

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

**Clinical Considerations for Conducting Child-Parent
Psychotherapy with Young Children with Developmental
Disabilities Who Have Experienced Trauma**

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ABSTRACT

Child-Parent Psychotherapy (CPP) is an evidence-based treatment for children age 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems. Harley, Williams, Zamora, & Lakatos (2014) use a case study approach to examine the utility of CPP for working with children with developmental disabilities. They share specific ways in which the model can be tailored for this population. In this commentary, we reflect on their work with James, a 14-month old Latino boy with global delays related to a stroke he suffered after surgery for a congenital heart defect, and Juan, a 6 year, 2 month old boy diagnosed as autistic who has also experienced multiple traumas. We highlight interventions that address core CPP goals and discuss the need to address four key topic areas when conducting CPP with children with disabilities: 1) the importance of addressing risks that present within the caregiver-child relationship, including caregivers' unresolved grief; 2) the potential for the caregiver or child's history of trauma to contribute to challenges in the child and caregiver's functioning; 3) the importance of working as part of an interdisciplinary team to coordinate care and better address the complex needs of families; and 4) the importance of applying a socio-cultural lens in every aspect of the work.

Key words: Child-Parent Psychotherapy (CPP); developmental disabilities; disabilities; medical trauma; child trauma; maltreatment; posttraumatic stress; early intervention; relationship-based treatment; Part C, IDEA; Child Abuse Prevention and Treatment Act (CAPTA); clinical case studies; case studies

Harley, Williams, Zamora, & Lakatos (2014) offer two rich clinical cases that illustrate how Child-Parent Psychotherapy (CPP) can be used to address the needs of young children with developmental disabilities who have experienced trauma. Their article contains many important lessons for clinicians seeking to work with this population. In this commentary, we highlight important clinical considerations for working with children with disabilities and their families, share research that underscores the importance of addressing these areas, and discuss ways in which the work with 14-month-old James, who is experiencing global delays following related to a medical trauma, and 6 years and 2 month old Juan, who has been diagnosed with autism and has experienced multiple traumas, and their families exemplifies how CPP is conducted with this population.

CPP is an evidence-based treatment for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems. Five randomized trials support its efficacy (Cicchetti, Rogosch, & Toth, 2006; Cicchetti, Toth, & Rogosch, 1999; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Weston, & Pawl, 1991; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). Although none of these studies was conducted with children with developmental delays, there is a solid clinical antecedent for employing CPP as an intervention with this population. Selma Fraiberg, whose work in infant mental health remains the foundation of child-parent psychotherapy, first established the basic tenets of infant-parent treatment in her pioneering work with blind babies and their caregivers (1987). Thus, as we examine the applicability of CPP to children with developmental delays or disabilities, we are, in fact, returning to the historical roots of the model.

Nevertheless, it is important to recognize that CPP has evolved since the 1960's when Fraiberg began this work. The model was expanded to include children in the three to five age range as well as those aged birth through three, and, as the field learned more about the prevalence and consequences of trauma exposure, CPP has more purposefully incorporated specific relationship-based interventions to address how trauma to the child, the caregiver, or the cultural group (historical trauma) affects the interactions and functioning of family members (Lieberman et al., 2005; Lieberman & Van Horn, 2005; 2008; Toth et al., 2002).

The emergence of developmental psychopathology as an integrated field of scientific inquiry and societal and system changes has also impacted current approaches to intervention with young children with disabilities. Among these changes, we can highlight: 1) Growing research and clinical knowledge on risk and protective factors specific to children with disabilities, particularly within the caregiver-child relationship; 2) A greater appreciation of the comorbidity of developmental delays and trauma exposure and greater understanding of the consequences of trauma exposure for this group, 3) Expansion of the early childhood system of care that supports families of children with disabilities, and 4) The increasing diversity of the United States population, which calls for greater attention to cultural considerations in developing effective approaches to intervention. These changes have important implications for the way CPP is conducted with children with developmental delays or disabilities.

