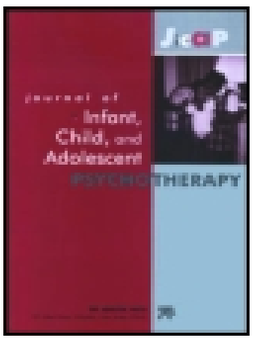

Routledge
Taylor & Francis Group

Journal of Infant, Child, and Adolescent Psychotherapy

ISSN: 1528-9168 (Print) 1940-9214 (Online) Journal homepage: https://www.tandfonline.com/loi/hicp20

The Family Cycle: An Activity to Enhance Parents' Mentalization in Children's Mental Health Treatment

Victoria Stob, Arietta Slade, Line Brotnow, Jean Adnopoz & Joseph Woolston

To cite this article: Victoria Stob, Arietta Slade, Line Brotnow, Jean Adnopoz & Joseph Woolston (2019): The Family Cycle: An Activity to Enhance Parents' Mentalization in Children's Mental Health Treatment, Journal of Infant, Child, and Adolescent Psychotherapy, DOI: 10.1080/15289168.2019.1591887

To link to this article: https://doi.org/10.1080/15289168.2019.1591887

Published online: 19 Apr 2019.

JOURNAL OF INFANT, CHILD, AND ADOLESCENT PSYCHOTHERAPY
https://doi.org/10.1080/15289168.2019.1591887

The Family Cycle: An Activity to Enhance Parents' Mentalization in Children's Mental Health Treatment

Victoria Stob, MA, LCSW, Arietta Slade, PhD, Line Brotnow, MSc, MA, Jean Adnopoz, MPH, and Joseph Woolston, MD

ABSTRACT

This article introduces the Family Cycle, a therapeutic activity informed by attachment theory, family systems theory, and current literature on reflective functioning. The Family Cycle helps clinicians and families create a narrative about a child's psychopathology that considers complex trauma and/or adverse childhood experiences. It reframes observable dysfunctional phenomena as behavioral sequelae of more deeply rooted emotional loss. After the theoretical underpinnings of the Family Cycle are laid out, we describe the implementation of the Family Cycle within the context of an intensive home-based, family-focused intervention created at the Yale Child Study Center, the Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS). The Family Cycle provides a teachable clinical framework to facilitate the treatment of families with complex, multigenerational trauma.

At the beginning and at the center of a child's early experiences is their relationship with their primary caregiver. This assertion underpins the whole of attachment and family systems theories, which posit children's relational environments will play a critical role in their psychosocial development. Many children with mental health needs come from families with high levels of stress and trauma (Bradley & Corwyn, 2002; Cook et al., 2017; Turner & Lloyd, 1995; Verhulst & Van der Ende, 1997), with the exact causal links between them likely intricate. Recent empirical findings have highlighted the multigenerational, nested nature of childhood trauma and psychopathology, identifying connections between parents' own childhood experiences and parenting practices that in turn affect children's wellbeing (Lyons-Ruth & Jacobvitz, 2016). A greater risk seems to be conferred onto

CONTACT Victoria Stob victoria.stob@yale.edu Yale Child Study Center In-Home Programs, 98 York Street, New Haven, CT.

Color versions of one or more of the figures in the article can be found online at www.tandfonline.com/hicp.

Victoria Stob, MA, LCSW is a Clinical Instructor of Social Work at the Yale Child Study Center. She developed the Family Cycle over her 8 years of experience as a Clinician in the Intensive In-Home Child and Adolescent Services program (IICAPS). She specializes in integrating social-science-based research and theory into practicable clinical applications for high-risk children and families living in multi-generational adversity.

Arietta Slade, Ph.D. is Professor of Child Clinical Psychology at the Yale Child Study Center, and one of the founders and directors of *Minding the Baby (r),* an intensive, interdisciplinary mentalization-based home visiting program for young families that has been replicated in the US, the UK, and Denmark. Dr. Slade's work has for many years focused on the impact of attachment, mentalization and trauma on clinical practice.

Line Brotnow is a licensed clinical psychologist in outpatient practice with children and adolescents in Oslo, Norway. She is an associated researcher working with IICAPS at the Yale Child Study Center.

Jean Adnopoz, MPH, is a Professor of Clinical Social Work in the Yale Child Study Center, where she is Director of In-Home Clinical Services and a co-developer of Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS). Adnopoz has a particular interest in exploring the ways in which parental perceptions and the ability to mentalize mediate the effect of the intergenerational adversity with which the children and families referred for home-based treatments struggle.

Dr. Joseph Woolston is the Albert J. Solnit Professor of Child Psychiatry and Pediatrics at Yale University School of Medicine. He is the Vice-Chair for Clinical Affairs for the Child Study Center. He is a co-developer of Intensive In-home Child and Adolescent Psychiatric Services (IICAPS). Dr. Woolston has focused his career on creating, implementing and improving clinical programs designed to treat children and families who are living in significant psychosocial adversity.

those children of traumatized parents who experience childhood trauma of their own (Cook et al., 2017; Lyons-Ruth, Yellin, Melnick, & Atwood, 2005).

Given the nested nature of childhood psychopathology and the complex cycles that link the minds and experience of parent and child, clinicians working both within the framework of mentalization-based interventions (Asen & Fonagy, 2012; Bateman & Fonagy, 2009; Ensink et al., 2013; Fearon et al., 2006; Midgley, Ensink, Lindqvist, Malberg, & Muller, 2017) and family-based narrative therapy (White, White, Wijaya, & Epston, 1990; Winslade & Monk, 2001, 2008) have recognized the value of illuminating the multiple layers of impact and influence within families, and addressing the powerful effect of reframing nonmentalizing cycles of interaction so as to shift and transform them (Fearon et al., 2006). This is accomplished by mentalizing or narrating thoughts, feelings, and perceptions and addressing their impact on both the parent and child.

In this article, we introduce the Family Cycle, a therapeutic activity that can be used to address cycles of nonmentalizing interactions between parents and children by illuminating for both parent and child the feelings and beliefs underneath their own and other family members' behaviors. Grounded in attachment theory, family systems theory, and current literature on mentalization and reflective functioning,[1] the Family Cycle is a clinical tool aimed at increasing mentalizing in high-stress families living in multigenerational adversity. The Family Cycle can be completed with a child, a parent, or both child and parent together. In this article, we describe the implementation of the Family Cycle within the context of an intensive home-based, family-focused intervention created at the Yale Child Study Center, the Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS) (Woolston, Adnopoz, Berkowitz, & Berkowitz, 2007). This program is delivered primarily to children struggling with severe emotional disturbance and their families. As will be described more fully below, IICAPS is aimed at meeting the multiple, complex needs of very disrupted families with histories of considerable adversity, at the level of the child, the parents, and the wider community. Importantly, although here we describe the use of the Family Cycle only within the framework of the IICAPS program, we believe it has the potential for broader implementation in a range of other settings.

Theoretical underpinnings of the family cycle: Parental childhood trauma, parenting behaviors and child wellbeing

Since its first formulation, attachment theory has provided a model for understanding the importance of early childhood experiences and child-caregiver dynamics (Holmes & Slade, 2017). Early on, infants begin to recognize and anticipate caregivers' responses to their distress and ability to regulate it, and infants begin to adapt their behavior accordingly (Ainsworth, Blehar, Waters, & Wall, 1978; Sroufe, 1988; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). Experiences of loss, intimidation, and separation in early childhood impact internal representations of self and other, informed by the way the caregiver responds to a child seeking comfort, protection, and emotional support in times of need (Bowlby, 1969, 1973, 1980).

