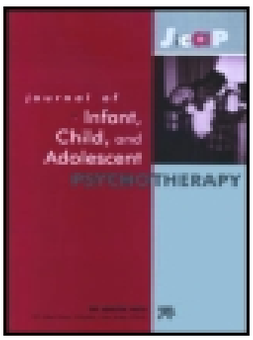

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The Family Cycle: Breaking the Intergenerational Transmission of Trauma through Mentalizing

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ABSTRACT

In recent years, attachment and mentalization theory have been used to guide and inform clinical work with complex, vulnerable adults and children, who struggle to make sense of their own experience or to understand and reflect upon the thoughts and feelings of others. Traumatized parents often have difficulty reflecting upon *their children's* thoughts and feelings, at great cost to the child's sense of trust and safety in the world. In this paper we describe the use of the Family Cycle a clinical activity designed to promote mentalizing in high-risk parents and children with histories of significant and often chronic developmental trauma – with parents whose children are enrolled in an intensive home visiting program aimed at avoiding psychiatric hospitalization. Our aim is to both help them make meaning of their own histories, and understand how these have, in turn, impacted their children. We first present the Family Cycle activity generally, and then use case material to describe its use with a parent in our program.

In recent years, attachment and mentalization theory have been used to guide and inform clinical work with complex, vulnerable adults and children (Allen & Fonagy, 2006; Allen et al., 2008; Bateman & Fonagy, 2004; Holmes & Slade, 2018; Midgley et al., 2017; Steele & Steele, 2017). Central to these approaches is the assumption that lifelong histories of trauma and adversity dramatically compromise the capacity to make meaning of one's own experience and understand or reflect upon the thoughts and feelings of others. That is, trauma – and particularly relational trauma – impairs the capacity to mentalize (Allen, 2012). For traumatized parents, this is often manifest in the inability to reflect upon *their children's* thoughts and feelings, at great cost to the child's sense of trust and safety in the world (Fonagy & Allison, 2014), and – ultimately – to their psychological health (Ensink et al., 2014; Fonagy et al., 1993; Kinniburgh et al., 2017).

Here we build on our recent paper (Stob et al., 2019) introducing the Family Cycle, a clinical activity designed to promote mentalizing in high-risk parents and children with histories of significant and often chronic developmental trauma. In our earlier paper, we described the clinical use of the Family Cycle with *children* in an intensive home visiting program for at-risk children and adolescents. In this paper, we describe the clinical use of the Family Cycle with *parents* in the same program, with the aim both of helping them make meaning of their own histories, and understanding how these have, in turn, had an effect on their children. One of our goals in using the Family Cycle with both parents and children is to begin to shift the intergenerational transmission of trauma by helping parents and children *mentalize*, that is to begin to put both their deep pain and their defenses against it into words. We see this as crucial to helping parents and children better understand and have compassion for each other, resulting in less disrupted and destructive interactions. We begin with a review of the literature

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on complex trauma and adverse childhood experiences, and then use these as the foundation for discussing the important role of mentalizing in trauma repair and recovery. We then turn to a description of the Family Cycle and illuminate its use through case example.

Background

Over the past twenty years, thanks largely to the work of Judith Herman (1992) and Bessel van der Kolk (1994, 2014), as well as the dramatic findings of the Adverse Childhood Experiences Study (Felitti et al., 1998; Hughes et al., 2017; Merrick et al., 2018), mental health practitioners have become increasingly aware of how profoundly early trauma impacts every aspect of an individual's functioning, including the capacity to think, to work, to grow, and to love. Clinicians have also become aware of the ways in which trauma and traumatic ways of being in the world are transmitted from one generation to the next. An early example of this work is Fraiberg and her colleagues' (Fraiberg et al., 1975) description of the ways that a mother's unmetabolized trauma profoundly affects the ways she is able to see, hear, and make meaning of her child. The Child-Parent Psychotherapy model, developed by Alicia Lieberman and her colleagues, has extended this work in a variety of critical ways (Lieberman et al., 2015; Lieberman & Van Horn, 2008). And yet there is still much to be understood about the implications of severe trauma for *parenting*, per se. That is, what is the particular impact of an adult's trauma on their capacity to parent, and how can we remedy the relational difficulties that flow from parental trauma?

Complex Trauma

We begin with the concept of "complex", "developmental", or "attachment" trauma disorder (Courtois, 2004; van der Kolk, 1994, 2017), because this so vividly describes many of the families who receive services in our intensive home-based therapeutic intervention. These terms[1] refer to the kinds of difficulties seen in individuals who have experienced ongoing, continuous trauma (sexual and physical abuse, interpersonal violence) across a range of developmental periods, often at the hands of attachment figures or other close family members. Such chronic and extended disruptions in the child's most intimate relationships not only profoundly distort development at the level of the mind, the body, and the brain, but also shatter the individual's sense of trust and meaning. Children who are under chronic threat are deprived of the kinds of experiences they need to build strong foundations for later learning, relating, and regulation, across domains such as workplace, home life, and community.