RISK AND PROTECTIVE FACTORS WITHIN THE PARENT-CHILD RELATIONSHIP

Most parents who learn that their child has a developmental disorder (like Juan) or disabling medical condition (like James) begin a journey filled with difficult decisions, uncertainties related to the cause and prognosis of the child's condition, multiple interactions with different providers and systems, and pressures to master specialized knowledge or skills in order to support and advocate for their child's well-being and developmental progression (Barnett, Kaplan-Estrin, McCaskill, Hunt, et al, 2006; Marvin & Pianta, 1996; Oppenheim, Dolev, Koren-Karie, Sher-Censor, Yirmina, et al, 2007; Wachtel & Carter, 2008).

Therefore, it is not unusual that these parents may present with high levels of stress, depression, or PTSD (Barnett et al, 2006; Marvin & Pianta, 1996). They may experience intense emotional reactions ranging from relief of having a diagnosis, to shock, confusion, sadness, and grief for the loss of the life they pictured for their child and themselves (Walters & Blane, 2000; Wachtel & Carter, 2008). Oppenheim and colleagues (2007) suggest that many parents who receive a diagnosis of a developmental disorder for their child "have likened this experience to a metaphorical loss of the child: It is as if the wished for typically developing child has been lost, and instead parents are faced with many questions, anxieties, and fears regarding their child's development" (p. 109) and their new role as parents of a child with a developmental challenge.

The process of adjusting to these new circumstances appears to be cyclical, involving, on the one hand, integration and understanding of the child's capacity and their altered parental role, and, on the other, intense affect, avoidance, and other defense mechanisms which impede the integrative process (Marvin & Pianta, 1996; Walters & Blane, 2005). Resolution takes place as caregivers, over the course of this cyclical process, integrate in a gradual manner, their conflicting feelings and representational models and are able to center their attention on the new reality, present and future. "Successful resolution involves accepting the diagnosis, incorporating the diagnosis into one's reality, and resisting self-blame" (Pianta & Marvin, 1993, as cited by Wachtel & Carter, 2008, p. 576). There is evidence that resolved parents are more able to adequately cope with the emotions raised by their child's diagnosis; to revise, over time, their views of the child; and to respond more sensitively to the child's signals of need (Marvin & Pianta, 1996; Oppenheim et al, 2007; Wachtel & Carter, 2008).

Research with mothers of young children with a variety of developmental problems (cerebral palsy, neurological disorders, autistic spectrum disorders) suggest a positive association between parental resolution of diagnosis, the security of the child-parent attachment, and child outcomes (Barnett et al, 2006; Marvin & Pianta, 1996; Wachtel & Carter, 2008). Caregivers who are resolved in terms of their young child's developmental disability are able to remain more attuned and responsive to their child's unique characteristics and to help their children feel more understood, accepted, and secure. In contrast, caregivers who are not yet resolved in their grief, distressing feelings or cognitions related to the child's condition may have difficulties interpreting and responding accurately to their child's cues and needs.

Even as we acknowledge the challenges and adjustment inherent in learning that a child has delayed or unusual development, it is important to recognize that caregivers vary considerably in their responses (Hauser-Cram, 2006). Factors such as the timing of the diagnosis, available sources of support, and resources (individual, family, economic, and socio-cultural) have been shown to affect the family's response and resolution (Marvin & Pianta, 1996). Nevertheless, the research suggests that challenges in parental adjustment and resolution of the child's disability appear to be both relatively common and stable and are not associated with the passage of time (Barnett et al, 2006; Oppenheim et al; 2007; Pianta, Marvin, Britner & Borowitz, 1996). Moreover, parental grief reactions may resurface with each developmental milestone that the child misses or accomplishes, and these reactions may, in turn, affect the parent's emotional availability and the developmental pathway for the child and family (Walters & Blane, 2000).

This evidence highlights the extreme importance of implementing early relationship-based interventions designed to promote adjustment and resilience in families of young children with developmental disabilities (Oppenheim et al, 2006; Watchel & Carter, 2008). As noted by Lieberman & Van Horn (2008) "the child-parent relationship remains the most parsimonious vehicle for improvement even when the child has a constitutionally based condition such as autism or pervasive developmental disorder" (p. 7).