Beyond early childhood, attachment style and relational disruptions have been found to predict adolescent psychological development and impact both adult intimate relationships and parenting practices (Bowlby & Ainsworth, 1951; Fraiberg, Adelson, & Shapiro, 1975; Fearon, Bakermans-Kranenburg, van Ijzendoorn, Lapsley, & Roisman, 2010; Grossmann, Grossman, & Waters, 2005; Slade, 2014; Steel, Steel, & Fonagy, 1996). Adults who have been victims of multiple or prolonged childhood trauma have complex and varied symptom presentations in adulthood, including affective dysregulation, negative self-concept, and interpersonal problems (Banyard, Williams, & Siegel, 2003; Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Cohen, Hien, & Batchelder, 2008; Courtois, 2004; van der Kolk, 2014; van der Kolk et al., 1996). Maternal childhood trauma has been associated with depression and substance abuse, both of which are associated with parenting behaviors such as punitiveness, psychological aggression, neglect, and physically aggressive discipline (Cohn, Campbell, Matias, & Hopkins, 1990; Banyard et al., 2003; Banyard, 1997; Gara, Allen, Herzog, & Woolfolk, 2000).

Highlighting the pathogenic multigenerational nature of such exposure, one longitudinal study found children whose mothers experienced childhood abuse were at more than 1.5 times greater risk of high depressive symptoms and nearly 2.5 times greater risk of persistent high depressive symptoms than children of women who did not experience abuse (Roberts et al., 2015).

Over and above mere exposure to traumatic events, it seems parents who have been unable to integrate the painful feelings associated with their own childhood adversity (described as "Unresolved" by Main & Hesse, or "Hostile/helpless" by Lyons-Ruth et al., 2005) are more likely to exhibit intrusive or insensitive parenting, which in turn predicts infant attachment disorganization (Lyons-Ruth, Bronfman, & Atwood, 1999; Lyons-Ruth et al., 2005; Madigan et al., 2006). Of relevance in this context is the finding that maternal adverse childhood experiences are intimately linked to deficits in mentalizing and reflective functioning capacity, that is, the attribution of feelings, needs, desires, and beliefs to a child's behavior (Bateman & Fonagy, 2010). In short, parental childhood trauma affects the ability to imagine the emotional and mental experience of the other.

A parent's capacity to mentalize—namely, to envision thoughts and feelings underlying their own or another's behavior—is essential to fostering a child's ability to develop emotion regulation, especially regarding painful or distressed emotional states (Fonagy, Gergely, Jurist, & Target, 2002; Grienenberger, Kelly, & Slade, 2005; Slade, 2005; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). Conversely, low reflective functioning capacity in mothers has been associated with disrupted parenting and infant disorganized attachment (Grienenberger et al., 2005), and children's development of anxiety disorders, poor affect regulation, and externalizing behaviors (Camoirano, 2017). The absence of mentalizing capacity is often referred to as "prementalizing" (Bateman & Fonagy, 2012; Fonagy & Luyten, 2009); the predilection within dyads (parent-child, partners, etc.) to respond to and try to change others' behaviors without considering the mental states that underlie them results in what Fearon et al. (2006) have referred to as cycles of nonmentalizing interactions. The more a parent lacks the capacity to imagine the mind of the child (Slade, 2002), the more likely such cycles will occur.

Adversity in the context of a disorganized attachment style is synergistically more pathogenic than in context of a secure attachment (Bergman, Sarkar, Glover, & O'Connor, 2010; Garg et al., 2018). In a compounded fashion, children who grow up with caregivers who themselves have had disorganized and traumatic attachments are simultaneously more likely to be exposed to adverse experiences and less likely to be cared for in a sensitive and predictable manner, both of which increase the likelihood of developing a disorganized attachment to the caregiver (Lyons-Ruth et al., 2005). Despite these well-elucidated links between attachment and adjustment, it remains difficult to identify and describe this psychopathological cycle at work in the context of a clinical intervention (Holmes & Slade, 2017).

Several prominent practitioners and researchers in the field of child psychopathology have stressed the need for a nosographic entity that specifically includes the psychological impact of repeated and prolonged interpersonal trauma within the context of inadequate caregiving systems (Cloitre et al., 2009; Cook et al., 2017; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; van der Kolk, 2017); typically, such phenomena are described as complex trauma, attachment trauma disorder, or developmental trauma disorder. The cycle which proceeds from a parent's exposure to early trauma, expressed as disrupted attachment or otherwise, is predictive of multigenerational pervasive dysregulation and interpersonal dysfunction (van der Kolk et al., 2005), the behavioral sequelae of which typically appear across diagnostic categories (anxiety, mood, and disruptive behavioral diagnoses). For both parent and child, these symptoms tend to persist throughout adolescence and into adulthood and are associated with an array of psychiatric and addictive disorders, chronic medical illness, legal problems, vocational challenges, and family issues (Anda et al., 2006; Dong et al., 2004; Putnam, Harris, & Putnam, 2013; Pynoos et al., 2008; Spinazzola et al., 2005; van der Kolk et al., 2005). The Family Cycle is used to help families identify and address these complex traumatic experiences and subsequent relational dynamics in the context of a family-based intervention. In the sections that follow, we begin with a description of the IICAPS intervention and

then describe the basic framework of the Family Cycle, guidelines for administration, and case material that exemplifies its clinical utility.

Context for the development of the family cycle: The IICAPS program

The Family Cycle was designed within the context of the Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS), a home-based, family-focused intervention created at the Yale Child Study Center (see Woolston et al., 2007). The IICAPS intervention was designed to address the needs of families when outpatient treatment has been ineffective due to difficulties with engagement and retention or deemed inappropriate due to clinical severity. Oftentimes the program is offered as a step down following hospitalization or to avoid hospitalization.

The IICAPS intervention is highly intensive, lasting six months,[2] and delivered to families in which the identified child is between 4 and 18 years of age. Services are provided by a two-person team of clinicians. One clinician is designated as the parent therapist and the other as the child therapist. Over the course of each week, the clinicians meet with the family three times: the parent clinician meets with parent(s), the child clinician meets with the identified child individually, and finally both therapists meet with the entire family.[3] It is delivered primarily to Medicaid-eligible families residing in Connecticut. All child recipients of IICAPS are required to meet the federal definition for serious emotional disturbance, which precludes a primary psychiatric disorder of developmental delays or substance use disorder. Given the high degree of acuity in IICAPS cases, a crisis/safety plan is created within the first week of treatment that involves child and family input. Over the course of the six-month intervention, the need for additional supportive services are discussed and referrals are made by the clinical team. To date, 13,269 families have completed treatment in the IICAPS program since 2009.

Most of the families seen in IICAPS are struggling with the sequelae of significant trauma. According to data collected from 6,723 families seen in the IICAPS program over the past five years, *parental* responses to the Adverse Childhood Experiences (ACE) questionnaire (see Felitti et al., 1998) indicate levels of trauma exposure exceeding those observed within both community samples and high-risk clinical populations. Results from the original ACE study (Anda et al., 1999, 2001, 2002; Dube, Anda, Felitti, Edwards, & Croft, 2002; Hillis, Anda, Felitti, Nordenberg, & Marchbanks, 2000) indicated having four or more adverse childhood events (sexual abuse, physical abuse, neglect, family dysfunction, mentally ill family member, etc.) is associated with high risk for a host of negative health outcomes, ranging from teenage pregnancy, heart disease, alcoholism, suicide, and diabetes. Exactly half of all biological IICAPS parents reported four or more ACEs, a rate that situates that population far afield of the norm (e.g., 12.5% per the Centers for Disease Control and Prevention, Kaiser Permanente, 2016), and closer to convicted male offenders (48.3%) (Reavis, Looman, Franco, & Rojas, 2013); homeless mothers (44.2%) (Narayan, Kalstabakken, Labella, Nerenber, Monn & Masten, 2017); and high-risk 18-year-old juvenile detainees (49.6%) (Baglivio et al., 2014). Despite these findings, at the time of the intervention only 15% of the primary caregivers report an independent need for mental health services.

