to the primary caregiver through an interview with the therapist. The measure includes 30 life events, including experiences with natural disasters, physical or sexual assault, death of a relative, domestic violence, illness and other traumatic events. Parents are asked whether or not they have experienced each event, and if so, the impact of the event on them currently. This measure is recommended as part of the Child-Parent Psychotherapy model, as parental trauma can often be triggered during the course of dyadic treatment, and it has been found to be useful for measuring the exposure and impact of parental exposure to trauma (Lieberman, Van Horn, & Ghosh Ippen, 2005).

The following measures were completed at the beginning and the end of treatment. All measures had published versions available in English and Spanish, excluding the FICDS, which was translated directly by the therapist.

The Family Impact of Childhood Disability Scale (FICDS; Trute & Hiebert-Murphy, 2002) is a 20-item parent-report questionnaire that assesses the parent's perception of the impact of their child's disability on their family. The measure has been found to have high internal consistency (Benzies et al., 2011) and to predict maternal perceptions of family functioning. Correlations with maternal depression, parenting stress, and family adjustment have also been noted (Benzies et al., 2011; Trute & Hiebert-Murphy, 2002).

The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) is a 90-item parent-report questionnaire that assesses trauma-related symptoms in children ages 3 to 12 who have been exposed to abuse or other traumatic experiences. It includes validity scales and clinical scales covering posttraumatic stress symptoms (intrusion, avoidance, and arousal), sexual concerns, anxiety, depression, dissociation, and anger/aggression, related to the child's experience of trauma. The measure has been shown to have good reliability and association with documented exposure to abuse (Briere et al., 2001), and moderate correlations with child self-report measures of trauma symptoms (Lanktree et al., 2008).

The Parenting Stress Index 3—Short Form (PSI-3- Short Form; Abidin, 1995) is a 36-item subset of the 120-item full-length measure. This parent-report questionnaire is designed for parents of children aged birth to 12 years to assess the parent's level of stress in the caregiving relationship. The test includes questions about parental distress, dysfunctional interaction, and the parent's perception of the difficulty of the child. The measure has been shown to have good reliability and validity (Haskett, Ahern, Ward, & Allaire, 2006) and has been widely used in a

range of child health and parenting studies to assess parents' level of stress and changes in stress following intervention (Williford, Calkins, & Keane, 2007), including in families with a child with a developmental disability (Davis & Carter, 2008; Hassall, Rose & McDonald, 2005).

Confidentiality

Families provided written permission to use clinical data, stripped of personally-identifiable information, in a case series report that might be published. Parents were informed that participation was voluntary and that refusing would not affect their treatment at the clinic.

2. CLIENTS

Client 1: "James"

James is a 14-month-old Latino boy who was referred to treatment due to concerns by the hospital social worker regarding his attachment relationships with his parents. The social worker was concerned about the parents' adjustment to James' diagnosis following medical trauma (surgery and stroke) and subsequent developmental delays. His mother and father are undocumented Latino/a immigrants, and his mother has a history of physical and sexual abuse. She also experiences chronic health concerns due to diabetes. The family lives under the poverty line, experiences little support from extended family members, and both caregivers are monolingual Spanish-speaking. James has three older siblings, and his mother became pregnant with her fifth child during the course of treatment.

Client 2: "Juan"

Juan is a 6-year, 2-month-old Latino boy, diagnosed with autism, who was referred to treatment by his community pediatrician due to concerns regarding his historical exposure to domestic violence, history of physical and emotional abuse, and difficulties with behavioral and social functioning. Juan's parents separated when Juan was 12 months old due to substance abuse and domestic violence by both parents toward each other. Juan lived with his mother until he was 4 years old; he then moved in with his father and paternal aunt, where he remained throughout the course of treatment. Juan was diagnosed with Autistic Disorder when he was 2 years old and he received early intervention and then special education services. His diagnosis of autism was confirmed through a psychological assessment completed during the course of treatment. In addition, Juan was diagnosed with Disruptive Behavior Disorder, Not Otherwise Specified, as detailed below.

Juan's mother, father, and paternal aunt are documented Latino/a immigrants and all caregivers are bilingual in English and Spanish. Juan's father has a history of substance abuse, domestic violence, and exposure to war. Juan's mother's history is largely unknown, outside of her reported history of substance abuse and domestic violence. Juan's paternal aunt reported a history of exposure to war and emotional abuse as well as a history of depression.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Complex Trauma

Complex trauma refers to multiple traumatic events which will likely lead to long-term consequences (Cook et al., 2005). In children, these severe and pervasive traumatic events are likely to interfere with the development of a secure attachment, decrease core capacities for self-regulation, disrupt interpersonal connections, and impact affect regulation and overall developmental trajectory, placing affected children at risk for lifelong problems. The impact of complex trauma is likely to extend beyond the early childhood years into adulthood (Cook et al., 2005; Shonkoff & Garner, 2012). Therefore, effective trauma interventions include elements to help the child and family cope with these events and minimize their long-term impact. The NCTSN Complex Trauma Workgroup identified the following essential elements in mental health trauma intervention: restoring safety in the child's environment as well as their internal sense of safety, increasing the child's self-regulation capacity, processing and integrating the traumatic experience, increasing relational engagement, and enhancing the child's self-worth, self-appraisal, and capacity to experience pleasure (Cook et al., 2005).

Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is a relationship-based intervention model for young children (aged birth through 5 years) who have experienced a traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems (Lieberman & Van Horn, 2005). Attachment theory is the foundation for the model, and trauma-based, developmental, cognitive-behavioral, and social learning theories are also integrated into the intervention. The primary goal for intervention is "to enhance the capacity of the child and primary caregiver(s) to create and maintain a growth-promoting partnership in the context of the other relationships in their lives" (Lieberman & Van Horn, 2005).

In most cases, the therapist holds sessions together with the child and the primary caregiver(s), using play and spontaneous child-parent interactions to target the following: 1) helping the parent understand the developmental and emotional meaning of the child's behavior; 2) helping parents to address maladaptive child behaviors in developmentally-appropriate ways; 3) encouraging parent-child activities that lead to mutual pleasure, help the child trust the parent, and help the parent develop positive attributions of the child; and 4) for children who have been exposed to trauma, to develop a joint trauma narrative of the traumatic event(s), identify and address trauma triggers, and help parents to understand the child's symptoms in light of their trauma history. Treatment also considers contextual factors that may impact the child and caregiver, such as culture, immigration experiences, socioeconomic circumstances, and the caregivers' own trauma history.

CPP has empirical support through five randomized controlled trials. It has been included in the Substance Abuse Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (SAMHSA, 2012), and was rated as "Level 2: Supported

by Research Evidence" by The California Evidence-Based Clearinghouse for Child Welfare (2012). Randomized controlled trials have demonstrated the effectiveness of CPP relative to alternative treatments of either psychoeducation or community treatment-as-usual with preschoolers exposed to domestic violence (Lieberman, Ghosh Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005), maltreated preschoolers (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002), maltreated infants (Cicchetti, Rogosch, & Toth, 2006), anxiously-attached Latino infants (Lieberman, Weston, & Pawl, 1991), and toddlers with depressed mothers (Cicchetti, Rogosch, & Toth, 2000; Cicchetti, Toth, & Rogosch, 1999; Toth, Rogosch, & Cicchetti, 2006).

Child-Parent Psychotherapy proceeds through three phases of treatment: assessment/engagement, intervention, and termination. The focus of the assessment/engagement phase is to engage the primary caregivers and the child in treatment, build a therapeutic alliance, and lay the foundation for treatment. Completion of standardized interviews and questionnaires contributes to the goals of the assessment/engagement phase and helps to establish a trauma frame by: (1) determining whether CPP is an appropriate model; (2) helping the caregiver (and child, if developmentally appropriate) to understand the purpose, focus, and process of treatment sessions; and (3) identifying traumatic experiences for both the child and the caregivers noting links between child and caregiver symptoms and their trauma experiences.

The intervention phase of CPP focuses on encouraging the normal developmental trajectory of the client and building his/her relationships with caregivers. As the child and caregiver(s) play together in sessions with the therapist, they are encouraged to engage in developmentally-appropriate, mutually enjoyable activities; learn to identify and manage bodily sensations; build reciprocity in their relationship; improve affect regulation in both parent and child; and increase the parents' understanding of the child's behavior, including recognition of times when behavior may be triggered by trauma reminders. Developmental guidance may also be provided to support the caregivers' understanding of the child's developmental needs and appropriate methods of addressing behaviors of concern.

The focus of the termination phase of CPP is on facilitating collaboration in planning for termination of services. This includes talking with the caregiver(s) and the child about the plan to end treatment, planning for and processing goodbyes, regularly reviewing the number of remaining sessions, discussing the course of treatment and the family's narrative, and facilitating future planning (e.g., monitoring of symptoms, presence of trauma reminders). This is often a very important phase for clients who have experienced traumatic separations as it provides both client and parent an opportunity to have a reparative experience around termination.

Child-Parent Psychotherapy and Developmental Disability

Most of the studies conducted to evaluate the efficacy of CPP have either excluded children with autism or an intellectual disability (Lieberman, Van Horn, & Ghosh Ippen, 2005), or provided no information about whether or not children with developmental disabilities were included (Cicchetti et al., 2006; Lieberman et al., 1991; Toth et al., 2006). One study of CPP (Toth et al., 2002) documented that participants had mean IQs in the low average range, but the

standard deviations indicated that at least some children in the study were functioning in the borderline range of intellectual functioning.