As a dyadic, attachment-based intervention, CPP is particularly well suited for working with families with children with developmental delays or disabilities, and, as was noted before, was originally developed through work with this population. Core CPP goals—including dyadic affect regulation, strengthening the caregiver-child relationship, making meaning, enhancing the understanding of the meaning of behavior, and supporting the child and caregiver in returning to a normal developmental trajectory—can be tailored to address the needs of this population.

For example, as can be seen in the cases of James and Juan, the CPP therapist supports the parents' emotional reactions to the child's diagnosis, including their grief reactions. She helps the parents make meaning of their child's condition and their altered parental role. She helps the parents both appreciate their child's possible limitations and recognize that in early childhood development is flexible and parent-child interactions and early intervention can still shape the child's development. She addresses parental attributions regarding the child, the diagnosis, and the parent's own trauma history that interfere with the parent's capacity to connect with the child and scaffold development to its greatest potential; and she nurtures the caregivers' ability to better read the child's cues, engage in more positive interactions, and become more attuned.

James

In the case of 14-month-old James, we see the classic roots of Selma Fraiberg's work with young vulnerable children and their caregivers. When the therapist enters the home, she meets a baby who is at risk not only because of a stroke that occurred after surgery for a congenital heart defect, but also because of the grief his condition provokes in his parents and the impact of this grief in shaping their attributions and responses to him. The therapist notes that James demonstrates an interest in his environment and appears to take pleasure in social games, yet his parents appear to be detached from him. In thinking about the adaptation of young

children with developmental challenges, Fraiberg noted, “the minus on the state of adaptiveness will require plusses on the side of the mother who will have to substitute for the deficit” (Fraiberg, 1987, p. 85).

Here we see the bind James and his parents are in. James desperately needs his parents to hold out hope for successful adaptation and to woo him into developing to his fullest potential, but an invisible wall constructed of fear, helplessness, anger, and sadness separates his caregivers from him and prevent them from giving him what he needs. They experience fear that his condition may worsen, helplessness in the face of an unknown disorder that threatens their child, anger at the doctors and the situation, and sadness over the loss of the James they once knew.

As she works with the family, the therapist allows them to connect to and acknowledge their feelings and in doing so helps them to slowly disassemble this wall. This work begins during the assessment and engagement phase. During this phase, the therapist not only gathers critical information but also creates a space where the parents can begin processing complex feelings regarding James’ and his disability, including feelings of unresolved grief. Key assessment domains include not only the child’s symptoms and functioning but risk and protective factors within the caregiver-child relationship including: 1) the parents’ beliefs about the cause of the developmental delay; 2) the way the child’s condition affects the different family members, including their emotional responses; 3) caregiver’s mental representations of the child and his/her capacity; 4) caregiver’s representations of themselves and their role as parents; and 5) caregivers’ coping mechanisms.

The therapist notices that the mother initially does not approach James, the father works long hours, and the siblings avoid interacting with James. As they work together, the mother is able to recognize that normal caregiving tasks have become triggers for her as even simple interactions remind her of the child she has lost. Acknowledgement and appreciation of her reality appears to help her become open to new information and to therapeutic interventions that include: 1) highlighting moments of connection; 2) helping the caregiver reclaim her sense of maternal competence; 3) enhancing the caregiver’s ability to see the child’s capacity to learn and grow; and 4) helping the caregivers gain new skills for parenting a child with special needs.

When she began working with the family, the therapist was uncertain as to the degree to which James’ delays were related to his medical condition, his experience of medical trauma, or disruptions in the parent-child relationship. For any of us working with families like James’, the answer is that we do not know, and yet, we must hold out hope as we work with families to build a relational context that recognizes and supports positive change, for it is within this context that children and their families can blossom to their fullest potential.