Given this high degree of parental early adversity, it is perhaps unsurprising that, in 2016, 65% of *youth* participating in IICAPS were reported to have a history of one or more traumatic experiences. This included 30% witnessing violence, 13% being a victim of violence, 12% sexual victimization, and 24% disrupted attachment (e.g., foster care placement or abandonment). In addition to these experiences, most children in IICAPS faced chronic stressors, including parental mental illness, high levels of family conflict, parental substance use, poverty, homelessness, physical and emotional neglect, and parental divorce, separation, or incarceration. The emotional impact of these experiences is difficult to capture diagnostically. As seen in other high-risk clinical populations, children in IICAPS have high rates of comorbidity: more than 65% of children meet criteria for two or more diagnoses. Further underscoring the diagnostic complexity of this group,

64% of children referred are diagnosed with an internalizing disorder, 57% with an externalizing disorder, and more than 28% with both.

The high rates of early childhood trauma and psychopathology amongst IICAPS parents and children suggest both parties' experiences can be contextualized within the framework of developmental trauma. What this means concretely is these families are difficult to engage in treatment and often live in challenging, chaotic, and threatening environments (both within the family and the community). It also means most family members likely have trouble trusting and relating to clinicians. Such families face multiple barriers to successful engagement in services (Tolan & McKay, 1996), as the sequelae of complex trauma disorder lead them to disengage from treatment, deny the problem (Headman & Cornille, 2008), or (often for legitimate reasons) distrust the mental health system (Whaley, 2001).

Children and adults with complex trauma histories need help making sense of their internal and relational experiences. We developed the Family Cycle to render this interconnectedness explicit by weaving together the external and the internal, identifying and placing feelings, thoughts, behaviors, and experiences into a coherent, mentalized narrative. It also puts the child's experience within the broader context of family processes, particularly their parents' own challenges and difficulties.

The family cycle: Fostering mentalization through a semi-structured clinical activity

Overview

The Family Cycle, whether completed by a child, parent(s), or the family, begins with a pen and a piece of paper, preferably a large piece of paper that will allow ample room for the clinician to add text. This activity is a *visual* activity, in that the connections the child or parent makes are mapped out in a way they can *see*; this has the advantage of concretizing the connections and making them real. This activity is also an exercise in co-construction, with the clinician asking questions, the parent or child responding, the clinician picking up the thread, and so on. Finally, the activity draws on materials collected in earlier sessions and can itself take many sessions to complete. Its aim is to provide a structure and meaning to experience. While there are few differences between the way the Family Cycle is conducted with children and adults, in this article we focus primarily on administration with children and then with families.

Administration

The clinician begins the activity by drawing a circle and then, as the activity proceeds, adding five more circles to form a closed circle. As the template in Figure 1 indicates, each of the five circles has a specific area of exploration and is linked to the other circles causally. These labels typically are not shared with families but serve only as guides for clinicians. The clinician draws one circle to begin. Typically, the clinician begins with the circle we refer to as Unacknowledged Loss.

The six circles

1. *Unacknowledged loss*

This circle is often the best place for the child to begin to put words to the compounded impact of developmental trauma in the context of a problematic parental relationship. Questions that assist the clinician in eliciting the Unacknowledged Loss can include: How would you describe your biggest hurt from the past? What did you feel like was missing in your relationships? How would you describe your childhood in one phrase? There are multiple dimensions to Loss. It can include an unmet basic physical need, an unmet need for safety and security, the lack of a sense of belonging and acceptance, or an unfulfilled expectation of a caregiver. The word Loss was chosen to represent

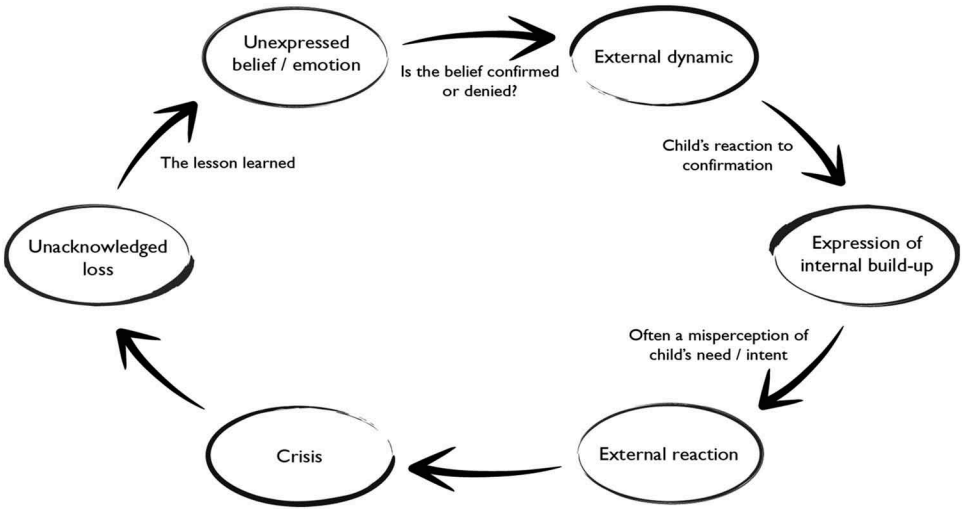

Figure 1. The model of the family cycle.

a series of events, an absence, or a missing relational dynamic that a child had and lost or became aware he or she should have had. Painful events to consider can include exposure to domestic violence, community violence, early childhood trauma, medical trauma, neglect, physical abuse, refugee trauma, immigration trauma, and school violence. This circle can also be used to capture feelings that one experiences due to social stigma or alienation, occasioned by identifying as lesbian, gay, bisexual, transgender, or queer; experiencing racism; feeling isolated in a family due to racial difference or having a different mother/father from siblings; being adopted; having a developmental delay; being on the autism spectrum; and so on. Additionally, this can articulate the emotional impact of experiences related to attachment disruptions, such as being removed from one's biological mother/father, placement in the foster care system, parental incarceration, experiencing the death or illness of an attachment figure, parental mental illness or disability, or divorce/separation.

When considering these factual events, it is imperative for the clinician to consider the meaning that has been made of these events and the child's perception of why the events were never explained, processed, or reflected upon. The word Unacknowledged refers to what keeps this Loss unspoken — the absence of emotional intimacy, the child's desire to protect their parent, the child's sense of insecurity or being physically threatened, mistrust around being made vulnerable, and/or the anticipation of rejection or an invalidating response. The clinician should assist the child in finding a phrase that represents the injury the child bears alone. The wording in the circle can be relatively nonspecific (e.g., "sad fragments"), but it is important to name the events and actions that can be concretely identified as potential sources of the sad fragments while doing the activity, for example, "watching mom and dad hurt each other," "getting taken away by the police," or "feeling lonely in a foster home." The goal for this circle is for the parent to be able to acknowledge for the first time that the painful experiences the child identifies did, in fact, happen, and emotionally affected her or him. By doing so, there is no longer silence surrounding these experiences and the unfulfilled expectation is acknowledged.

When given the opportunity, children can be poetic in their characterizations of their childhoods. One child used the phrase "missing pieces" to capture disrupted attachment. Another child said, "I lost my voice" to capture the silence that surrounded her experience of sexual abuse. Another child described his experience of domestic violence as "nothing was safe." One child characterized his childhood as "you never know what you're gonna get," referencing his mother's mood lability.

2. *Unexpressed emotion/belief*

The Unexpressed Belief is the internalization of the Unacknowledged Loss. Sometimes the two may seem the same to the outsider, but to the child the Unacknowledged Loss is happening to her or him, and the Unexpressed Belief is how what has happened/is happening is incorporated into the child's sense of self (see "internal working model of attachment" described by Bowlby, 1969). Often these early life experiences influence a child's sense of self-worth. Questions that assist the clinician in eliciting the Unexpressed belief can include: How did that make you feel, or what did that make you believe, about yourself? This circle presents an opportunity for the clinician to assist the child in the process of turning an *implicit* emotional experience or belief into an *explicit* expression. It is a chance for the therapist to challenge superficial judgments based on appearances. At the outset of therapy, parents may claim their child never thinks about adverse experiences, is unaware of them, or doesn't remember them just because they never speak about them. The child's verbalization of the Unexpressed Belief emphasizes how memories of loss experiences are triggered by cues encountered in daily life. If the unexpressed belief is too sophisticated for a child to verbalize, it can also be captured in unexpressed emotions such as anxiety, sadness, loneliness, hopelessness, or helplessness.