In her exceptional review paper on complex trauma, Courtois (2004) notes that one of the essential differences between "simple" PTSD and complex trauma is that PTSD is typically linked to an acute trauma or series of linked traumatic events, whereas complex trauma is a response to ongoing trauma exposure from which there is no escape. This leads to an array of psychological problems that are distinct from PTSD, namely "depression, anxiety, self-hatred, dissociation, substance use, self-destructive and risk-taking behaviors, revictimization, problems with interpersonal and intimate relationships (*including parenting* [emphasis added]), medical and somatic concerns, and despair." (2004, p. 413). Courtois links the pathology of complex trauma disorder to a series of posttraumatic adaptions in: 1) the regulation of affective impulses (impulsive acting out), 2) attention and consciousness (tendency to dissociate), 3) self-perception (extreme shame, guilt, and self-hatred), 4) perceptions of the perpetrator (seeing the self as bad and the perpetrator as justified), 5) relationships (inability to see others as trustworthy), and finally 6) a tendency to express through the body what cannot be tolerated emotionally or expressed verbally.

Each of these adaptations – which proliferate in high-risk populations – profoundly affect the capacity to parent. A parent prone to acting out or dissociation, who is gripped by feelings of shame and self-hatred, sees themselves as deserving of harm, is prone to somatizing, and/or lacking a fundamental sense of safety in relationships is going to have a very difficult time providing safety

and security for a child. In point of fact, any or all of these adaptations are likely to ensure that the parent is frightening to the child (Lyons-Ruth & Jacobvitz, 2016).

Adverse childhood experiences

We now turn briefly to a description of the Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998). We do so, in part, because the study provides an evidence base for the assumptions of trauma theory, and the link between prolonged attachment trauma and later mental health difficulties. We also do so because the ACE study methodology figures significantly in our clinical assessment and in the organization of the Family Cycle activity. In 1998, the first of a series of landmark investigations based on the ACE Study was published. The study asked roughly 17,000 adult patients in the Kaiser Permanente health system to endorse adverse childhood experiences (abuse, neglect, and family dysfunction) in their first 18 years of life, using the 10 item self-report Adverse Childhood Experiences questionnaire (ACE-Q). The 10-items are interrelated and have been shown in a series of studies to have a dose-response effect on a variety of social, behavioral, and health outcomes, ranging from teenage pregnancy and paternity, substance abuse, heart disease, life opportunities, homelessness, and the prevalence of mental health disorders (Hughes et al., 2017). As the number of adverse childhood experiences increases, there are higher rates of negative health outcomes including smoking, substance abuse, alcoholism, financial stress, intimate partner violence, poor work performance, lack of physical activity, risk for sexual violence, early initiation into sex, obesity, diabetes, liver disease, unintended pregnancies, poor academic achievement, adolescent pregnancy, depression, STIs, heart disease, cancer, stroke, broken bones, and COPD, and fetal death (Felitti et al., 1998; Hughes et al., 2017). ACEs are also highly associated with poverty, class, and race; in the US, black and Hispanic children and youth are far more likely to experience ACEs than their white or Asian peers (Merrick et al., 2017; Sacks & Murphey, 2018).

For better or worse, even though there are currently many self-report, and clinician administered measures of trauma exposure, the strong findings of the ACE study and the simplicity of the ACE-Q have led to its wide use across a range of medical, psychiatric, and social service settings in the United States. This, despite the fact that there is limited literature around use of the ACE-Q in trauma-informed care and no known antidote or prescribed treatment for a high ACE score (Finkelhor, 2018). Providers in both medical and clinical practice have recognized the need to train those who administer questionnaires about painful and overwhelming childhood events to do so with care and professional sensitivity (Pletcher et al., 2019; Ranjbar & Erb, 2019). As such, there remains a great deal of debate amongst clinicians about the growing use of a research check-list like the ACE-Q whose content at best is somewhat callous and at worst potentially re-traumatizing. We share these concerns; however, we also believe that when the ACE-Q is used thoughtfully and with complete cognizance of its potential impact, it can serve to open necessary discussions of early trauma and create the potential for increased mentalization.