In the treatment manual for CPP (Lieberman & Van Horn, 2008), information is provided that would support the appropriateness of the treatment model for children who have developmental delays or disabilities. For example, the intervention uses a developmental approach in which the activities used during sessions and the developmental guidance provided to parents vary depending on the developmental level of the child. Since the treatment is appropriate for young, preverbal infants, it is reasonable to assume that children with developmental delays would also be able to participate and benefit. In addition, the treatment manual provides guidance for evaluating the individual characteristics of the child, including cognitive level and developmental problems, and case examples include information about sharing findings from developmental assessments with parents and helping them to access appropriate educational services to address concerns in these areas. Nonetheless, research is needed to determine if CPP is effective with children who have developmental disabilities, and whether modifications in approach may be needed to address the unique needs of children with developmental disabilities and their parents.

Reflective Supervision

Working with children and families who have experienced trauma can be emotionally taxing to a therapist. When developmental disabilities and the cumulative impact of stressors experienced by families within the public mental health system are added, the demands of the work can be overwhelming. Therapists need a space to step back from the immediate experience and reflect on the thoughts and feelings that often come up during treatment so they can remain emotionally present for the families they work with. Reflective supervision has been established within the field of infant and early childhood mental health as the vehicle to do this (Fenichel & Zero to Three/National Center for Clinical Infant Programs' Work Group on Supervision and Mentoring, 1992). The principal and fourth authors in this article held weekly reflective supervision meetings to jointly understand the needs of the clients presented and address the goals of the CPP treatment.

Reflective supervision is quite different from administrative supervision. It is a collaborative relationship for learning that is established within regularly held encounters (Shahmoon-Shanok, 2009). It is collaborative because the role of the supervisor is to help the supervisee notice what is happening in his/her encounters with the family, explore feelings aroused, and consider the multiple courses of action that will support the therapeutic relationship. It is a relationship for learning because the supervisor's role is to guide the therapist in answering his/her own questions about the work while moving toward greater levels of understanding and competence (Parlakian, 2001). The basic premise behind this kind of supervision is that relationships affect relationships; therefore the quality and dynamics of the supervisory relationship will influence the therapist-family relationship, which in turn will influence the parent-child relationship. This is often referred to as a "parallel process" where the supervisor should "do unto others as you would have others do unto others" (Pawl, 1995, p. 43).

Child-Parent Psychotherapy is a relationship-based model centered on the idea of supporting growth within the parent-child dyad in the context of the relationship with the therapist. Unlike more structured manualized treatments that provide a session-by-session map for intervention, the CPP manuals provide a theoretical framework, guiding principles, and case examples; the therapist must choose specific interventions in the moment depending on the material the family brings into the session that day. Through reflective supervision or consultation, a therapist has the opportunity to slow down time and step back to think about the work and the feelings the work brings up. When reflective supervision is going well, a safe and holding environment is created that helps the therapist hold the child and family. The therapist can "reflect on action" so that later within the session s/he can "reflect in action" (Schon, 1987) and implement appropriate interventions to address treatment goals. This was the supervisor's goal during the weekly encounters with the therapist. Videotaped sessions or therapist's notes provided the springboard for reflection.

Latino/Hispanic Access to Mental Health Services

Despite the rapid growth of the Latino population of the United States with projections that by the year 2030, Latinos will likely constitute 21.34 % of the U.S. population (approximately 86 million people; U.S. Census Bureau, 2012), this population has experienced gaps in access to mental health services (National Council of La Raza, 2009; National Healthcare Disparities Report, 2005) and continues to experience disparities when accessing these services (Aguilar-Gaxiola et al., 2012). Historically, research has identified many factors contributing to this gap, including low educational and economic status, discrimination, illegal immigration status, lack of Spanish-speaking and Latino mental health care providers, lack of health insurance, religious beliefs, acculturation, and beliefs about mental illness and treatment (Ruiz, 2005). Therefore, when working with the Latino population these factors need to be identified and addressed in a sensitive and culturally- and linguistically-appropriate way in order to maximize engagement in mental health services.

Over 70% of the population served in the clinic where the case study was conducted are Latino families, and almost all are low income, living under the poverty line. Over 70% of the clinic's team of early childhood mental health providers are bilingual and bicultural. The clinic is committed to providing quality comprehensive mental health care to Latino families as well as training mental health providers that can successfully serve diverse and minority populations. Guidelines proposed by experts when working with Latino families are considered by clinicians, such as, respecting Latino values (e.g. Familismo, Simpatia, Respeto, etc.), respecting different cultural experiences, considering level of education and acculturation levels, integrating Latino values into the therapeutic process, and conducting modified assessment taking into consideration the cultural diversity of the families (NCTSN, 2007). The clinic aims to provide culturally and linguistically sensitive services to Latino families and to assist in addressing the disparities that these minority populations face.

Therapist and Supervisor Training and Experience

Both clients were assigned to one therapist (the first author), a female licensed psychologist and Postdoctoral Psychology Fellow in the early childhood program at a university

and hospital-based program. Treatment was supervised by a licensed staff psychologist trained in Child-Parent Psychotherapy who had over twenty years of experience working with diverse families and their young children (the fourth author). Both the therapist and the supervisor were bilingual in Spanish and English; the therapist was Caucasian, and the supervisor was Latina.

The authors all received formal CPP training from one of the developers of the model. Training lasted 18 months and included six days of didactic training, bi-monthly consultation with the CPP trainer, and bi-weekly CPP group supervision.

4A-6A. THE CASE OF "JAMES"

4A. *Assessment of James' Presenting Problems, Goals, Strengths, and History*

Presenting Problems

James lives with both parents and three older siblings in one bedroom of a home that is shared with eight other (non-related) people. Both parents are undocumented immigrants from Mexico, and the family lives in poverty. At age 12 months, James was developing typically according to his parents, including eating solid foods, vocalizing and saying a few words, walking, and demonstrating reciprocal play. James had heart surgery at approximately 13 months of age due to a congenital heart defect.

After being discharged from the hospital, James experienced what his doctors believed to be a stroke. Following this episode, he began having frequent seizures, continual Huntington's Chorea-like movements, and regression in functioning in all developmental domains. That is, he lost all postural control, stopped vocalizing, did not engage in reciprocal play, was not able to maintain consistent eye gaze, and required feeding through a gastrostomy tube.

At age 14 months, James was referred to the early childhood mental health program by the hospital social worker due to concerns about his parents' adjustment to his changed developmental functioning, and the attachment relationship between James and his parents. At the onset of treatment, James was diagnosed with global developmental delays and a DC:0 – 3 diagnosis of Adjustment Disorder, given his experience of exposure to a stressor that impacted his development and relationships with others within one month of exposure and lasting for more than two weeks (Zero to Three, 2005). In addition, restrictions in adaptive abilities, engagement, attention, mutuality, and affection were noted. However, it is not clear whether these disturbances were solely secondary to his global developmental delay or were exacerbated by experiencing medical trauma and resulting disruptions in the parent-child relationship.

Formal Assessment

During the assessment/engagement phase of treatment, James' mother completed *the Traumatic Events Screening Inventory (TESI-PRR), Life Stressor Checklist-Revised, Family Impact of Childhood Disability Scale (FICD), and Parenting Stress Index, Short Form (PSI-SF).* Client developmental observations, play observations (with James and his mother, father, siblings, and nurse care provider), and an unstructured clinical interview were also completed at

the beginning of treatment. Efforts were made to include various family members throughout the assessment/engagement process. Fidelity checklists, process notes, and videotape were used as a form of assessment throughout treatment.

As noted, James had heart surgery at approximately 13 months of age. The *TESI-PRR* was helpful in gathering more specific information about James' experiences related to medical stress. James remained in the hospital for several weeks after heart surgery, experiencing a separation from his primary caregivers. After being discharged from the hospital, James returned home and experienced an episode that doctors labeled as a stroke. However, his parents noted that etiology related to the stroke was undetermined. His parents reported that he had frequent seizures, continual movements, and suddenly began to lose functioning in all developmental domains. They noted their fear as they began to see these changes occur, and reported that James appeared to be disoriented and confused.

James had a home nurse care provider throughout the course of CPP treatment, and attended frequent medical appointments with a cardiologist, neurologist, and nutritionist. James' mother noted that James cried during every medical appointment, and she reported that she often cried and experienced feelings of panic when returning to the hospital for medical appointments. Medical appointments thus seemed to serve as trauma triggers for both James and his mother.

Information regarding parent trauma histories was obtained using the *Life Stressors Checklist-Revised;* parents were interviewed individually. James' mother immigrated to Los Angeles from Mexico at the age of 16 with her mother and siblings. At that time, she placed her education on hold. She did not identify the immigration experience as dangerous or traumatic, but reported that she experienced challenges in understanding how to access the different systems of care in the US, and had no understanding of the English language which made it difficult for her to communicate while adapting to her new environment. James' mother reported that she was raised in a home where domestic violence was on-going and where she experienced physical and sexual abuse. She noted that her father left her family when she was young. She reported that her mother never told her that she loved her, or showed much regard for her well-being. In adulthood, she reported that she did not have a close relationship with her mother or her extended family members, many of whom live locally. James' mother also experienced chronic health concerns due to diabetes, but she had been able to access healthcare.

James' father emigrated from Mexico at the age of 19. He immigrated to the U.S. with friends, and also did not identify his immigration experience as dangerous or traumatic. He did not complete high school, has experienced unstable employment, and reported that he idealized the United States before immigrating here, believing in the "American Dream." He often commented on the difficulty he has experienced in obtaining stable employment and earning an adequate income. He reported being very close to his mother, who resided in Mexico and who was ill. As such, his support system was limited and he frequently shared his emotional struggle of remaining in the United States with his family versus being closer to his mother. James' father had an older brother who died from medical complications before James's father was born.