CO-OCCURRENCE OF DISABILITY AND TRAUMA

Although there is considerable debate in the field regarding the connection between disabilities and maltreatment, a number of studies have found increased risk for children with disabilities. Using cross-national data from Child Protective Services Agencies, Crosse, Kaye, and Ratnofsky (1993) reported that the incidence of maltreatment was 1.7 times higher for children with disabilities than for those without disabilities. Sullivan and Knutson (2000)

examined school-based data and found a 9% prevalence rate of maltreatment for nondisabled children, and a 31% prevalence rate for disabled children. They also noted that children with disabilities tended to be maltreated at younger ages, highlighting the need for services that address the specific needs of young children with disabilities who have also experienced interpersonal trauma. Mandell, Walrath, Manteuffel, Sgro, and Pinto-Martin (2005) reported that approximately one in five children treated at community mental health settings for autism or Asperger's disorder had experienced physical abuse, and one in six had experienced sexual abuse. They suggested that because the etiology of these disorders is presumed to be primarily biological, many clinicians may not screen for maltreatment, but their findings highlight the need to both screen for trauma and to consider how it may interact with the child's disability to affect functioning.

It is true that the research in this area is subject to methodological limitations due to varying definitions of disability; differences in risk based on type of disability; and the need to consider important variables that might better account for the link between disability status and abuse potential, including child age and gender, parents' resolution regarding the child's diagnosis, social support, and the ecological context (Howe, 2006; Newman, Christopher, & Berry, 2000; Spencer et al., 2005; Sullivan & Knutson, 2000). However, the data from these studies underscores the need to address maltreatment within this population both in terms of prevention and intervention.

Multiple complex pathways may account for the association between disability and maltreatment. In some cases, the child's disability may place him/her at increased risk for abuse or neglect and in other cases maltreatment may cause or exacerbate the disability. Howe (2006) proposed that an attachment-based transactional model that recognizes both parental and child vulnerability and resilience factors may help the field understand how different sources of risk and protection interact and may lead to the development of effective interventions. Within the model, child risk factors—including high levels of dependence, communication problems, and difficult to read attachment and emotional signals—interact with parental risk factors. Sources of parental risk include unresolved states of mind with respect to attachment; lack of resolution regarding the child's diagnosis; difficulty reading cues and reflecting on the meaning of a child's distress and behavior; parental history of rejection, harsh discipline, or trauma; and heightened sensitivity and arousal to children's distress.

For example, a child who is difficult to soothe and who is more easily distressed may more readily trigger a caregiver who is unresolved, more easily aroused, and has his or her own history of negative childhood experiences. In addition to risks within the child and caregiving system, Algood, Hong, Goudine, and Williams (2011) highlight the need to think about ecological contextual factors that may contribute to risk or protection, including the parent's social support and social network, neighborhood characteristics, economic resources, and interactions between the family and different service sectors (e.g., school, early intervention, and/or social services).

CPP is based on an ecological transactional model and integrates a focus on how trauma and maltreatment experienced by child, caregiver, or both may shape these complex interactions. In the work with both James and Juan and their families, we see how a focus on traumatic

experiences is central to the intervention. In both treatments, consistent with CPP fidelity, screening of the child's and caregiver's trauma history is a key component of the assessment and engagement phase. The goal of trauma screening is not only to gather data regarding the family's history but to understand the way the caregiver thinks about and emotionally responds to this history and to begin to help the caregiver reflect on how these experiences may be impacting the interactions and functioning of different family members.

James

For James, his only identified trauma is a medical trauma, yet as his mother thinks about the medical trauma, both from her own perspective and from James', she is able to see how his weekly medical treatments and numerous appointments serve as trauma reminders that dysregulate and negatively affect both of them. As she reflects on this with the therapist, she can think of ways that both she and James can feel safe, make meaning of these experiences, and regulate emotionally during these appointments. The therapist is also aware of the mother's trauma history—which included exposure to domestic violence, sexual abuse, and physical abuse—and can reflect in supervision and with mom about how these earlier experiences may affect the way that mom is coping with this more recent event. Although treatment with the father is not discussed in detail, during the assessment the therapist learned that the father had an older brother who died from medical complications before the father was born. It may be important to reflect on how this family history of trauma may have affected James' father's response to him.