Examples of a child's Unexpressed Beliefs can include:

(1) "I'm not safe."
(2) "It's my fault."
(3) "I'm disgusting."
(4) "I'm unlovable."
(5) "I might disappear."
(6) "I'm alone in the world."
(7) "I need to take care of myself."
(8) "I hate myself."
(9) "Feelings are scary."
(10) "No one cares."

3. *External dynamic*

This circle represents the baseline in the home that is serving as an insidious confirmation of unexpressed negative beliefs/emotions that are explored in the circle preceding it. The clinician can ask, "what's going on in the home that makes that feeling worse or confirms that belief?" to begin to brainstorm what goes in this circle. At this point, the clinician can make observations about what he or she has observed in the family dynamic. Much can be captured in this circle, so it is important for the clinician to consider which dynamic to bring to the therapeutic surface for discussion. Is the home environment chaotic, with lots of children, friends, and extended family in and out? This may confirm for a child he or she is invisible because no one pays attention to the child. Does everyone in the home seem to have separate lives and spend very little time together? This may confirm for a child he or she is unlovable because no one has made the time to listen to the child. Is there ongoing arguing between parents that often becomes violent? This may confirm for a child he or she is to blame because the child cannot prevent the conflict. Is the child being told he or she is overweight and lazy? This may confirm the child is disgusting because he or she is frequently criticized. When the External Dynamic confirms the Unexpressed Belief, it leads to an internal build-up of negative emotions that cannot be communicated and so are, instead, behaviorally expressed.

4. *Expression of internal build-up*

This circle represents the behavioral expression/manifestation of the Unexpressed Belief and is frequently the explicit reason for referral. Clinicians can think of this as the client's internalizing or

externalizing behavior. They might also think of this circle as the child's defense against potentially overwhelming negative affect. Questions to ask to begin to capture what goes in this circle can include: How did you feel, and what did you do with those feelings when they would build up, or when that belief was confirmed? This circle is often the most obvious to the clinician as it is often the reason for referral.

This circle can contain examples of internalizing behaviour, such as depression, isolation, social withdrawal, somatic complaints, irritability, insomnia or hypersomnia, self-injury, avoidance, fantasy, delusional thinking, dissociation, denial, disordered eating, excessive masturbation, and so on. It may also include examples of externalizing behaviour, such as acting out, disruptive, hyperactive, oppositional, or destructive behavior, aggression, temper tantrums, head-banging, delinquency, impulsivity, poor boundaries, substance use, sexual acting out, negative attention-seeking, and so on. Most children in IICAPS have behaviors that cut across these diagnostic categories, and the family is asked to define the most distressing, concerning, or disruptive behaviors.

While this is often the most obvious circle to families, it is for that reason it is not recommended as the starting point for the activity: this circle represents an opportunity to reinterpret intolerable *behavior* in the context of intolerable *emotional pain*. It is also useful for families to conceptualize this behavior as a Build-up of the Unexpressed Belief that is being triggered by the family dynamic and can be mediated. It is sometimes helpful to draw a line across this circle, separating it in two. Working together, clinicians and families can note the emotional description of the Build-up in one half of the circle. In the other half, they can name and discuss the internalizing/externalizing expression of the behavior. This process helps families understand they are one and the same (i.e., anxiety as acting out, or sadness as isolation).

5. *External reaction*

On the surface, this circle captures the ways the caregiver tends to respond to the child's behavior. The clinician can ask the child, how do your parents respond to your build-up/this behavior? Followed by, where do they think your behavior is coming from? More fundamentally, however, it initiates a conversation about how the caregiver understands the child's behavior. It captures how the parents responds to the child's behavior when they don't contextualize the behavior as a response to trauma/loss, that is, when they fail to mentalize. When they are prone to prementalizing, parents may think of the behavior as deliberate, antagonizing, or just bad, whereas the Unexpressed Belief and the Build-up circles have demonstrated that it is a reaction to negative internal representations. This is the point in the narration when parents may recognize their misperception of behavior. When addressed and processed in conjunction with the circles adjoining it, the External Reaction circle in The Family Cycle can begin to assist parents in shifting to an alternative/explicit, less reactive, and more mentalized conceptualization of their child's behavior. By providing an empathic

Table 1. Common examples of non-mentalizing.

Clinician observation	External Reaction
Parent focus on child's behaviors or diagnosis, without reflection on feelings	*Caregiver: Says I'm bad, lazy, manipulative, greedy, sick, etc.; Puts me down; Picks on me;*
Parent denies child's feelings (preoccupation with "should" or "should nots")	*Caregiver: Denies my feelings; Thinks I'm fine; Tells me it's a phase; Takes no responsibility; Lectures; Talks at me; Blames outsiders;*
Underreactions to child's feelings	*Caregiver: Is hands-off; Disengaged; Can't talk about it, is easy on me; No one cares; No one notices; Changes the subject; Avoids me; Shuts down; Leaves;*
Parent distorts child's feelings	*Caregiver: Takes it personally; Say's I'm taunting him; Pretends everything's okay; Expects the worst; Says I'm doing it for attention;*
Overidentification with child's feelings	*Caregiver: Mirrors my mood; Matches me; Engages and agrees; Assumes he understands;*

contextual narrative for the behavior, the Family Cycle can help a parent to reinterpret its meaning. Some of the most common examples of nonmentalizing as well as sample phrasing for the Family Cycle are included in Table 1.

The invalidation experienced with these types of reactions, especially when it becomes a chronic response, will send a child into Crisis.

6. *Crisis*

This circle captures the circumstances that put the child at risk for hospitalization, juvenile detention, or out-of-home placement. The clinician can ask, what happens when your parents react that way? What gets you into the hospital? What happens if this (pointing to the Build-Up and the External Reaction) keeps happening over and over? Again, *Crisis* can be broken down into the subcategories of internalized crisis and externalized crisis and is a natural extension of the Internal Build-up. Examples of externalized crisis can include out-of-control behavior, suicide attempts, homicidal thoughts, being arrested, unsafe behavior, risky behavior, overdose, running away, sexual acting out or sexual aggression, self-destructive behavior, and so on. Internalized crises include suicidal thoughts/gestures, school refusal, excessive weight loss, and so on. The idea is to emphasize that children rarely go into Crisis on their own; in fact, crisis is the product of low self-esteem that is exacerbated by a longstanding dynamic and triggered by an acute sense of invalidation. The Family Cycle strings together these components to allow families to identify exactly how that process can take place.

Implementation of the family cycle

Prior to completing the Family Cycle, and over several sessions, clinicians complete a series of activities with family members that facilitate engagement, foster mentalization, and eventually inform the Family Cycle activity itself. Within the first several weeks of treatment the team of clinicians completes a genogram with parent and child that assists the family in recognizing and reflecting upon multigenerational dynamics and patterns. Following that, the parent and parent clinician complete the ACE inventory, often incorporating questions from the Adult Attachment Interview (George, Kaplan, & Main, 1984, 1985, 1996) and/or a timeline of the parent's life. This then provides the data for the parent clinician to assist the parents in completing their Family Cycle from when they were children, an activity that follows the same guidelines outlined here for children, the biggest difference being each circle is retrospective (i.e., based on when the parent was a child/adolescent). Once this is completed, the parent clinician often uses the Parent Development Interview (Slade et al., 2004) to segue the parent into thinking about the child.

From there the parent and parent clinician begin a draft of what the parent imagines might be the child's Family Cycle. Simultaneously, the child clinician uses a series of drawings and journaling activities (feeling body drawings, timeline, inside/outside collage) and questions from the Child Attachment Interview (Target, Fonagy, & Shmueli-Goetz, 2003) to gather information for the child's Family Cycle. In family sessions the child shares activities done in individual session as they are completed, provided the child gives consent. With this foundation laid, the Family Cycle is then presented by the child during a family session, ideally at 10–15 weeks into treatment.