The *Family Implications of Childhood Disability Scale* (FICD) asks the respondent to indicate the consequences to the family of having a child with a disability. Standardized scores and normative data are not available for the measure; rather responses are used qualitatively, with particular attention paid to the parent's report of the impact as being primarily positive or negative. The FICD was presented to James' mother in interview format, with the therapist translating the items into Spanish. During the assessment/engagement phase of treatment, James' mother reported negative impacts of having a child with a disability including extraordinary time demands, disruption to normal family routines, and increased stress. She also reported positive impacts of having a child with a disability including an increase in her family's level of spirituality and improvement in her relationship with her husband. James' mother did not identify any additional financial costs related to having a child with a disability nor limitations in social contacts outside of the home.

As shown in Table 1, at the outset of treatment James' mother reported normal levels of stress in her responses to the *Parenting Stress Index.* While her score on the validity scale did not suggest defensive responding, her response to some items suggested that she may have been minimizing or unaware of the extent of her son's developmental delays. For example, her response to the item "My child is not able to do as much as I expected" was "disagree." In addition, some of the items on the measure may not have been applicable given the degree of James' developmental delays at the beginning of treatment, such as "Sometimes my child does things that bother me just to be mean," and questions about the number of problem behaviors such as "dawdles, refuses to listen, interrupts, fights, whines, etc."

Play observations with James and his mother, father, siblings, and nurse care provider showed disruptions in the relationships. James' mother and father appeared depressed and remained withdrawn from James, demonstrating a lack of positive affect, attunement, and responsivity to James. In particular, James' mother appeared to be overwhelmed by James' presentation and changes in care needs: she demonstrated a lack of responsiveness to James' cues, noted how James "used to be," requested the home nurse care provider's assistance with basic caregiving tasks, and left the home nurse provider to manage James' daily needs. The home nurse care provider often removed James from his parents in order to provide him with care, and took on the role of "protective shield." Through discussion with the family and observation the therapist noted that James' siblings demonstrated anger (e.g., agitation; slamming doors), sadness (e.g., oldest sister often became teary when discussing James' surgery), and confusion regarding how to interact with James (e.g., noted that James could no longer play; often ignored James when present in play interactions). James' challenges in adaptive skills, engagement, attention, mutuality, and affection contributed to these disruptions.

Strengths

James demonstrated an interest in exploring his environment. He also showed positive affect in response to social routines such as peek-a-boo, and was able to vocalize sounds.

James' mother demonstrated insight regarding her emotional state. For example, over time she was able to recognize that she experienced "trauma triggers" or reminders of James'

medical trauma on a weekly basis when she and James attended medical appointments at the hospital where his surgery took place. She was able to recognize and describe the deep sadness that she felt when she experienced these traumatic reminders. In addition, she verbalized feelings of anger towards the physicians involved in James' surgery. James' mother's ability to recognize these feelings and to speak about them was viewed as a strength by the therapist because it highlighted a "port of entry," i.e., a space from which growth could occur.

James' father was effective in providing both financial and emotional support for the family. It was apparent that he initially felt somewhat powerless in regards to James' state, but his determination to provide for his family and support James' mother emotionally allowed him to contribute in a unique way. The therapist viewed this as a strength, and often commented on James' father's work ethic and important role in keeping the family intact.

Close relationships were observed among all family members (e.g., mother and father, siblings), and the family's religious faith and connection with their religious community were noted as strengths. James' mother and father regularly attended church, and their pastor communicated feelings of hopefulness from the beginning. The therapist provided opportunities for the parents to talk about their faith in God and encouraged their engagement in their church community. James' home nurse care provider was also effective in supporting James and his family, as they transitioned to providing James with a new level of care by participating in feeding, administering medication, and other caregiving tasks. Throughout treatment, the therapist commented on these strengths in order to build rapport and establish a positive therapeutic alliance. It also allowed the therapist to support James' parents and siblings in taking note of James' strengths.

5A. Formulation and Treatment Plan for James and His Family

Individualized Case Formulation

Given both the child and parent histories of trauma, and attachment concerns related to parental adjustment to James' change in developmental functioning, the child-parent relationships were considered to be at-risk. During the assessment/engagement phase of treatment, James' mother and father appeared to be detached from James. They both expressed grief in response to James' significant change in developmental functioning following surgery. Their grief was compounded by multiple environmental risk factors, including poverty, crowded housing, lack of transportation, language barriers, ethnic minority status, and stress related to acculturation. Their grief and the environmental risk factors made it difficult for them to connect with James, and they experienced challenges in reading and responding to his cues. However, the family's religious faith served as a strength and a protective factor by providing a sense of hopefulness and a community of support.

Individualized Treatment Plan

The overall focus of treatment was on (a) strengthening the relationship between James and his parents; (b) restoring attachment, (c) linking the family to critical community resources,

(d) providing psychoeducation about the impact of trauma on early childhood development, (e) the identification of "trauma triggers" related to James' medical experiences, and (f) improving James' cognitive, behavioral, and social functioning.

Interdisciplinary consultation with a speech-language pathologist, occupational therapist, and child psychiatrist provided individualized guidance. This consultation assisted the therapist to explore non-verbal means of communication, integrate movement into therapy, identify developmentally-appropriate activities to use during therapy sessions, and provide the family with psychoeducation related to James' developmental status.

Given the family's multiple environmental challenges, treatment was provided in the home. Providing treatment in the home also allowed the therapist to reach multiple family members, including both parents, the home nurse care provider, and James' three older siblings.

6A. Course of Therapy with James and His Family

Assessment/Engagement Phase (6 sessions)

This initial phase of treatment had several goals: to build a therapeutic alliance, establish a trauma frame, support the family's understanding of the treatment model and engagement in the treatment process, and understand James' level of developmental functioning. In addition, the therapist needed to address the family's grief associated with his medical condition.

Given the family's multiple needs and as prescribed by the CPP model, environmental risk factors needed to be addressed right away by linking the family to critical community resources first in order to fully engage James' parents in treatment, address James' developmental needs, and support the parents' trust in mental health services. For example, the therapist supported the family in applying for Social Security Disability Income, obtaining nutrition services through the Women, Infants and Children program (WIC), identifying alternative housing options, obtaining early intervention services through the local developmental disabilities system, and obtaining California Children's Services to ensure that medical care and other necessary therapies would be paid for.

CPP assessment measures helped the therapist to gain an understanding of the parents' and child's trauma histories and set a trauma framework before beginning the intervention. The therapist provided a rationale for dyadic trauma treatment and assessed the parents' cultural beliefs regarding talking about trauma. Demonstrating an authentic interest in understanding the family's culture and religion served to build rapport. Throughout this initial process, both parents were able to acknowledge James' history of medical trauma and its potential impact, but they appeared to be triggered and overwhelmed by James' symptoms and developmental functioning.

The therapist obtained information about the level of James' developmental delays. As noted, at the age of 14 months, James had lost all postural control, stopped vocalizing, did not engage in reciprocal play, was not able to maintain a consistent eye gaze, and required feeding

through a gastrostomy tube. He was also having seizures multiple times per day. James' parents were profoundly impacted by all these changes and demonstrated symptoms of grief and possible depression. His mother appeared to be detached and unresponsive; she often avoided eye contact, did not interact with James, maintained a physical distance and demonstrated flat affect. James' father was working long hours, possibly as a way to avoid dealing with his feelings about James as well as to ensure that the family's increased needs would be provided for. James' siblings were confused about James' condition and they avoided interacting with him.

Intervention Phase (26 sessions)

Sessions occurred weekly in the home for approximately 60 minutes. In addition to James' mother, at least one of his siblings and his home nurse care provider were generally present. The sessions began with the therapist checking in about James' functioning during the week, his routines including eating, sleeping, and feeding, as well as any developmental advancements. These conversations allowed the therapist to set the frame for the session and highlight any changes and/or challenges during the week.

The therapist then facilitated a play interaction between James and his mother, working to connect the dyad both emotionally and physically to strengthen the relationship between James and his parents and restore their attachment. During the initial phase of treatment, James and his mother were always physically separated during therapy sessions. His mother was often seated on a chair or the bed, sitting quietly and observing, while James played on the floor with the therapist and home nurse care provider. This physical and emotional distance was initially viewed as a challenge for the therapist. The process note below captures the therapist's reflections early in treatment (all quotes in this case study have been translated from Spanish to English):

> I enter the family's room and find mother and the nurse sitting on the bed watching a soap opera on television. James is positioned on his belly sound asleep.
>
> There are smashed Cheetos on the floor. Mother is nibbling on a bunch of fresh cilantro.
>
> Mother and the nurse acknowledge my presence and shift their attention in my direction. Mother offers me a chair.
>
> "How is James doing?" I ask.
>
> "Fine," mother notes. "He is getting bigger. He just got new medication to help with his convulsions. It's helping."
>
> "And, how are you?" I ask.
>
> "Okay. James' father's car overheated so he has been unable to work," mother notes.
>
> The nurse has shifted her attention back to the soap opera, but she leans forward to turn the volume down on the television.

> "I'm sorry to hear that. I know that working is important to father, both for income and coping," I reply.
>
> Mother nods her head in agreement. "Yes, I have been stressed about that. I am worried about him because he's not working. He is unhappy when he's not working," she notes.
>
> I chose to communicate that I hear mother's concern, but I am wanting to stay on the topic of James. Mother often shifts to father, avoiding the topic of James and especially herself.
>
> James begins to stir, rolling over to face mother, the nurse, and myself.
>
> "Well, hello," I say with bright affect.
>
> Mother glances in James's direction, and looks back at me.
>
> The nurse says, "Good morning, James" and scoops him up in her arms, smiling.
>
> In this moment I feel like mother is disconnected from James. I know that she cares for him, and I have seen her demonstrate warmth and affection but I feel stuck when I see her response to his awakening. I wonder if she is overwhelmed with James' care. Does she need a break? Or maybe she is just feeling disconnected, in general? Is she feeling depressed again?
>
> I am wanting to connect them somehow, but it feels like there are separate beings sitting on the bed… side by side… but quite far apart… emotionally.