Juan

Juan's trauma history is more complicated. As the therapist meets Juan and his family, she considers how his trauma history shapes his functioning. Prior to the age of one, Juan lived with his mother and father and was exposed to both parental substance abuse and domestic violence, including an incident where his mother pulled a knife on his father. Juan's parents separated when he was one, and although Juan's father reported that he saw Juan on weekends, it is unclear what Juan may have experienced in his mother's home from age one to age four. At age four, there were reports that Juan had been physically abused by his mother and had witnessed arguments between his mother and her boyfriend. At that time, he was separated from his mother.

As we review Juan's life, we see that it included at a minimum four Adverse Childhood Experiences (ACEs; Felitti et al. 1998; [acestudy.org](http://www.acestudy.org)): 1) domestic violence; 2) parental separation; 3) parental substance use; and 4) physical abuse. The literature suggests that these ACEs are linked to behavior problems, more negative social interactions, and worse cognitive performance (Chu & Lieberman, 2010; Ghosh Ippen & Lieberman, 2008).

Juan was diagnosed with Autistic Disorder at age 2. As his CPP therapist worked with him and his father, she delved into complex questions regarding which of his symptoms might be accounted for by autism and which might be better attributed to his trauma history. Additionally, the therapist learned that Juan's father and aunt had their own personal experiences of trauma, which may have affected the way they responded to Juan. For example, the father's guilt around

having been aggressive affected his capacity to set limits and appropriately socialize Juan. Given Juan's significant trauma history, treatment incorporated several trauma-informed components including: 1) helping the caregivers to reflect on the connection between Juan's history and his functioning during the assessment; 2) openly acknowledging to Juan that his caregivers were aware of and sorry about what he had been through; 3) allowing Juan to process his experience through play with his caregivers, and 4) helping to restore Juan's sense of safety both through play and through real life interactions with his caregivers.

While the work that the therapist does is beautifully sensitive and skillful in creating a space where Juan's history can be acknowledged and openly addressed, we would like to highlight the importance of ensuring that this process is one that is guided by the child's and the caregiver's emotional and developmental capacity. In accordance with CPP fidelity, following a feedback session where the caregivers and therapists discussed what was learned during the assessment phase and planned treatment, the therapist introduced Juan to CPP. In this introductory session, the therapist and caregiver acknowledged the child's history of trauma, explained that what happened to him is related to the child's current feelings and behavior, and talked about treatment as being a place where the child can talk or play about what happened.

This introductory session is done as a way of opening the door to family communication about past traumatic experiences and allowing the family, at their own pace, to begin processing this history. The child's and caregiver's response during this session and subsequent sessions must guide the way treatment is conducted. During this session, the therapist learned that Juan had difficulty hearing her talk, play, and draw about his family history.

Given this avoidant response, which signifies that child's difficulty processing the intense emotional responses evoked by hearing a narrative of his traumatic experience, the therapist and caregiver need to respect the child's rhythm. Rather than reintroducing themes related to the trauma, they might observe Juan for cues that he is giving about his readiness to have his trauma addressed again. At first, he may need to simply play with his father in order to build relational safety. He may make brief forays into his history only to pull back and engage in play that is unrelated to what happened as a way of regulating the difficult emotions that these memories bring up.

Juan's difficulty engaging in symbolic play and talking about his past may be in part associated with his diagnosis of autism, but it is also important to remember that this is a challenge that many young children face. It is for this reason that in working with young children with or without disabilities, a dual focus on emotion regulation, including body-based regulation and processing of difficult traumatic experiences, always go hand in hand. The CPP therapist needs to remain aware of the child's developmental capacities and their role in shaping the modality and speed with which these experiences are processed.

WORKING AS PARTNERS WITH THE EARLY CHILDHOOD INTERVENTION SYSTEM

In reviewing the treatments of James and Juan, there are numerous examples of how the therapist connected the family to needed services and partnered with other service providers

around the family's complex needs. Coordination of care is a core CPP treatment goal and one that is significantly expanded in work with young children with disabilities. CPP therapists working with this population need to be aware of key pieces of legislation that affect service provision. They need to learn how to navigate complex early intervention systems, and they need to understand their potential role as members of an interdisciplinary team.