For the Family Cycle session with the family, which follows administration with both child and parent separately, the clinicians bring construction paper and have the child cut out circles while the activity is reintroduced. The clinician begins by explaining the first circle alternatively called "Loss" or "Pain" from the past and directing the child to choose a phrase that describes his or her experiences. The child has been prepared to describe why he or she has chosen this phrase and what it means to them. The clinician then introduces the next circle called "Belief" and describes it as the lesson learned from the painful experience or how that experience made the child feel about themselves. This will have already been determined and discussed in the child's individual session, making it easier for the child to identify and discuss with their parent. Once this circle is complete

the clinician then introduces the circle called the "Dynamic," or more simply, what's happening at home that confirms the belief or makes the belief worse. The next circle is called the "Build-Up" and is described by the clinician as what happens when the first three circles build up inside of the child. This circle is followed by what the clinician calls the "Reaction" and is described by the clinician as how the parent reacts, often without understanding the "Build-Up" came from the first three circles. The child is then asked to describe his or her "Crisis" and make connections between how what's happening outside and inside of the child contributes. The child is then asked to reflect on how the "Crisis" leads to more "Loss," thereby completing the circle.

The clinician then narrates the entire cycle, connecting each circle for the family to hear and process. The final verbal narration of each circle and how they connect is a crucial piece of creating the Family Cycle. The clinician must understand how each circle is connected to help construct a cohesive story. A clinician's ability to mentalize the child's experience, thereby imagining the point of view and emotional state of the child, is essential. The connections should be made in the child's words and language to ensure understanding. The narration assists the family in bringing it all together, reflecting on links between inner and outer, feeling and behavior, across a complex web of family relationships. Once completed, the child's Family Cycle is revisited multiple times over the course of treatment and used to identify treatment goals, highlight progress, and identify ways to shift the relational dynamics. Ultimately, the Family Cycle is meant to help parents and children begin to mentalize, give voice, or narrate the emotional circumstances and behavioral sequelae of their family's immediate crisis and long-term disruption. The activity serves the purpose of concretizing their experience, and scaffolds the conversations necessary to enlist a fuller and deeper engagement in treatment.

When working with high acuity behaviors, it can be tempting for clinicians and family members to spend most of their time together problem-solving the crisis-of-the-moment instead of looking at the larger picture. The Family Cycle activity is meant to encourage a stepping-back from the crisis, helping everyone take a mentalizing stance (Bateman & Fonagy, 2010; Slade, 2005, 2009). It should be completed with the parent and child after safety is established and a secure working alliance is in place. The activity should be administered in a phase-based fashion with substantial build-up to each circle. For the clinician, the activity is useful to generate clinical hypotheses that are likely to change as the therapeutic relationship builds and new information is gathered. When creating a hypothesis, it is important for clinicians to recognize that while there is no right or wrong frame, specificity in language and use of a child's words or terminology will get the clinician closer to the child's experience. As clinicians develop their hypotheses of what each circle means for a child, the circles left blank can point them in the direction of where to gather more information. Once clinicians have developed an initial conceptualization, they can begin the therapeutic process of co-creating the Family Cycle with the family. The clinician facilitates this process by referencing parent and child insights from previous sessions in addition to using the prompt questions for each circle.

Using the Unacknowledged Loss circle as a departure point is ideal because it allows the child to articulate what he or she sees as the source of pain. Given the frequently implicit nature of this emotional experience, identifying the contents of this circle requires an attentive clinician and considerable preparation in individual child sessions. Working through the circle, Unacknowledged Loss provides the context for the child's "Unexpressed belief." The conversation that families are guided through in relation to this circle allows a clinician to hypothesize aloud with the family how memories or internalized messages related to the Unacknowledged Loss may have shaped the child's internal beliefs, fears, urges, and shame. The External Dynamic and External Reaction circles provide a visual representation of how the past is repeated/reinforced in the present. The Expression of Internal Build-up and Crisis circles are opportunities to reinterpret what is often perceived as "bad" or "disruptive" behavior as words or actions that are rooted in pain, hurt, loss, and anxiety. The narration process with the family underscores the need for a tentatively outlined hypothesis by the clinician. Using a hypothesis, clinicians can practice narrating and linking together the circles of a child's family cycle in

language that is accessible to the family, thus capturing oft-recurring patterns that have been repeated with varying degrees of intensity but rarely connected and discussed. The case study below outlines the use of the Family Cycle in a family session and the various prompts used to facilitate reflection and processing as the circles connect.

Case study

Dwayne

Dwayne, an 8-year-old African American male living with his biological parents, was referred to IICAPS by the Department of Children and Families (DCF) due to suicidal statements in school. Dwayne came to IICAPS with a previous diagnosis of attention deficit hyperactivity disorder. He had a history of neglect, disrupted attachment, and sexual abuse in the foster care system. He had been exposed to domestic violence, verbal abuse/threatening, and maternal depression and had witnessed his mother's suicide attempt. His mother endorsed six ACEs: emotional abuse, sexual abuse, experiencing a mentally ill caregiver, parental substance use, parental separation, and witnessing domestic violence.

In Dwayne's individual sessions, the clinician used a series of drawing activities to engage him, build trust, and explore his perspective on his life and behavior. He struggled with his family portrait, initially just drawing himself and his sister, but later scribbling out his sister. He expressed ambivalence about his father's role in his life and anxiety about his mother's mental health. This information assisted the clinician in conceptualizing the Unacknowledged Loss and the External Dynamic. He was prompted by his clinician to draw his "Anger Monster," which he drew as a boy with red eyes and his mouth bound shut with a metal grate. Dwayne said that his "monster" didn't talk and had lasers for eyes. From there, the clinician could make observations about the similarities between Dwayne and his "monster" — that he was very observant and didn't express his anger/worry verbally. At the next session, the clinician had Dwayne draw a "Feelings body" of himself at school. In his body he drew his head full of fear/worry, his stomach and chest full of sadness, worry in his hands, and mixture of anger/worry in his feet. He described feeling distracted at school, often making disruptive noises with his pencil and walking out of class. Later he drew a "Feelings Body" of himself at home. He filled this body almost entirely with sadness and put worry in his head. This activity assisted the clinician in exploring how Dwayne expressed the build-up of his feelings facilitating the conceptualization of his Build-Up. Next, the clinician did an activity called "Agree/Disagree," which is a list of statements that the child can put an x or a check-mark next to. Dwayne agreed and disagreed with many items. Most poignantly, Dwayne agreed "I am to blame for the bad things that have happened to me." The clinician explored with Dwayne his associations with that statement and began to conceptualize his Unexpressed Belief.

This set the stage for the completion of his timeline and Family Cycle. The clinician used a timeline activity to explore Dwayne's thoughts and feelings about witnessing domestic violence, witnessing his mother's suicide attempt, and being removed by police and placed in a foster home. When he completed his timeline, he was asked to view it in its entirety and tell the clinician a few words that came to mind. This was used for his Unacknowledged Loss. The Family Cycle activity was explained to Dwayne as "putting all the pieces that we've been working on together." As the circles began to narrate the connections, Dwayne processed his fear of burdening his mother by talking to her about his feelings. He drew a line between the middle of the circle connecting "Blames himself" and "Mom is easy on me." He further explained that he worried if his mom became upset, she may try to hurt herself again, which would start his Family Cycle all over again. Dwayne said he had "mixed feelings" about sharing his Family Cycle with his Mom, but he would do it if his clinician was present and helped him explain. Simultaneously, the parent clinician had been completing a series of activities to prepare Dwayne's mom for hearing his Family Cycle.

In the family session, when asked to describe his early childhood, Dwayne said, "All I have are sad thoughts" and elaborated on several specific memories. Afterwards, his mother became tearful

and stated that she had no idea he still thought about those experiences. The clinician then chose to use this phrase as the Unacknowledged Loss. Dwayne stated that when he thought about the "sad thoughts" he "blames himself." "Blames himself" was the "unexpressed belief." When asked to describe his home life, he stacked markers on top of one another. He said one marker was his mom, one was his dad, one was his sister, and one was him. He then made a shaky motion and said that everyone kept "falling out." He went on to describe his father and sister both leaving the home for stretches of time without explanation, and his mother sleeping for most of the day. At the time of the session, his sister was in a residential treatment program, and his father had been gone for several weeks without contact.