To encourage interactions between James and his mother, the therapist brought toys that would create an interaction and support greater joyful expression, such as pinwheels and bubbles. She also physically turned James around so that he would be facing his mother instead of the therapist or nurse. During such play interactions, relational strengths were continually pointed out and the therapist would comment on both James and his mother's positive affect and use narration to enhance the overall interaction. For example, the therapist would say to James: "James, look at you smiling at your mom;" and to his mother: "Wow, he really likes to be close to you."

In addition, the therapist worked to "scoop" James' mother into such situations by noting her ability to be a "safe base" for James. For example, the therapist would say, "I love how you are remaining present for James, and observing him. He can see that you are available if he needs you." Such play interactions increased both physical and emotional closeness, allowed James' mother to better recognize James' cues, and enhanced overall attunement. Narration and translation (i.e., "speaking for" James) were also utilized throughout sessions to support James' mother in understanding his experience, and facilitating emotional connection. For example, the therapist would speak for James when he approached his mother by saying, "When I was in the hospital I felt alone. I was scared. Now I am close to my family. They are here to take care of me and keep me safe."

The therapist also described the events in the environment, her observations of James' response to his parents, and ways that James' parents were able to read and respond to his cues. For example, the therapist said, "You noticed that James was fussy and understood that he was hungry. You are very attuned to his needs." Describing events in the environment, the therapist noted, "James is learning how to move his body in its new form. Sometimes he becomes frustrated and cries, when he is not able to do something that he was able to do before" (when James was trying to grasp a set of toy keys). In addition, advancements in James' cognitive, behavioral, and social development were monitored and pointed out in order to highlight parent and child capacity.

As treatment progressed, emotional connection was fostered through physical proximity, by, for example, encouraging his parents to sit close to James and to care for his basic needs rather than deferring to his home nurse care provider. The therapist provided his parents with opportunities to increase their self-confidence in their parental role, and cope with their grief and any associated feelings regarding James' developmental delays. For example, James' mother began to participate in James' feeding by administering food through his gastrostomy tube, and by allowing him to taste foods that she knew he enjoyed.

James' home nurse contributed by increasing the parents' ability to attend to James' medical needs through modeling and encouraging their learning to care for his needs. Metaphors and psychoeducation were also used to explain treatment and introduce the concepts of medical trauma and "trauma triggers." Reflective questions (e.g., "I wonder what he is trying to tell you?") were used to foster his parents' ability to understand James' emotional experience and support their attunement. Overall, supporting James' parents' reflective capacity by posing reflective questions was critical in strengthening the relationship and re-establishing James' sense of his parents as a "protective shield," able to provide physical and emotional safety. Their shift in reflective capacity was also important in empowering James' parents in his care, and their role as nurturing protectors.

Case management needs were addressed throughout the treatment. Three months into treatment, James had obtained additional services including physical and occupational therapy, and infant stimulation, and his family began to receive Social Security Disability Income. These services helped the family tremendously to assist James financially and to begin to restore his developmental trajectory.

The therapist played a key role in linking the family to community resources and was present for many in-home early intervention sessions, which allowed the therapist to observe, consult, and integrate cultural values into the therapeutic process by, for example: (1) identifying the parents' beliefs about the cause of the developmental delays and helping them to make meaning of James' medical history and resulting condition; (2) engaging the family in treatment by maintaining regularity of the treatment schedule and facilitating hopefulness); (3) exploring attitudes and expectations related to therapy by checking in regularly about therapeutic process; (4) supporting James' parents in acquiring skills so that they could implement interventions in the home by providing modeling and educational resources; and (5) providing family support, including encouraging the maintenance of parents' relationship with their church community, and

connecting the family to parent support networks. Maintaining a balance between case management needs and the CPP model was critical to allow James' parents to be more fully engaged in treatment.

After approximately five months of treatment, James' mother began to demonstrate increased hopefulness and attachment, such as reading and responding to James' cues and recognizing his developmental progress, as James demonstrated developmental advancements. Her symptoms of depression lessened, and her advocacy skills in tapping into community resources increased. She was more responsive to James both physically and verbally, and was able to perform care activities independently, without the assistance of James' home nurse care provider.

James' home nurse care provider, who was initially an active participant in helping to maintain James' engagement during sessions, became less central. James' mother was able to articulate an increased understanding of the impact of trauma on early childhood development and identify "trauma triggers" in their daily life, such as taking James to the hospital for medical appointments, being pregnant, and seeing her other children experience health concerns.

James' father experienced challenges in being a regular participant in treatment due to his work schedule, and his involvement in treatment waned over time. However, James' mother noted that she continued to feel supported by James' father, and when he was present he conveyed increased hopefulness and responsivity to James.

James began to demonstrate developmental progress, while still being significantly delayed compared to same-age peers. By 21 months (7 months into treatment), he was able to sit with support, grasp objects, and hold his head up without support. He babbled consonant vowel combinations, demonstrated an increased range of facial expressions, and visually referenced his mother and home nurse care provider often. In addition, his siblings began to interact with him through play and demonstrated an increased understanding of his condition by asking questions and talking about his developmental progress. In terms of health status, James' seizures decreased and his Huntington's Chorea-like movements were minimized.

Termination Phase (8 sessions)

By the termination phase of treatment, the focus shifted to facilitating collaboration in planning for termination. This included strengthening the child-parent relationship during a time of transition and stress that included the mother's pregnancy, the family's move to a more stable living situation, and the termination of therapy. The therapist continued to facilitate play interactions to maintain James' and his mother's engagement with each other through emotional and physical connection, as well as verbal and non-verbal communication. The number of remaining sessions was reviewed regularly, and the course of treatment and the family's narrative about their experiences were discussed.

James' mother was able to recognize and point out James' developmental progress. She identified changes in herself, including increased parental insight, hopefulness, and

empowerment as a parent. She actively participated in discussions about future planning, including the importance of monitoring James' development over time, recognizing and managing trauma reminders as they would arise in the future, and coordinating the services provided by community agencies. For example, in terms of identifying changes in herself, James' mother recalled initial feelings of depression related to James' medical trauma but was able to see that she no longer experienced equal feelings of sadness and anger during the termination phase. She noted, "I remember that I used to wear my pajamas all day and would stay in bed crying. Now, I feel lighter. I have faith. James continues to develop. He has the desire to learn new skills."

At this time, the therapist worked to create additional linkages to support systems, particularly the hospital social worker, and supported James' mother in completing the *Parenting Stress Index-Short Form (PSI), Family Implications of Childhood Disability Scale (FICD),* and exit interview.

4B-6B. THE CASE OF "JUAN"

4B. Assessment of Juan's Presenting Problems, Goals, Strengths, and History

Presenting Problems

Juan is a 6 year, 2 month old Latino boy who was referred for therapy by his community pediatrician due to concerns regarding his historical exposure to domestic violence, history of physical and emotional abuse, and challenges with his cognitive, behavioral, and social functioning. Juan was diagnosed with Autistic Disorder when he was 2 years old and he received early intervention and then special education services. His diagnosis of autism was confirmed through a psychological assessment completed during the course of treatment. He demonstrated impairments in social interactions (e.g., poor eye contact, a failure to develop age-appropriate peer relationships, lack of social reciprocity), communication (e.g., a delay in the development of spoken language, stereotyped language), and restricted, repetitive and stereotyped behavior (e.g., adherence to specific routines, repetitive motor mannerisms). In addition, Juan was diagnosed with Disruptive Behavior Disorder, Not Otherwise Specified. He presented with physical aggression (e.g., hitting, biting, kicking), defiance (e.g., significant challenges in compliance), an inability to take responsibility for his behavior, retaliation against peers when he felt wronged, and disturbances in school functioning.

Formal Assessment

At the beginning of treatment, Juan's father completed the *Traumatic Events Screening Inventory (TESI-PRR), Life Stressor Checklist-Revised, Family Impact of Childhood Disability Scale (FICD), Parenting Stress Index (PSI), and Trauma Symptom Checklist for Young Children (TSCYC).* Child observations, a father/child play observation, and an unstructured clinical interview were also completed at the beginning of treatment. Fidelity checklists, process notes, and videotape were used as a form of assessment throughout treatment.

In completing the FICD at the beginning of treatment, Juan's father noted some negative consequences of having a child with a disability, including substantial limitations in his social contacts outside of the home and moderate consequences related to time demands in looking after Juan's needs, disruptions in family routines, additional financial costs, doing more for others than himself, and feeling chronic stress. In terms of positive consequences of having a child with a disability, Juan endorsed mild positive experiences in the areas of becoming more spiritual, coming to terms with what should be valued in life, and life becoming more meaningful for family members.

As shown in Table 2, Juan's father's scores on the PSI-SF at the beginning of treatment indicated that he was experiencing a high level of total parenting stress. His scores were clinically significant in all subscales, including Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. On the TSCYC, Juan's father's scores indicated that Juan was possibly experiencing symptoms of Post-Traumatic Stress Disorder. Scores were in the clinically significant range for the following subscales: Anger/Aggression, Posttraumatic Stress: Avoidance, Posttraumatic Stress: Arousal, and Posttraumatic Stress: Total. Juan's scores were in the normal range for the scales measuring Anxiety, Depression, and Sexual Concerns. Overall, the pre-treatment measures indicated a high level of symptomatology and stress and supported the need for treatment that focused on mental health needs and not only autism.