The Federal Developmental Disabilities Assistance and Bill of Rights Act defined a development disability in part as a severe chronic condition that may necessitate a combination and sequence of special, interdisciplinary services that are of extended or lifelong duration. For young children with developmental disabilities and their families those services are available through Early Intervention. The Early Intervention Program (EI) for Infants and Toddlers with Disabilities, or Part C of the Individuals with Disabilities Education Act (IDEA), was established by Congress in 1986 and reauthorized in 2004. This federal grant assists states in operating a collaborative and comprehensive statewide system of services, including educational and therapeutic supports, for children aged birth to three with established diagnoses or disabilities that are likely to result in a developmental delay (e.g. congenital rubella, spina bifida, autism, cerebrovascular accidents, Down Syndrome).

States have flexibility in defining the amount of delay required for eligibility and are encouraged but not required to serve children at increased risk for developmental delays due to environmental or caregiving circumstances (e.g., poverty, homelessness, parental age, parental illegal substance abuse, parental mental illness and child abuse). Currently only five states serve at-risk children (Gilkerson et al, 2013; National Early Childhood Technical Assistance Center, 2011; Jones, 2009).

Part C was created in response to an urgent need to: 1) enhance the development of infants and toddlers with disabilities; 2) minimize potential developmental delay, as well as the likelihood of institutionalization, and maximize independent living; 3) reduce educational costs to society by minimizing the need for special education through early intervention, and 4) enhance the capacity of families to meet their child's needs (National Early Childhood Technical Assistance Center, 2011; Wrightslaw, 2014; Jones, 2009). Early Intervention Program services are designed to identify and meet the child's developmental needs in five domains: physical, cognitive, communication, social-emotional and adaptive development. Services may include case management (service coordination), assistive technology, speech and language therapy, occupational therapy, physical therapy, special instruction, developmental monitoring, health-related services, family training, counseling, audiology, and social work services.

One crucial aspect of Part C is the requirement that Early Intervention Program services develop an Individualized Family Service Plan (IFSP). This plan, which is developed in collaboration with family members, guides the intervention process and contains information about the child, his or her family's strengths and needs, and the services required to facilitate the child's development and promote the family's capacity to support the child's progression. It acknowledges that families play an instrumental role in the optimal development of young

children, and it focuses on the family rather than on the child. Providers are expected to enhance and preserve the caregiver-child relationship by coaching and supporting the primary caregivers

rather than implementing one-on-one activities with the child (Hauser-Cram & Howell, 2003; Wrightslaw, 2014).

In considering how to best serve children with developmental disabilities who have also experienced maltreatment, the National Symposium on Abuse and Neglect of Children with Disabilities emphasized the need for collaboration across all service sectors to enhance service effectiveness. As they noted, “there’s no one professional group that has all the wisdom associated with this problem” (National Symposium on Abuse and Neglect of Children with Disabilities, 1995, p. 16). They highlighted the need for shared information and open communication across different service sectors, interdisciplinary teams that include experts on disabilities and child abuse, and integration of models from the varying service sectors.

Two types of legislation support interdisciplinary collaboration for children who have been maltreated: (a) the amendments to the Child Abuse Prevention and Treatment Act (CAPTA) of 2003 that are in the *Keeping Children and Families Safe Act* of 2003 (Pub. L. No. 108-136, 117 Stat. 800, 2003, signed into Public Law 111-320 on December 20, 2010); and (b) the IDEA 2004 reauthorization (Pub. L. No. 108-446, 118 Stat. 2647, 2004, [Final regulations issued in September of 2011]). This legislation requires state early intervention and child welfare systems to develop coordinated procedures to guarantee that all children under the age of three who are involved in substantiated incidents of neglect or abuse are referred to Part C services (Casanueva, Cross & Ringeisen, 2014; Cohen, Cole & Szrom, 2011; Osofsky & Lieberman, 2011; Zero to Three Policy Center, 2006; Jones, 2009). According to Gilkerson et al. (2013) these two pieces of federal legislation command states to develop trauma-informed Early Intervention Program services.