The clinician gave him the definition of "instability", which he agreed was used to describe the External Dynamic. When asked what he did when under stress due to family instability and blaming himself, Dwayne said he "acted out" at school. He then described feeling anxious and preoccupied whenever he was away from home. This was used for the "Expression of the Internal Build-up." For External Reaction, Dwayne said, "mom is easy on me." This was an accurate depiction of what the clinician would have described as his mother's presentation being flat and disconnected. His mother's behavior made sense in the context of her childhood trauma. Dwayne said his mother's under-reaction made him feel like he didn't want to live. He explained that his school social worker had called this, "suicidal thoughts." "Suicidal thoughts" was used for Crisis.

Dwayne's Family Cycle helped him to organize and express his memories and connect them to his beliefs about himself, the feelings in his body, and how those feelings are expressed to those around him. In parent sessions, Dwayne's Family Cycle was used to highlight the importance of his mother's mental health and subsequent reactions in improving Dwayne's mental health. His mother began to understand her depressive symptoms and her disconnected presentation as her avoidance of all the "sad thoughts" she had experienced as a child and as an adult. The Family Cycle was a catalyst for Dwayne's mother to reflect on how she copes with her emotions affects her child. It began the conversation about her own mental health needs and facilitated a referral to treatment. It also changed her understanding of the function of Dwayne's "acting out," motivating her to provide more intentional warmth and positive attention. This enabled Dwayne to feel more secure and "act out" less (See Figure 2).

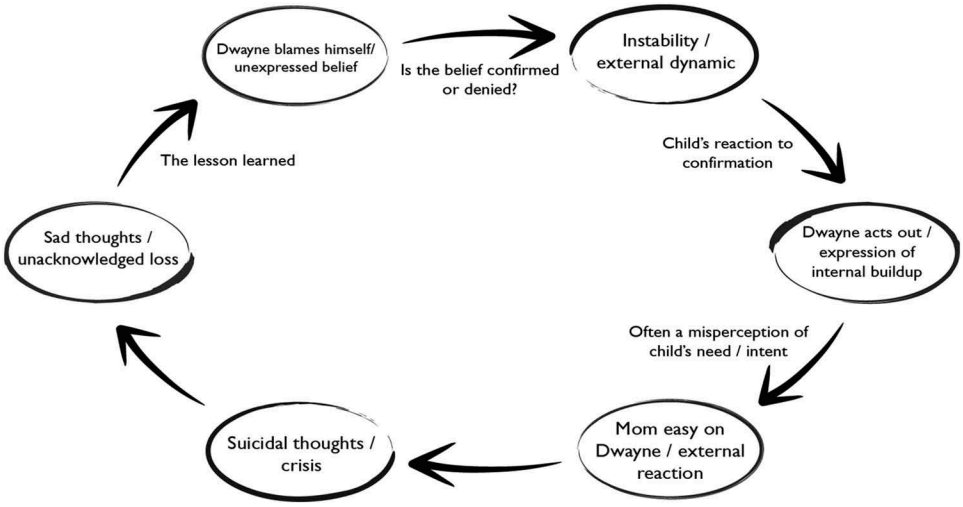

Figure 2. Dwayne's family cycle.

Discussion

Today, despite growing empirical support for both the relational nature of severe psychopathology and the utility of mentalization-based treatment in addressing a range of complex disorders, few theory-based assessment and treatment protocols have made their way into regular clinical practice in community-based family-focused interventions (Moffett, Brotnow, Patel, Adnopoz, & Woolston, 2018). As a result, there is a pressing need for the wider availability of clinical methods that can serve as concrete, teachable components for community-based interventions. We see the development of the Family Cycle as critical to progress in this domain.

The Family Cycle is based on the central tenet that children's and parents' psychological wellbeing or maladaptation are inextricably interconnected. Parents who have experienced childhood trauma themselves or who are struggling with their own mental health may become emotionally triggered and struggle with reactions such as withdrawal, anger, dissociation, projection and numbness in the face of children's difficulties. These parental reactions disrupt mentalizing and perpetuate a child's ongoing difficulties regulating their own emotions. As this pattern deepens and repeats, the likelihood of a family crisis increases. It is frequently in this context that children's symptoms surface and are identified as a target for psychiatric treatment.

By expressly identifying a child's thoughts and perceptions, the process of co-constructing the Family Cycle with the therapist appears to foster the reflective capacity of parents who struggle to adequately mentalize their children's inner worlds and who may not acknowledge the interconnectedness of their own mental health and that of their child. By providing a visual narrative of the child's interior and exterior worlds, the parent can imagine the child's mental state and respond to the child's pain in a regulated and validating way. Thus, not only is the mind and inner world of the child made into an object that can be thought about, but the Family Cycle also highlights the importance of the parent in the child's experience of the world. The child's experience of pain and loss is thus narrated, perhaps for the first time, within the context of the primary relationship to the caregiver. Fundamentally, the process of establishing the Family Cycle creates a shared language between the clinical team and family members that allows for the exploration of important experiences that have shaped both child and parent.

The IICAPs model allows a great deal of flexibility and creativity when engaging and retaining high-risk families in treatment. The adaptability of the location of service, structure of each session, and the intimacy of entering someone's home allow for a unique depth of relationship that fosters the creation of the Family Cycle. The fact that both parent and child have their own clinician who are working together as a team and come together in family sessions to support the work greatly enhances the potential depth of the Family Cycle Activity. Individual parent sessions and individual child sessions scaffold the family work and build up to the creation of Family Cycle together.

In the case vignette above, the Family Cycle was used to organize the clinicians' and families' work together to understand the family dynamic underlying child-related crises and to help both parents and children make meaning of their relationships. By design, the Family Cycle avoids the use of pathologizing language or labels, instead pursuing narrative connections. Once completed, the Family Cycle serves as a visual and symbolic representation that outlines child behavior through the lens of loss, painful feelings, and family interactions rather than mental illness, character deficits, or in-born traits. The Family Cycle also provides an opportunity to think about the intergenerational transmission of trauma, to consider the impact of parents' own attachment experiences and developmental trauma on both a child's behavior and the parent's reactions. Often, this activity constitutes "naming the elephant in the room" by acknowledging the sources of sadness and anger that are so pervasive and overwhelming that they have become invisible to a family. By visually connecting experiences of loss to a child's internalized beliefs and self-esteem, the Family Cycle provides an opportunity for parents to recognize and engage with their child's internal experience, quite literally, in their own words. The Family Cycle also allows children to reflect on, communicate, and experience their affect in an emotionally secure setting. For children, this begins the process of

uncovering the feelings, thoughts, and intentions behind their behaviors, opening alternative avenues to impulsively acting out their pain.

Limitations and future directions

The Family Cycle was developed in the context of an intensive home-based, family-focused intervention. To date, despite the pervasiveness of intensive home-based interventions, little research has been conducted to establish the empirical evidence base of these interventions or their constituent activities (Moffett et al., 2018). Given the complexity of the families referred, it is essential the clinician possess a great deal of grit, adaptability, and creativity to succeed with engaging this population. IICAPS is staffed primarily by clinicians in their first two years of practice who are supervised by a senior clinician. Frequently, the population is difficult to engage and unlikely to consistently attend outpatient therapy. IICAPS is intensive and puts clinicians in families' homes three times weekly, affording them unusual first-hand access to dynamics that families might not wish or think to describe in an outpatient setting. Although IICAPS clinicians' reports support the Family Cycle's effectiveness, further empirical study is needed, including studies of fidelity to the Family Cycle activity within IICAPS itself. The Family Cycle has been piloted at the Yale Child Study Center IICAPS for more than one year, and to date 136 families have completed the activity. At present, it remains to be seen how the Family Cycle can be effectively implemented in outpatient settings. While this article introduces the purpose, theoretical underpinnings, and construction of the Family Cycle, it is by no means a training manual. Building the clinical skills to form a hypothesis and elicit the Family Cycle in session may require additional training, practice, and clinical supervision.