The Traumatic Events Screening Inventory was completed in an interview with Juan's father, and helped the therapist to gather the following information about Juan's history. Juan's parents separated when Juan was 12 months of age due to substance abuse and domestic violence. According to his father, Juan's mother pulled a knife on his father; his mother and father engaged in frequent verbal arguments; and physical violence between the parents was on-going. Physical violence and verbal arguments stopped after separation. Juan lived with his mother until he was 4 years of age. Juan's father reported that he saw Juan often after his separation from Juan's mother, spending weekends with him frequently.

When Juan was 4 years old, his father found out that there were allegations of physical and emotional abuse by Juan's mother, which included mother reportedly covering Juan's face with a pillow in order to muffle his crying, exposure to verbal arguments between mother and her boyfriend, and mother hitting Juan with a shoe. Juan's father discovered this information when he received a phone call from Juan's mother, stating that Juan needed to move in with him or the Department of Children and Family Services (DCFS) was going to place Juan in foster care. Since that time, Juan lived with his father and paternal aunt. Juan historically had weekly visits with his mother. However, his mother had been somewhat inconsistent with the visits, and Juan's father did not feel that his mother was creating a safe environment for visits, so all visits were determined on an individual basis (approximately bi-monthly with father serving as a monitor).

The Life Stressors Checklist was administered in an interview with Juan's father and his paternal aunt separately, to obtain information about their own histories of trauma. Juan's mother, father, and paternal aunt are documented Latino/a immigrants and all caregivers are

bilingual in English and Spanish. Juan's father has a history of substance abuse, domestic violence, and exposure to war. Juan's mother's history is largely unknown, outside of her reported history of substance abuse and domestic violence, as she did not participate in treatment. Juan's paternal aunt reported a history of exposure to war and emotional abuse as well as a history of depression. Juan' father and paternal aunt both emigrated from El Salvador due to exposure to war; Juan's father was 11 and his aunt was 14 at the time of the move. They immigrated to the United States with their mother and siblings, and neither identified their emigration as dangerous or traumatic. Juan's father is unemployed, and is working on completing his associate's degree. Juan's paternal aunt completed her associate's degree, was employed throughout the course of treatment, and self-identified as the "family protector." Juan's father's and paternal aunt's siblings who live in the area were identified as a main support system.

Strengths

Juan demonstrated resilience in his ability to tolerate the discussion of difficult topics (such as his relationship with his mother and history of abuse); his learned self-regulation strategies were also viewed as protective factors (e.g., deep pressure through his father or aunt offering a hug, breathing deeply, jumping). Juan's father and aunt demonstrated strengths in their openness to treatment, compassion for Juan, and desire to obtain new knowledge and skills. These strengths allowed the therapist to build a strong therapeutic alliance with Juan and his family. That is, Juan's learned self-regulation methods were acknowledged and built upon, and his father and aunt's openness, compassion, and desire were noted, allowing each individual to feel seen and understood by the therapist.

5B. Formulation and Treatment Plan for Juan and His Family

Individualized Case Formulation

Juan's parent-child relationship was deemed at-risk given both Juan's and his caregivers' histories of traumatic experiences. These included Juan's historical exposure to domestic violence; history of physical and emotional abuse; difficulties with his cognitive, behavioral, and social functioning; and historical separation from his parents (both mother and father). Juan often presented with a high level of activity and arousal, such as jumping around the room, throwing toys, smashing block towers, and difficulty engaging in one play activity for more than a few minutes at a time. These challenges in self-regulation made it difficult for him to engage in reciprocal social interactions. Juan's father experienced Juan's presentation as difficult and was challenged in connecting with Juan. His father experienced guilt related to setting limits; he felt that any limit-setting was too punitive. Juan's father identified limit-setting as a "trauma trigger," in that it reminded him of his own history as a perpetrator of aggression in relationships. The therapist wondered how much of Juan's presentation could be accounted for by autism, and which symptoms were better attributed to his trauma history; it was critical to reflect on and understand this interaction in order to plan treatment.

Individualized Treatment Plan

The initial focus of treatment was on (a) strengthening the child-caregiver relationships; (b) psychoeducation about the impact of trauma on development; (c) identification of "trauma triggers" and their link to dysregulated symptoms; (d) improving Juan's cognitive, behavioral, and social functioning; and (e) providing case management, such as school advocacy. Juan was also referred early in treatment for a psychological assessment in order to clarify his diagnosis. His therapist and father were interested in better understanding whether Juan's symptoms were a result of his autism diagnosis, a response to trauma, or a combination of both. Diagnosis of autism is more complex in children who have experienced trauma, and so additional consultation was needed to ensure that the focus of treatment would best meet Juan's needs. Juan's diagnosis of autism was confirmed through the psychological assessment, and treatment was designed to address the complex presentation of autism symptoms, disruptive behaviors, and trauma history.

6B. Course of Therapy with Juan and His Family

Assessment/Engagement Phase (11_sessions)

During the assessment/engagement phase, efforts were made to build rapport and engage Juan's father and paternal aunt in treatment. CPP assessment measures allowed the therapist to better understand the father's, paternal aunt's, and Juan's trauma histories, and set a trauma frame. Setting the trauma frame included helping Juan's father and aunt recognize the impact of trauma on development and on family relationships, and obtaining their permission to introduce trauma-related props and toys during therapy sessions so that Juan would have opportunities to tell and show his story to the therapist and to his family.

Following discussion of the therapy plan with Juan's father and aunt, sessions were held with both caregivers and Juan to explain treatment in a developmentally appropriate way and to let Juan know that the therapist knew about his family history and that therapy was a place to talk and play about his experiences. These early sessions included family drawings created by the therapist with Juan's and his father's support to demonstrate transitions in the family and show how Juan's home and living situation had changed over time.

The therapist also introduced family doll figures and doll houses to talk with Juan about his experience living with his mother. The therapist noted that in the past Juan lived with his mother and his mother's boyfriend and sometimes saw, felt, and heard scary things. She then noted how he was now living with his father and aunt and they wanted to help him with sharing his feelings. The therapist also focused on Juan's bodily sensations and levels of arousal using the metaphor of a car engine. That is, the therapist noted that when Juan felt excited his car engine was running high and when he was relaxed his car engine was running low. An emotion thermometer was also used to help Juan recognize and talk about his emotions and levels of arousal. Different colors represented different emotions and level of arousal, and Juan was periodically asked to identify his state. In general, the therapist let Juan know that therapy was a safe place to both talk and play about some of the things that he saw, felt, and heard.

The therapist worked to support the caregivers during the introduction to treatment, noting their emotional responses. Both Juan's father and aunt were able to acknowledge their difficulty in discussing Juan's trauma history, but demonstrated a desire to proceed. Juan also had difficulty hearing the therapist talk, play, and draw about his family history. A benevolent explanation for Juan's high level of arousal and aggression towards peers was provided, connecting his presentation to his history of feeling unsafe and also his diagnosis of autism. Ultimately, both Juan's father and aunt were able to acknowledge Juan's traumatic experiences and their potential impact on his present functioning. Reflecting on their own personal trauma histories supported this understanding. Juan's father was also able to acknowledge that he felt triggered by Juan's aggression because it reminded him of his own history of domestic violence with Juan's mother. In fact, he noted a certain level of guilt, taking responsibility for Juan's current behavioral challenges, and reporting his difficulty with setting appropriate limits.

Intervention Phase (27 sessions)

Treatment occurred in the clinic each week for approximately 60 minutes. Juan's father was present in each session, and his aunt often participated as well. The focus of the intervention phase was on strengthening the relationship between Juan and his father and aunt and on continuing to change their attributions related to his behavior. The psychological assessment assisted in clarifying Juan's diagnosis and helped his father and aunt to better understand his presentation, including the interaction of his trauma history and his autism. Treatment used play and narration. Reflective questions and comments were used during the sessions to support the development of parental insight. The therapist would wonder with Juan's father about whether or not he thought it was difficult for him to set limits or boundaries with Juan based on his own trauma history. Supporting Juan's father's reflective capacity was critical in strengthening the relationship and re-establishing him as a "protective shield" for Juan.

Sessions began with checking in on Juan's functioning both in the home and at school. A play interaction was then initiated in order to facilitate the development of Juan's social functioning, and to support him in sharing his feelings about his history. That is, figurines (e.g., mom, dad, aunt, Juan) and playhouses were introduced in order to represent Juan's family members, as well as his current and past homes. The therapist initially placed a figurine representing Juan in the playhouse with mom and dad figurines, and explained that when Juan was a baby he lived with his mom and dad. The therapist noted that his mom and dad yelled a lot so his dad moved out; Juan was left with his mom. The therapist verbally acknowledged that the yelling must have been very scary for Juan. The therapist noted that Juan's mom was not always very nice to him, so Juan eventually went to live with his dad and aunt.

The therapist then spoke to Juan directly, confirming that Juan was now safe and that his dad and aunt would take care of him. When this narrative was initially introduced through play, Juan often attended to the therapist for a short period of time and then escaped the play interaction by changing the topic or engaging in a different play activity (often involved gross motor activities or "rough" play). Over time, Juan was able to remain present for longer periods of time, and he eventually contributed verbally (e.g., "My mom was mean to me"). Juan's transition to contributing verbally demonstrated his increased sense of safety and affect

regulation. In addition, over time therapy sessions included current events in Juan's interactions with his mother, father, and aunt, with the use of the family dolls and houses making it easier for him to tell the therapist about his experiences and for his father to demonstrate how he was caring for Juan and keeping him safe.