As members of an interdisciplinary team, CPP clinicians may play a key role in the development of trauma-informed services. Currently, most services provided to young children with developmental disabilities do not address caregivers’ and children’s psychological responses or needs (Gilkerson et al., 2013; Oppenheim et al., 2006; Wachtel & Carter, 2006). This focus is central to the work of the CPP therapist. The CPP therapist also has the capacity to engage in screening and dialogue with the families regarding any potential traumatic events that they may have experienced and can develop services with this history in mind.

Through consultation, CPP therapists may also be able to assist other providers in considering how trauma may be impacting the child and caregiver’s current functioning, their response to services, and their capacity for growth (Gilkerson et al., 2013). This may be especially important because although Early Intervention Program services providers are well trained on infant and toddler development, and offer specialized services in their area to address developmental disabilities and delays, they are not usually trained to consider or assess the impact of trauma on development and on relationships.

Juan

The CPP therapist’s interventions with James and Juan provide beautiful examples of creative and successful efforts at working across disciplines to meet the complex needs of children and families. In her therapy with Juan, the therapist worked collaboratively with the

occupational therapist to integrate non-verbal, body-based proprioceptive and vestibular affect regulation strategies into his treatment. She also integrated a focus on Juan's school functioning and helped his father understand the Individualized Education Plan (IEP) process and advocate for him so that he received appropriate educational services.

James

James' system of care included the therapist, the hospital social worker, home nurse care provider, cardiologist, neurologist, nutritionist, speech and language pathologist, occupational therapist, and child psychiatrist. The therapist and nurse worked collaboratively to enhance the mother's competence in managing James' complex medical needs, in reading his cues, and in directly caring for him. During the course of treatment, the therapist used her knowledge of the complex system of care to connect the family to key services including Social Security Disability Income; Women, Infants, and Children program (WIC); housing services; and early intervention services through the developmental disabilities system.

Moreover, as she worked with the family, she helped them to understand the role of the different service providers, to learn how to better communicate with them to address James' developmental needs, and to navigate the system of care. It may have been beyond the scope of the case studies article to detail specifically all the work done with the other service providers, but in our work with the Children's Hospital Los Angeles team, we have seen how therapists often work collaboratively with medical personnel, including hospital social workers, nurses, and doctors when possible. This work involves helping these personnel understand how ongoing medical procedures may serve to trigger the family and to think about ways to enhance the family's sense of safety and regulation around these experiences. Simple interactions like these that help other service providers think about how traumatic experiences may shape engagement with and response to services and providers that are key to developing trauma informed systems.

INTEGRATING A FOCUS ON CULTURE AND DIVERSITY

CPP has traditionally incorporated a focus on the family's ecological context and cultural beliefs and practices. In working with children with disabilities and their families, we extend this sociocultural lens to reflect on how the family understands and responds to the child's condition. Kapitanoff, Lutzer, and Bigelow's (2001) model of cultural influences on the relation of disabilities and child abuse may be particularly helpful even in families where there has been no maltreatment. Within this model, they identify cultural factors that may affect the ways parents interpret and respond to a child's disability including: 1) cultural beliefs regarding the illness and disability; 2) the meaning of the disability within the cultural setting; 3) the role and meaning of children in a particular culture; and 4) the specific type and degree of disability. They further posit that the parents' response may be shaped by personal and cultural beliefs about appropriate child rearing behavior; cultural appropriateness of interventions, and alternate cultural interventions; acculturation; and family resources and stress.

Throughout the treatments of James and Juan we see numerous examples of how the therapist integrated a sociocultural perspective into the work. She begins with a comprehensive assessment that incorporates a focus on the ecological context and allows her to gather

information to answer the following questions offered by Lewis and Ghosh Ippen (2004) to guide the CPP therapist's assessment of the sociocultural context: 1) Where did the family come from? 2) How did they get here? 3) What is their environment like now? 4) How does their culture view and cope with the potentially traumatic event they have experienced? James and Juan's therapist incorporates measures, such as the Family Impact of Childhood Disability Scale (Trute & Hiebert-Murphy, 2002), which facilitates dialogue with the caregivers related to the way the parents see the child's disability as impacting their family.