Notwithstanding these shortcomings, the Family Cycle is a conceptually and theoretically supported attachment-based, trauma-informed activity that may assist in structuring and deepening therapeutic work with multigenerationally traumatized families. It is designed to augment child reflection and self-understanding as well as parent mentalization. It represents one of the first trainable activities to explicate the multigenerational developmental trauma and attachment disruption associated with community-based, family-focused interventions to be published for dissemination and scrutiny. As such, it represents a potential step forward not only for the field of family-orientated community interventions but also for the dynamic, attachment-based, trauma-informed treatment of childhood psychopathology.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes

1. These two terms are used interchangeably here.
2. While many families would obviously benefit from longer engagement, the program is designed to provide an intensive dose so that the identified client can move either to outpatient treatment, or into a residential setting. In rare instances, the treatment is extended, based on clinical need.
3. Given the nature of the population seen in IICAPS, meetings are often cancelled or missed, although every attempt is made to reschedule them in accord with the family's schedule.

ORCID

Victoria Stob http://orcid.org/0000-0002-8709-3785
Arietta Slade http://orcid.org/0000-0002-7100-8531
Line Brotnow http://orcid.org/0000-0003-4678-7606
Jean Adnopoz http://orcid.org/0000-0001-8126-6270
Joseph Woolston http://orcid.org/0000-0002-4067-2763

References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Anda, R. F., Croft, J. B., Felitti, V. J., Nordenberg, D., Giles, W. H., Williamson, D. F., & Giovino, G. A. (1999). Adverse childhood experiences and smoking during adolescence and adulthood. *JAMA*, *282*(17), 1652–1658.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174–186. doi:10.1007/s00406-005-0624-4

Anda, R. F., Felitti, V. J., Chapman, D. P., Croft, J. B., Williamson, D. F., Santelli, J., … Marks, J. S. (2001). Abused boys, battered mothers, and male involvement in teen pregnancy. *Pediatrics*, *107*(2), e19–e19.

Anda, R. F., Whitfield, C. L., Felitti, V. J., Chapman, D., Edwards, V. J., Dube, S. R., & Williamson, D. F. (2002). Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric Services*, *53*(8), 1001–1009. doi:10.1176/appi.ps.53.8.1001

Asen, E., & Fonagy, P. (2012). Mentalization-based therapeutic interventions for families. *Journal of Family Therapy*, *34*(4), 347–370. doi:10.1111/joft.2012.34.issue-4

Baglivio, M. T., Epps, N., Swartz, K., Sayedul, M., Sheer, A., & Hardt, N. S. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice*, *3*(2), 1–23.

Banyard, V. L. (1997). The impact of childhood sexual abuse and family functioning on four dimensions of women's later parenting. *Child Abuse and Neglect*, *21*, 1095–1107. doi:10.1016/S0145-2134(97)00068-9

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2003). The impact of complex trauma and depression on parenting: An exploration of mediating risk and protective factors. *Child Maltreatment*, *8*, 333–349. doi:10.1177/1077559503257106

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry*, *166*(12), 1355–1364. doi:10.1176/appi.ajp.2009.09040539

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry*, *9*(1), 11.

Bateman, A. W., & Fonagy, P. (Eds.). (2012). *Handbook of mentalizing in mental health practice*. Arlington, VA: American Psychiatric Publishing, Inc.

Bergman, K., Sarkar, P., Glover, V., & O'Connor, T. G. (2010). Maternal prenatal cortisol and infant cognitive development: Moderation by infant–Mother attachment. *Biological Psychiatry*, *67*(11), 1026–1032. doi:10.1016/j.biopsych.2010.01.002

Bowlby, J., & Ainsworth, M. D. S. (1951). *Maternal care and mental health* (Vol. 2). Geneva: World Health Organization.

Bowlby, J. (1969). *Attachment and loss: Volume 1. Attachment*. New York, NY: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Volume 2. Separation*. New York, NY: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Volume 3. Loss*. New York, NY: Basic Books.

Bradley, R. H., & Corwyn, R. F. (2002). Socioeconomic status and child development. *Annual Review of Psychology*, *53*, 371–399. doi:10.1146/annurev.psych.53.100901.135233

Camoirano, A. (2017). Mentalizing makes parenting work: A review about parental reflective functioning and clinical interventions to improve it. *Frontiers in Psychology*, *8*, 14. doi:10.3389/fpsyg.2017.00014

Centers for Disease Control and Prevention, Kaiser Permanente. (2016, June 14). *The ACE study survey data* (Unpublished data). Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/about.html

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology*, *4*, 1. doi:10.3402/ejpt.v4i0.20706

Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. V. D., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, *22*(5), 399–408. doi:10.1002/jts.20444

Cohen, L. R., Hien, D. A., & Batchelder, S. (2008). The impact of cumulative maternal trauma and diagnosis on parenting behavior. *Child Maltreatment*, *13*(1), 27–38. doi:10.1177/1077559507310045

Cohn, J. F., Campbell, S. B., Matias, R., & Hopkins, J. (1990). Face-to-face interactions of postpartum depressed and nondepressed mother-infant pairs at 2 months. *Developmental Psychology*, *26*(1), 15–23. doi:10.1037/0012-1649.26.1.15

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., & Mallah, K. (2017). Complex trauma in children and adolescents. *Psychiatric Annals*, *35*(5), 390–398. doi:10.3928/00485713-20050501-05

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 412–425. doi:10.1037/0033-3204.41.4.412

Dong, M. A., Anda, R. F., Feletti, V. J., Dube, S. R., Wiliamson, D. F., Thompson, T. J., … Giles, W. H. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect*, *28*, 771–784. doi:10.1016/j.chiabu.2004.01.008

Dube, S. R., Anda, R. F., Felitti, V. J., Edwards, V. J., & Croft, J. B. (2002). Adverse childhood experiences and personal alcohol abuse as an adult. *Addictive Behaviors*, *27*(5), 713–725.

Ensink, K., Maheux, J., Normandin, L., Sabourin, S., Diguer, L., Berthelot, N., & Parent, K. (2013). The impact of mentalization training on the reflective function of novice therapists: A randomized controlled trial. *Psychotherapy Research*, *23*(5), 526–538. doi:10.1080/10503307.2013.800950

Fearon, P., Target, M., Sargent, J., Williams, L. L., McGregor, J., Bleiberg, E., & Fonagy, P. (2006). Short-term mentalization and relational therapy (SMART): An integrative family therapy for children and adolescents. *Handbook of Mentalization-Based Treatment* (pp. 201–222). London: John Wiley.

Fearon, R. P., Bakermans-Kranenburg, M. J., Van IJzendoorn, M. H., Lapsley, A. M., & Roisman, G. I. (2010). The significance of insecure attachment and disorganization in the development of children's externalizing behavior: A meta-analytic study. *Child Development*, *81*(2), 435–456.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *14*(4), 245–258.

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

Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology*, *21*(4), 1355–1381. doi:10.1017/S0954579409990198

Fraiberg, S. H., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problem of impaired infant mother relationships. *Journal of the American Academy of Child Psychiatry*, *14*, 387–421.

Gara, M. A., Allen, L. A., Herzog, E. P., & Woolfolk, R. L. (2000). The abused child as parent: The structure and content of physically abused mothers' perceptions of their babies. *Child Abuse & Neglect*, *24*(5), 627–639.

Garg, E., Chen, L., Nguyen, T. T., Pokhvisneva, I., Chen, L. M., Unternaehrer, E., … Levitan, R. (2018). The early care environment and DNA methylome variation in childhood. *Development and Psychopathology*, *30*(3), 891–903. doi:10.1017/S0954579418000627

George, C., Kaplan, N., & Main, M. (1984). *Adult attachment interview protocol* (Unpublished manuscript). University of California at Berkeley.