It became evident that it was challenging for Juan to engage in symbolic play, and that he often used his body to express his feelings or demonstrate his level of arousal by jumping, banging on objects, or throwing play materials. In response, the therapist moved to a co-treat model with an occupational therapist in order to further strengthen dyadic affect regulation capacities through the teaching of non-verbal, body-based self-regulation techniques, such as requesting a hug from his father or aunt, banging on a toy drum, deep breathing, and/or jumping). Juan's father was better able to respond in soothing ways when Juan was upset, and Juan was better able to label his emotional experience and communicate his needs.

Visual aides were used to help Juan to identify and verbalize his feelings. As noted, the therapist used an emotion thermometer and would ask Juan to identify his emotions and level of arousal. Juan, his father, and paternal aunt learned regulation strategies to support Juan, such as providing deep pressure through tight hugs when Juan's level of arousal was high, and by creating opportunities for proprioceptive (e.g., squeeze toy, jumping) and vestibular input (e.g., swinging), as well as breathing techniques when Juan required support during discussion of his family history.

Focusing on Juan's tendency to express himself non-verbally instead of verbally helped Juan to become more engaged in the treatment process. When Juan isolated himself or avoided verbal interactions, the therapist used the non-verbal, body-based self-regulation interventions mentioned above, with the support of the occupational therapist in order to engage Juan. Because Juan experienced both a trauma history and autism it was important to review recommendations from Juan's psychological assessment and collaborate with interdisciplinary team members, shifting to a co-treat model at the mid-point of treatment in order to better address both autism and trauma symptoms. Such consultation also allowed the therapist to better explain Juan's presentation to his caregivers, ultimately shifting their attributions of his behavior.

Parenting was also a focus of treatment in order to support Juan's sense of safety and address disruptive behaviors. By the intervention phase, the caregivers' differing parenting styles became more evident. That is, Juan's father was less likely to set limits or provide consequences, whereas Juan's aunt appeared to believe that Juan would benefit from greater parent management. The therapist highlighted how their differing parenting styles could be complementary for Juan, strengthening family relationships. After discussing this, the father and aunt's appreciation for each other seemed to evolve and a greater balance in parenting occurred both within and outside of the treatment room. That is, instead of feeling challenged by each other, they saw that each individual had a unique approach, neither one being more effective than the other but most effective together. Over time, Juan's father also emerged as a "safe base" for Juan, embracing his parent role, and his ability to advocate for Juan's needs. For example, Juan's father joined the therapist in advocating for Juan's educational needs. He initiated an

Individualized Education Plan (IEP) at Juan's school, volunteered at Juan's school, observed Juan in the classroom, and consulted with his teachers.

Juan's father demonstrated an ability to differentiate between past and present, and greater regulation was observed in the dyad as a result. That is, the therapist highlighted strengths and changes that she observed in Juan, his aunt, and father regularly, and noted how things were different now compared to the past. Reflective questions allowed the therapist to evaluate the caregivers' understanding of this change. For example, the therapist would ask, "How is your parental role different than it was in the past?" Juan's father was able to identify that he was better able to understand Juan's emotions, levels of arousal, and behavior, and know how to support him. He noted that he was also able to better understand his own trauma history and how it impacted him as a caregiver, ultimately allowing him to be more present for Juan.

Termination Phase (8 sessions)

In the termination phase of treatment, the therapist collaborated with the father and aunt in planning for ending Child-Parent Psychotherapy and deciding whether Juan needed additional intervention of a different type to continue to address his autism symptoms. The therapist made an effort to model corrective transitions and goodbyes for Juan and his caregivers, given their histories of traumatic separations.

An effort to solidify the father's role as Juan's "protective shield" was made by using play to emphasize the father's role as protector and helping Juan and his father to talk about feeling safe in his family. In addition, the therapist reinforced Juan's father's and aunt's use of behavioral interventions (e.g., providing access to breaks, utilizing praise/reinforcement systems, and giving clear directions with positive language) that were trauma-informed in order to maintain Juan's ability to attend and regulate his behavior. To assist Juan in self-regulation, Juan's father and aunt were encouraged to take the lead with implementing sensory strategies (e.g., use of a safe calm-down place and creating opportunities for body movement) and behavioral strategies (e.g, giving choices, providing clear expectations of behavior, and being consistent).

The number of remaining sessions was reviewed regularly through the use of a calendar and verbal reminders, and the course of treatment and future planning (e.g., monitoring of symptoms, presence of trauma reminders, changes in service provision) was facilitated. The occupational therapist participated in each aspect of termination. Juan initially had a difficult time accepting the end of the therapy relationship, but he was able to use words to identify his feelings over time with the support of the therapist, occupational therapist, and his caregivers. Each person acknowledged their own feelings of sadness related to termination, thereby modeling and allowing Juan to understand that any feeling of sadness or loss that he might have had were shared. For example, the therapist said, "Juan, I am really going to miss working with you each week. Even though I will not get to see you regularly, I will always think of you." The therapist ensured that prior to termination, Juan had appropriate services in place at school and that his father understood the IEP process and how to request further assistance from the school if needed in the future.

7. THERAPY MONITORING AND THE ROLE OF REFLECTIVE SUPERVISION IN OUTCOME

Various methods of therapy monitoring were essential to maintaining fidelity to the treatment approach. First, reflective supervision, which is a core component of the CPP model, played a key role in allowing the therapist to step back and take note of interpersonal interactions. It allowed the therapist to slow down, remain present in the therapeutic process, and form meaningful, trusting therapeutic relationships. James and Juan were seen and supported by the therapist, which ultimately allowed the parents to better see their children, as well. As the therapist's reflective capacity was nurtured in reflective supervision, she was better able to support this development in James' and Juan's parents.

In the case of James, slowing down and building reflective capacity allowed James' mother to see James in a different way. She became more connected to him physically and emotionally, and her ability to read and respond to his cues increased. Juan's father and paternal aunt began to better understand Juan's body-based behavior as they developed greater awareness of their own "trauma triggers" and body-based reactions. In focusing on feelings, thoughts, and experiences, the therapist mirrored her own journey in reflective supervision, demonstrating a parallel process. Attunement among the clients, parents, and therapist, as well as the reflective supervisor, built the foundation for a positive therapeutic relationship.

As an aid to reflective supervision and mastery of the CPP model, the therapist completed CPP Fidelity Checklists, which were designed by one of the CPP model developers to help therapists and supervisors monitor the use of CPP strategies. In addition, for purposes of this study the co-authors reviewed videotapes of sessions and completed fidelity checklists independently in order to provide input about adherence to the model. The fidelity checklists for CPP therapy include: (1) Trauma-Informed CPP Procedural Fidelity, which includes checklists for the Assessment and Engagement Phase, the First Treatment Session, and the Termination Phase; and 2) CPP Intervention Fidelity, which helps the therapist to track adherence during the Intervention Phase to the core strands of Reflective Practice Fidelity, Emotional Process Fidelity, Dyadic-Relational Fidelity, CPP Case Conceptualization and Content Fidelity, and Trauma Framework Fidelity.

In addition to weekly individual reflective supervision, the therapist and co-authors participated in bi-monthly consultation with the CPP model developer/trainer. James' case was reviewed. The developer/trainer helped the therapist to think about how to connect James and his caregivers emotionally and physically, highlighted the importance of transitions and future planning, encouraged the therapist to be present for in-home therapies in order to support the caregivers in generalizing learned skills, discussed the importance of psychoeducation (e.g., provided resources related to brain development), and helped the therapist to think about ways to further empower the caregivers in their role as parents.

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8. CONCLUDING EVALUATION OF THERAPY PROCESS AND OUTCOME

This study explored the applicability of Child-Parent Psychotherapy for young children with developmental disabilities. The intervention was implemented in a training clinic within a children's hospital serving a largely Latino, low-income population of families exposed to complex, often inter-generational traumatic experiences. The clinic serves children with acute and chronic medical conditions as well as developmental disabilities, a population for which Child-Parent Psychotherapy had not previously been studied.

Outcome Measures at Termination for James and His Family

During the termination phase of treatment, James' mother's responses on the FICD indicated some positive consequences of having a child with a disability. These included a better understanding of what should be valued in life, appreciation for how every child has a unique personality and special talents, increased tolerance of difference and awareness of disability, and awareness of special pleasures that come from having a child with a disability. In terms of negative consequences of having a child with a disability, James' mother reported increased financial costs. Compared to her report at the beginning of treatment, James' responses on the FICD at the end of treatment indicated fewer negative consequences, such as time demands, disruptions to family routine, and stress in the family.

As shown in Table 1, James' mother reported higher levels of stress on the Parenting Stress Index at the end of treatment compared to the beginning of treatment. While 2 of the 3 subscales were still within the normal range, the score on the Parent-Child Dysfunctional Interaction scale rose to the clinically significant range at the end of treatment.

Various hypotheses may be considered in interpreting this finding. First, it may be that the intervention provided was insufficient to significantly reduce parenting stress, in the context of this family's poverty, overcrowded living situation, having a child with a severe developmental disability and chronic health concerns, and the recent birth of a new baby shortly prior to completion of treatment. Second, James' mother expressed anxiety related to the impending loss of support of the therapist due to the planned termination of treatment; she began again questioning her ability to care for James' needs without this support. Therefore, completion of the measure during this period of transition out of therapy may have contributed to the mother's report of increased stress compared to the pre-treatment measure. Finally, it may be that the scale items were reflecting mother's increased accurate perceptions of the level of her son's disability, rather than increased parenting stress. The scale that showed an increase into the clinically significant range was the scale that includes items related to the child's capacities. For example, the following items on that subscale may not be interpreted accurately as reflecting "parenting stress" or "parent-child dysfunctional interaction" in a child with a significant developmental disability: "My child rarely does things for me that make me feel good;" "My child doesn't seem to learn as quickly as most children;" "My child doesn't seem to smile as much as most children;" or "My child is not able to do as much as I expected."