As she conducts the trauma screening, she inquires about potentially traumatic experiences that may have occurred during the emigration process. Prior work with immigrants highlights the importance of evaluating trauma exposure at three critical stages: 1) pre-immigration; 2) during the journey to the new country; 3) and in the new setting (Perez Foster, 2001). While neither James' nor Juan's family members identified their emigration experience as dangerous or traumatic, dialogue regarding this experience likely led to conversations that helped the therapist better understand sources of stress related to immigration and acculturation.

James

James' parents are unauthorized immigrants. His father struggles to obtain stable employment, and his mother has difficulties understanding the United States' system of care for children with disabilities. As immigrants, both James' and Juan's families may not be aware of key legislation that protects their children and makes them eligible for services. The CPP therapist was in a position to share this information and help the family obtain needed services. As she did this, she also built upon and honored strengths in the family's community, including the family's connection with their pastor and church. Many families, like James' are able to reflect on the meaning of their child's illness with religious leaders. They receive much needed social support from their religious community, and they find hope and resolution through their connection with God.

SUMMARY

In November 1994, the National Symposium on Abuse and Neglect of Children with Disabilities convened. As we review their core recommendations, we see that CPP intersects particularly well with the needs of this population. They highlighted the need to: 1) base all prevention and intervention programs on best practices, including ongoing evaluation; 2) use an ecological approach to understanding, preventing, and reducing maltreatment; 3) increase the capacity of families to withstand stressors that contribute to the abuse and neglect of children; 4) collaborate across all professionals to increase effectiveness of services of children and families; and 5) train professionals on the multiple issues regarding children with disabilities who have been abused and neglected.

In this commentary we offered four key areas of clinical considerations for CPP therapists working with families of children with developmental disabilities: 1) the importance of addressing risks that present within the caregiver-child relationship, including caregivers' unresolved grief; 2) the potential for the caregiver or child's history of trauma to contribute to challenges in the child and caregiver's functioning; 3) the importance of working as part of an

interdisciplinary team to coordinate care and better address the complex needs of families; and 4) the importance of applying a socio-cultural lens in every aspect of the work. The detailed descriptions of the treatments of James and Juan help us to see how these areas are interconnected.

In both the cases of James and Juan, Child-Parent Psychotherapy seemed to have helped the caregivers in: 1) making meaning of the children's disability; 2) increasing their competence in reading and responding to their children's cues and needs and supporting their developmental progression; 3) being able to identify and develop appropriate coping strategies to manage the feelings and thoughts evoked by their children's condition, and their own and the children's trauma triggers; 4) increasing their attunement and the possibility to take a protective role in the care of their children; and 5) developing a more realistic, positive and developmentally appropriate view of their children. All of the above seems to indicate that in these cases Child-Parent Psychotherapy was successful in strengthening the child-parent attachment, in preventing patterns that could negatively impact the parent and the child, and in setting the stage for acceptance and a resolution process.

The results of some of the instruments at the end of treatment (PSI, FICD) suggest that challenges remain in the children's and parents' functioning, and in the child-parent interactions (particularly in Juan's case). These findings seem to indicate the need of further therapeutic work to continue supporting the resolution process in each of these families. However, the profound value of the CPP therapist's intervention is that it took place at an early stage of the children's lives and at a time when their families were learning about the implications of the children's disabilities and were extremely vulnerable as a result of the intersection of the child and parents' trauma histories and the traumatic loss that the children's developmental disability represented for the families. CPP holds the promise of creating a restorative ripple effect in the lives of these families because of the evidence presented that the therapy increased the parental sense of competence and their reflective and protective abilities. As the author stated "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" (Harley, Williams, Zamora, & Lakatos, 2014, p. 189).

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