George, C., Kaplan, N., & Main, M. (1985). *Adult attachment interview protocol* (2nd ed.). Unpublished manuscript. University of California at Berkeley.

George, C., Kaplan, N., & Main, M. (1996). *Adult attachment interview protocol* (3rd ed.). Unpulished manuscript. University of California at Berkeley.

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

Grossmann, K. E., Grossman, K., & Waters, E. (2005). *Attachment from infancy into adulthood: The major longitudinal studies*. New York, NY: Guildford Press.

Headman, N. C., & Cornille, T. A. (2008). Family functioning patterns as predictors of engagement: Which families participate in services and which ones do not? *Journal of Family Social Work*, *11*(2), 117–140. doi:10.1080/10522150802165630

Hillis, S. D., Anda, R. F., Felitti, V. J., Nordenberg, D., & Marchbanks, P. (2000). Adverse childhood experiences and sexually transmitted diseases in men and women: A retrospective study. *Pediatrics*, *106*, E11. doi:10.1542/peds.106.1.e11

Holmes, J., & Slade, A. (2017). *Attachment in therapeutic practice*. London, UK: Sage.

Lyons-Ruth, K., Bronfman, E., & Atwood, G. (1999). A relational diathesis model of hostile-helpless states of mind: Expressions in mother–infant interaction. In J. Solomon & C. George (Eds.), *Attachment disorganization* (pp. 33–70). New York, NY: Guilford Press.

Lyons-Ruth, K., & Jacobvitz, D. (2016). Attachment disorganization from infancy to adulthood: Neurobiological correlates, parenting contexts, and pathways to disorder. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (3rd ed., pp. 667–695). New York: NY: Guilford Press.

Lyons-Ruth, K., Yellin, C., Melnick, S., & Atwood, G. (2005). Expanding the concept of unresolved mental states: Hostile/helpless states of mind on the adult attachment interview are associated with disrupted mother–Infant communication and infant disorganization. *Development and Psychopathology*, *17*(1), 1–23.

Madigan, S., Bakermans-Kranenburg, M. J., Van Ijzendoorn, M. H., Moran, G., Pederson, D. R., & Benoit, D. (2006). Unresolved states of mind, anomalous parental behavior, and disorganized attachment: A review and meta-analysis of a transmission gap. *Attachment & Human Development*, *8*(2), 89–111. doi:10.1080/14616730600774458

Midgley, N., Ensink, K., Lindqvist, K., Malberg, N., & Muller, N. (2017). *Mentalization-based treatment for children: A time limited approach*. Washington, DC: APA Publications.

Moffett, S., Brotnow, L., Patel, A., Adnopoz, J., & Woolston, J. (2018). Intensive home-based programs for youth with serious emotional disturbances: A comprehensive review of experimental findings. *Children and Youth Services Review, Elsevier*, *85*(C), 319–325. doi:10.1016/j.childyouth.2017.10.004

Narayan, A. J., Kalstabakken, A. W., Labella, M. H., Nerenberg, L. S., Monn, A. R., & Masten, A. S. (2017). Intergenerational continuity of adverse childhood experiences in homeless families: Unpacking exposure to maltreatment versus family dysfunction. *American Journal Of Orthopsychiatry*, *87*(1), 3.

Putnam, K. T., Harris, W. W., & Putnam, F. W. (2013). Synergistic childhood adversities and complex adult psychopathology. *Journal of Traumatic Stress*, *26*(4), 435–442. doi:10.1002/jts.21833

Pynoos, R. S., Fairbank, J. A., Steinberg, A. M., Amaya-Jackson, L., Gerrity, E., Mount, M. L., & Maze, J. (2008). The national child traumatic stress network: Collaborating to improve the standard of care. *Professional Psychology: Research and Practice*, *39*(4), 389–395. doi:10.1037/a0012551

Reavis, J. A., Looman, J., Franco, K. A., & Rojas, B. (2013). Adverse childhood experiences and adult criminality: How long must we live before we possess our own lives? *The Permanente Journal*, *17*, 44–48. doi:10.7812/TPP/12-072

Roberts, A. L., Chen, Y., Slopen, N., McLaughlin, K. A., Koenen, K. C., & Austin, S. B. (2015). Maternal experience of abuse in childhood and depressive symptoms in adolescent and adult offspring: A 21-year longitudinal study. *Depression and Anxiety*, *32*(10), 709–719. doi:10.1002/da.22395

Slade, A. (2002). Keeping the baby in mind. *Zero to Three*, *6*, 10–15.

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

Slade, A. (2009). Mentalizing the unmentalizable: Parenting children on the spectrum. *Journal of Infant, Child, and Adolescent Psychotherapy*, *8*(1), 7–21. doi:10.1080/15289160802683054

Slade, A. (2014). Imagining fear: Attachment, threat, and psychic experience. *Psychoanalytic dialogues*, *24*(3), 253–266. doi:10.1080/10481885.2014.911608

Slade, A., Aber, J. L., Bresgi, I., Berger, B., & Kaplan, M. (2004). The parent development interview–revised. Unpublished protocol. New York, NY: The City University of New York.

Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment and Human Development*, *7*, 283–298. doi:10.1080/14616730500245880

Spinazzola, J., Ford, J. D., Zucker, M., van der Kolk, B. A., Silva, S., Smith, S. F., & Blaustein, M. (2005). Survey evaluates complex trauma exposure, outcome, and intervention among children and adolescents. *Psychiatric Annals*, *35*, 433–439. doi:10.3928/00485713-20050501-09

Sroufe, L. A. (1988). The role of infant-caregiver attachment in development. In J. Belsky & T. Nezworski (Eds.), *Child psychology. Clinical implications of attachment* (pp. 18–38). Hillsdale, NJ: Erlbaum Associates.

Steel, H., Steel, M., & Fonagy, P. (1996). Associations among attachment classifications of mothers, fathers, and their infants. *Child Development*, *67*, 541–555.

Target, M., Fonagy, P., & Shmueli-Goetz, Y. (2003). Attachment representations in school-age children: The development of the child attachment interview (CAI). *Journal of Child Psychotherapy*, *29*(2), 171–186. doi:10.1080/0075417031000138433

Tolan, P. H., & McKay, M. M. (1996). Preventing serious antisocial behavior in inner-city children: An empirically based family intervention program. *Family Relations*, 148–155.

Turner, R., & Lloyd, D. (1995). Lifetime traumas and mental health: The significance of cumulative adversity. *Journal of Health and Social Behavior*, *36*(4), 360–376. Retrieved from http://www.jstor.org/stable/2137325

van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Viking.

Van der Kolk, B. A. (2017). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, *35*(5), 401–408.

van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry*, *153*(7), 83–93. doi:10.1176/ajp.153.7.83

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*, 389–399. doi:10.1002/(ISSN)1573-6598

van IJzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants and sequelae. *Developmental Psychopathology*, *11*(2), 225–250. doi:10.1017/S0954579499002035

Verhulst, F., & Van der Ende, J. (1997). Factors associated with child mental health service use in the community. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 901–909. doi:10.1097/00004583-199707000-00011

Whaley, A. L. (2001). Cultural mistrust: An important psychological construct for diagnosis and treatment of African Americans. *Professional Psychology: Research and Practice*, *32*, 555–562. doi:10.1037/0735-7028.32.6.555

White, M., White, M. K., Wijaya, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: WW Norton & Company.

Winslade, J., & Monk, G. (2001). *A new approach to conflict resolution*. San Francisco, CA: Jossey-Bass.

Winslade, J., & Monk, G. D. (2008). *Practicing narrative mediation: Loosening the grip of conflict*. San Francisco, CA: Jossey-Bass.

Woolston, J., Adnopoz, J., Berkowitz, S., & Berkowitz, S. J. (2007). *IICAPS: A home-based psychiatric treatment for children and adolescents*. New Haven, CT: Yale University Press.