During the exit interview, James' mother noted that she now better understood the definition of trauma, the impact of trauma on development, and how to advocate for James. Above all, she noted that the therapist's positive affect, efforts to engage her and build the connection between her and her son, and communication of feelings of hopefulness enabled her to trust in the therapeutic process.

Outcome Measures at Termination for Juan and His Family

In completing the FICD at the termination of treatment, Juan's father continued to report some negative consequences of having a child with a disability, including increased time demands, a tendency to do more for others than for oneself, limitations with social contacts outside the home and reduced time spent with friends. However, it was notable that Juan's father endorsed many more positive consequences of having a child with a disability than were noted at the beginning of treatment, including to a "moderate degree" coming to terms with what should be valued in life, greater appreciation of the unique personality traits and special talents of every child, increased tolerance and acceptance of differences between people, positive personal growth, awareness of other people's needs and struggles, and enjoyment of special pleasures associated with having a child with a disability.

As shown in Table 2, Juan's father's scores on the PSI-SF at the end of treatment indicated that he was continuing to experience a high level of stress in the areas of Parent-Child Dysfunctional Interaction and Difficult Child scales. However, it was notable that he indicated a decrease in Parental Distress, with this scale moving from the clinically significant range to the normal range by the end of treatment. As noted in the discussion of the PSI scores for James' mother, it may be that the Parenting Stress Index should be interpreted differently in parents of children with developmental disabilities compared to typically developing children, since some items are likely to reflect accurate differences in the child's capabilities rather than reflecting parenting stress. As noted before, many items on the Parent-Child Dysfunctional Interaction scale report the child's difficulty with learning, smiling, or being able to do things that other children do. In addition, in Juan's case, some items on the Difficult Child scale may reflect accurate differences in the challenges exhibited by children with autism. For example, the following items may reflect typical autism symptoms rather than a parent's perception of their child as being "difficult": "My child reacts very strongly when something happens that my child doesn't like;" "My child's sleeping or eating schedule was much harder to establish than I expected;" or "I have found that getting my child to do something or stop doing something is harder than I expected." In addition, it may be that the scores on the PSI remained high in Juan's father's case because treatment that focused on the parent-child relationship was not sufficient to reduce his overall stress related to parenting a child with autism.

Examination of TSCYC scores at the end of treatment indicated substantial improvement in Juan's symptoms, as shown in Table 2. All but one scale had moved into the normal range, and the profile was no longer suggestive of a posttraumatic stress disorder diagnosis. Juan's disruptive behaviors had significantly decreased, as indicated by his normal score on the Anger/Aggression subscale, and his father's and teacher's verbal report that he was no longer displaying aggressive and disruptive behaviors at school. The Posttraumatic Stress: Avoidance

scale remained in the clinically significant range at the end of treatment. Examples of items on this scale that continued to be endorsed by Juan's father at post-treatment included "Not wanting to talk about something that happened to him;" and "Changing the subject or not answering when he was asked about a bad thing that happened to him."

During the exit interview Juan's father and paternal aunt noted a deeper understanding of the interaction between Juan's trauma history and diagnosis of autism. In particular, they reported that they better understood how Juan processed information, such as the importance of non-verbal, body-based communication. In addition, they shared that they had a better sense of how their own trauma histories interacted with Juan's.

Juan continued to meet criteria for a diagnosis of Autistic Disorder at the end of treatment, but no longer met criteria for Disruptive Behavior Disorder, NOS. Juan's disruptive behaviors had decreased greatly and he was consistently receiving positive daily reports from school. Juan was also able to verbally share some of his experiences related to his history (i.e., "When I lived with my mom, she wasn't very nice to me"). His eye contact and initiation of social overtures also increased. Juan's therapist, in collaboration with his father and aunt, recommended that Juan participate in a social skills group for children with challenges in communication and social reciprocity following the completion of Child-Parent Psychotherapy. Given Juan's improvements in affect regulation and self-regulation and the reduction in aggressive behaviors, it was felt that he could now successfully participate in a group intervention with other children.

Comparison of the Outcomes for the James and Juan Cases

The two families presented here both met the primary CPP goals of enhancing attachment relationships between parent and child, re-establishing a sense of safety and trust between parent and child, helping the parents develop a more positive and developmentally-appropriate view of their child, empowering the parents to address maladaptive child behaviors, and helping the parents learn to recognize and respond appropriately to trauma triggers in their child and themselves.

In the case of James, progress was seen in the parents' increased closeness to their infant and acceptance of his developmental disability. Over the course of therapy, a physical shift was observed that mirrored a psychological shift to greater closeness. At the beginning of treatment, either the home nurse care provider or the therapist maintained physical proximity to the baby on the floor of the apartment, while the mother sat at some distance on the bed and the father literally left the home. By the end of treatment, the mother had taken on primary responsibility for care giving, the therapist and nurse moved to a role of supporting the mother rather than caring directly for the baby, and the mother reported increased support from her husband and a closer relationship with him.

James' mother learned to recognize her own response of withdrawal and depression when faced with her own trauma triggers (reminders of her abusive childhood; reminders of the medical trauma occurring in the hospital at the onset of James' illness and subsequent decline in

functioning). As she gained awareness of her own response, she was able to use coping strategies to manage her own affective arousal and to move to a protective and attachment-oriented response to her son rather than withdrawing.

James' siblings and father also gained an appreciation for his ability to interact with them and were able to demonstrate more playfulness and engagement. James' parents learned to recognize subtle or slow progress in his development, and to find enjoyment in his progress and their changing interactions with him.

Finally, the therapist's knowledge of resources and the service system for children with developmental disabilities and consultation with the interdisciplinary team enabled her to link the family to critical early intervention and medical services in the community. By the end of treatment, the family had developed an understanding of how to navigate the service system and communicate with providers who would help to address James' developmental needs over time. While medical, developmental and educational interventions will be needed throughout James' life, a relatively short-term course of mental health services changed the family's emotional trajectory in terms of greater closeness to each other and to James, acceptance of the reality of James' developmental disability, and activation of their care giving capacities.

In the case of Juan, Juan's father and paternal aunt were able to acknowledge Juan's traumatic experiences and their potential impact. Reflecting on their personal trauma histories and identifying trauma triggers supported this process by shifting their attributions about Juan's disruptive behaviors. At the beginning of treatment, Juan, his father, and his aunt demonstrated avoidance in exploring Juan's trauma history. In addition, Juan's father experienced guilt in setting limits and applying parent management techniques. Conflicting parenting styles between Juan's father and aunt further complicated family dynamics.

By the end of treatment, Juan's caregivers were more likely to view their parenting styles as complementary. Both Juan's father and aunt appeared to better understand Juan's behavior, given his trauma history and confirmation of his autism diagnosis, and they took an active role in identifying ways to promote Juan's self-regulation. Overall, the development of greater insight was observed. Juan's father emerged as a "safe base" for Juan, and both Juan's father and aunt demonstrated an increased capacity to advocate on Juan's behalf. For example, by the end of treatment Juan's father had worked with the school to put an IEP in place including classroom accommodations to support his learning, such as movement breaks, preferential seating, a behavior support plan, and social goals. Therapist modeling and interdisciplinary consultation, as well as a co-treat model through the inclusion of an occupational therapist, supported learning and clinical creativity in the interventions. That is, the therapist and occupational therapist were required to "think out of the box" (e.g., focus on non-verbal versus verbal expression) in order to meet Juan's individual needs. Over time, Juan's ability to identify and verbalize his feelings increased. He was also better able to communicate his needs and wants, remain engaged in interactions, and regulate his body when experiencing a high level of arousal. Juan appeared to feel understood, supported and nurtured by his caregivers, demonstrating an increased sense of felt safety.

Therapy Monitoring and Reflective Supervision

Two crucial components of the therapy in facilitating positive outcomes for both clients were the use of various methods of therapy monitoring to maintain fidelity to the treatment approach; and the use of reflective supervision to positively engage and support the therapist in the intervention process. These two components are discussed in detail above in section 7.

Cultural Factors Impacting Treatment Process and Outcome

Both clients were from low-income Latino families, headed by immigrant parents. James' parents emigrated from Mexico as older teenagers, and have struggled to earn sufficient income to support their family. Speaking only Spanish, they encountered challenges when communicating with medical personnel during their son's illness, surgery, and sudden developmental decline. Cultural factors impacted the family's ability to access available community services due to transportation barriers related to poverty, fear of reaching out to service agencies due to their undocumented immigrant status, and language. Further, poverty led to increased stress as the family of five lived in one bedroom of a home shared by multiple unrelated families. In addition, immigration led the father to be separated from his family of origin and increased his stress as he was unable to freely travel to visit his mother when she was ill, or receive support from his extended family in caring for his own ill son.

Juan's father and paternal aunt immigrated to the United States together with their mother and siblings from El Salvador due to exposure to war. Both Juan's father and aunt are bilingual (i.e., English and Spanish). When discussing Juan's needs, they noted that in their culture autism was not understood as a specific condition. Instead children with autism are grouped with children with an intellectual disability and considered to lack competence, abilities, or strengths. As such, Juan's father and aunt did not understand that autism was a separate condition on a spectrum of severity, and that intervention could assist Juan in reaching a higher level of developmental functioning.

Child-Parent Psychotherapy explicitly considers the cultural context of the family in designing the intervention plan. In both case examples, a bilingual therapist was chosen so that communication could be direct between parents and therapist, without the separation created by interpretation or translation services. The therapist met James' family in their home throughout treatment, to reduce transportation barriers and ensure that interventions were contextually appropriate to the family's living space and enabled inclusion of all family members as well as the home nurse care provider. In both cases, the therapist spent time building trust and connection with the parents before attempting to intervene in their relationship with their child.

The assessment/engagement phase of CPP provided an explicit opportunity within the treatment model to listen empathically to the parents' own histories of immigration, separation from extended family, abuse within their families of origin, and the role of religion in their view of illness and family relationships. This listening phase helped to build trust between the parents and the therapist that laid the foundation for change. In this way, recommended cultural adaptations for therapists providing trauma-informed treatment to Latino families were explicitly

incorporated, including: (a) establish trust and rapport (e.g., demonstrate knowledge of cultural values); (b) conduct a thorough assessment (e.g., immigration and documentation status); (c) stress integration of extended family members in treatment: (d) examine attitudes towards trauma and DD; and (e) incorporate protective factors (The Workgroup on Adapting Latino Services, 2008).

Fit of Child-Parent Psychotherapy Model for Children with Developmental Disabilities

This exploratory study provides evidence for the fit of the CPP model for children with developmental disabilities who have been exposed to traumatic experiences and/or have challenges in attachment relationships with their parents. While early intervention and educational services are geared to the child's individual growth and development, CPP is a mental health intervention that targets the parent-child relationship as the agent and object of change. In cases such as James' where the developmental disability itself and the medical trauma leading to the developmental disability put the parent-child relationship at risk, CPP provides an opportunity for strengthening that relationship. CPP helped James' parents to explore how their own life experiences impacted their perceptions of their child and to focus on fostering healthy parent-child interactions. In these ways, CPP led James' parents to an acceptance of his new reality; an awareness of his progress and the potential for future progress even in the face of significant disability; and an increase in the quantity and quality of enjoyable interactions for both parent and child.

In Juan's case, interventions focused on autism alone would not have provided an avenue to address Juan's exposure to domestic violence between his parents and abuse by his mother, and to the impact of those experiences on his relationship with his father and his ability to respond to developmental or behavioral interventions. When children with both autism and trauma exhibit disruptive and aggressive behaviors, it may be impossible to tease out the relative influence of the developmental disability and the exposure to trauma on the presenting behavioral symptoms. CPP provides a forum to address both issues. For example, CPP has a combined focus on developmental guidance, a developmental understanding of the child's behaviors, and reflection on the impact of prior modeling of aggressive behaviors as well as triggers for emotional arousal. These enable the therapist and parent to devise ways to respond to aggression and noncompliance that are sensitive to both the developmental disability and the occurrence of aggression in response to trauma triggers. By recognizing when behaviors are normal for the developmental level of the child, when they reflect a response to unclear limit-setting, and when they reflect emotional arousal triggered by a trauma reminder, the parent can effectively vary their response to the behaviors.

Finally, since CPP was designed to be provided to infants and young children, the limited communicative capabilities of a child with a developmental disability are not an impediment to the intervention. The model uses naturally occurring parent-child interactions within the context of the child's developmental level as the material for intervention sessions. Thus, regardless of developmental delay or disability, there is ample material within the parent-child interactions for the work of therapy.

Recommendations for Applying CPP to Children with Developmental Disabilities

Screening and Selection of Clients

When determining whether or not CPP would be an appropriate intervention for a child with a developmental disability, it is important to screen for child traumatic experiences and for perturbations in the parent-child relationship. If neither of these concerns is present, then treatment focused primarily on the child's development and/or behaviors may be most efficient, and CPP may not be indicated. While CPP was designed for children from age birth through five years, in cases of children with developmental disabilities it may be appropriate for older children as well. If the child's level of developmental functioning precludes reliance on verbal and cognitive skills for intervention, then CPP may be useful for families with school-aged children.

Assessment and Engagement Phase

During the initial phase of treatment, families who have a young child with a developmental disability may need to focus on linkage to community services and learning to navigate the service system, before they can focus on their relationship with their child or their child's behavioral symptoms. Therapists need to develop knowledge about the service system, eligibility for various types of intervention, and linkages with community providers in order to best meet families' needs, particularly when the diagnosis of a developmental disability is recent. In addition, case management interventions can be an important part of establishing safety in the parent-child relationship (as the parent learns to effectively meet the child's developmental needs), and may be a port of entry for the family to engage in a relationship with the therapist.

Assessment measures play an important role in contributing to the goals of identifying traumatic experiences for both the child and the parents, noting links between child and parent symptoms and their trauma experiences, determining whether CPP is an appropriate model, and establishing a trauma frame with the caregiver. In addition, outcomes can be evaluated in order to determine treatment gains. Because parents of young children with developmental disabilities experience unique stressors, it may be more useful to collect information in a qualitative format versus quantitative format in order to fully capture a family's experiences. Semi-structured interviews may allow for the collection of richer information, whereas Likert scales may limit information provided. In addition, collecting information qualitatively may be more effective in capturing cultural factors.

Role of Other Providers

Children with developmental disabilities often benefit from the perspective of an interdisciplinary team to fully understand their developmental strengths and needs and the interplay of developmental and health challenges in different domains. Formal assessments of the child's functioning in different areas may be critical to designing a comprehensive treatment plan, of which CPP may be one component. Consultation with interdisciplinary team members (such as speech-language pathologists, nutritionists, occupational and/or physical therapists,

pediatricians, special education teachers, etc.) may be important to both therapist and parents in fully understanding the child's needs. In some cases, co-treatment may be most effective. For example, children with feeding difficulties, traumatic medical experiences, and developmental disabilities may benefit from combined treatment sessions by a nutritionist and/or occupational therapist together with a CPP-trained psychologist to address feeding challenges in the context of the parent-child relationship and the child's trauma experiences.

Parents may also benefit from linkage with other families who have children with developmental disabilities. Such families can be a source of support as well as information about strategies for navigating the service system and gaining knowledge about the disability.

Children with developmental disabilities are often involved with an array of service providers, and the mental health therapist may be most effective in integrating the perspectives of the different team members and helping the parent to understand each of their unique roles. Further, the therapist may need to provide support to other providers as well as guidance to help them understand the child's attachment and emotional needs, in addition to providing that support to the parents. In CPP with children with developmental disabilities, the therapist supports and guides complex systems and not just the immediate family.

Modes of Communication in Therapy Sessions

Children with developmental disabilities often present with communication challenges, and one role of the CPP therapist may be to help the parent to develop flexible methods of communicating with their child. For example, if the child is using a picture exchange system or other augmentative and alternative communication in speech therapy or school, the therapist can enhance parent-child communication and closeness by helping the parents learn to use these strategies within dyadic therapy sessions and ultimately independently in the home setting. Often, parents find that the cues of children with developmental disabilities are more challenging to understand, and this can challenge the development of parent-child attachment. Therefore, therapy sessions may partially focus on helping the parent to recognize more subtle or ambiguous cues and respond appropriately.

Adjustment to Disability over Time

In some families, the diagnosis of a developmental disability may represent a trauma to the family system. Mental health therapy becomes important in supporting the family. Therapy may include support to the parents in grieving the loss of the child they expected or dreamed of, to pave the way to acceptance of their child. This support may include anticipatory guidance about adjustments to their child's disability over the course of time. At different points in the course of development (e.g., starting school, puberty, completing high school), parents may be reminded again of missed developmental milestones. CPP early in the life of a child with a disability can help lay the foundation for strong parent-child attachments that can last a lifetime.

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Table 1
Scores on Outcome Measures at Beginning and End of Treatment: James

Scale	Subscale	Pre-Treatment		Post-Treatment	
		Percentile	Level	Percentile	Level
Parenting Stress Index – Short Form	Total Stress	20	Normal	80	Normal
	Parental Distress	55	Normal	30	Normal
	Parent-Child Dysfunctional Interaction	65	Normal	99	Clinically Significant
	Difficult Child	1	Normal	55	Normal

Note. On the PSI-SF, percentile scores from 16 to 80 are considered to be in the normal range; those from 81 to 84 are considered borderline, and those from 85 and above are clinically significant.

Table 2
Scores on Outcome Measures at Beginning and End of Treatment: Juan

Scale	Subscale	Pre-Treatment			Post-Treatment		
		T Score	Per-centile	Level	T score	Per-centile	Level
Parenting Stress Index – Short Form	Total Stress	N/A	>99	Clinically significant	N/A	>99	Clinically significant
	Parental Distress	N/A	85	Clinically significant	N/A	70	Normal
	Parent-Child Dysfunctional Interaction	N/A	95	Clinically significant	N/A	>99	Clinically Significant
	Difficult Child	N/A	95	Clinically significant	N/A	>99	Clinically significant
Trauma Symptom Checklist for Young Children	Anxiety	46	34	Normal	52	67	Normal
	Depression	54	68	Normal	44	30	Normal
	Anger/Aggression	71	98	Clinically significant	58	84	Normal
	Posttraumatic Stress: Intrusion	62	88	Normal	47	50	Normal
	Posttraumatic Stress: Avoidance	79	99	Clinically significant	74	97	Clinically significant
	Posttraumatic Stress: Arousal	72	99	Clinically significant	67	94	Borderline
	Posttraumatic Stress: Total	74	99	Clinically significant	66	94	Borderline
	Dissociation	63	91	Normal	56	82	Normal
	Sexual Concerns	46	34	Normal	56	82	Normal

Note:
On the PSI-SF, percentile scores from 16 to 80 are considered to be in the normal range; those from 81 to 84 are considered borderline, and those from 85 and above are clinically significant. On the TSCYC, T scores below 65 are in the normal range, those from 65-70 are borderline, and those above 70 are clinically significant.