Mentalization and Trauma

Early relational trauma profoundly affects the capacity to mentalize, namely to perceive and interpret the thoughts and feelings underlying overt behavior (Allen, 2012; Bateman & Fonagy, 2012; Slade, 2005). The ability to mentalize is associated with attachment security, emotion regulation and mental health in adolescents (Borelli, Brugnera, et al., 2019; Duval et al., 2018) and in parents (Fonagy et al., 1991; Borelli et al., 2016; Slade et al., 2005). A parent's capacity to mentalize promotes sensitive parenting, which in turn, facilitates a child's capacity to develop a secure attachment and a coherent sense of self (Allen, 2018; Camoirano, 2017; Shai & Belsky, 2011; Slade et al., 2005). In contrast, a parent prone to non- or impaired mentalizing, at best leaves the child without any stabilizing influence, and at worst, raises the child's stress-reactivity and leaves them in a state of chronic fear (Allen, 2012; Gunnar & Quevedo, 2007; Slade, 2014). Perhaps most important in the context of high-risk families, parental reflective functioning[2] has been demonstrated to have a mediating effect on the

intergenerational transmission of childhood maltreatment (Berthelot et al., 2019, 2015; Grienenberger et al., 2005). This means that for parents who have histories of childhood abuse and/or neglect, those who can mentalize are less likely to transmit an insecure attachment to their child through insensitive parenting practices.

Trauma Reflective Functioning (RF-T) is an adult's capacity to hold and reflect on their own traumatic experiences, to attribute mental states to their behaviors and reflect on internal experiences (Berthelot et al., 2015; Ensink et al., 2015). Recent research has demonstrated that a mother's inability to consider her traumatic experiences in terms of mental states is linked to negative outcomes for her child. In one study, deficits in mentalizing specific to trauma (RF-T) amongst mothers who have experienced childhood abuse and neglect are linked to the intergenerational transmission of insecure attachment to their children (Berthelot et al., 2015; Borelli, Brugnera, et al., 2019; Ensink et al., 2015). Another found that low RF-T is associated with difficulties in intimate relationships, difficulty feeling invested in pregnancy, and lack of positive feelings about the baby and motherhood (Ensink et al., 2014). Thus, it appears that a mother's capacity to make meaning of her own traumatic experiences is protective for the child. For example, amongst mothers who have a history of child sexual abuse, high maternal RF-T was associated with lower likelihood of their child being sexually abused (Borelli, Cohen, et al., 2019). These studies suggest that it is not necessarily the experiences of trauma that lead to negative outcomes, but the absence of mentalizing regarding traumatic experiences (Ensink et al., 2014).

This directly informs our basic premise, namely the idea that fostering a parent's ability to mentalize traumatic relational experiences may decrease the likelihood of the child's victimization and increase the parent's ability to mentalize the child's traumatic experience. The Family Cycle provides a way to integrate theory and research about attachment trauma and mentalization into grounded clinical practice.

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)] is a large-scale home-based intervention for children and adolescents with serious emotional disturbance who are at risk of psychiatric hospitalization (Woolston, Adnopoz, & Berkowitz, 2007). It was developed by a team of clinicians at the Yale Child Study Center to lower the rate of psychiatric hospital readmission and improve outcomes post-hospitalization in children and adolescents. What began as a small pilot in 1996, has now been implemented across the state of Connecticut as a Medicaid and commercial insurance funded treatment. While many of the families seen in IICAPS come to the program following hospitalization, a number are now also referred by the Department of Children and Families (DCF), other social service and child mental health agencies and providers as well as by parents themselves. Typically, children and adolescents referred to IICAPS have high rates of adversity and developmental trauma and are being raised in families with numerous physical and mental health problems, socio-economic risk factors, and low treatment adherence (Barbot et al., 2016; Kamody et al., under review). IICAPS serves over 2000 families annually and 74% of cases are rated as successfully completing a four to six-month IICAPS episode of care. In the IICAPS model, families are seen 3–4 times weekly by a team of clinicians. One clinician works primarily with the parent, one clinician works with the child, and the team comes together for family sessions weekly. IICAPS clinicians also attend a variety of other meetings in the community including with the child's school, Department of Child and Family Services (DCF), and other behavioral health providers.

In 2014, IICAPS began using the Adverse Childhood Experiences Questionnaire (ACE-Q), as a semi-structured conversational activity with the child's parent about their childhood experiences. The data from the ACE-Q from 2016–2018 revealed that the parents in IICAPS treatment endorsed high rates of childhood adversity. Unlike the general population, where between 33–39% of adults report no adverse childhood experiences and 6.2% of adults report four or more ACEs (CDC, Kaiser Permanente, 2016), only 15% parents in IICAPS reported no adverse experiences and 47% reported 4 or more adverse childhood experiences.

Although the ACE-Q helped clinicians and parents appreciate the pervasiveness of parental childhood adversity, clinicians had great difficulty in deepening, or even sustaining, this conversation in

a way that informed the treatment. The Family Cycle grew largely out of the first author's efforts to find ways – within the framework of complex and often chaotic home visits – to help parents and children access difficult emotional experiences and more deeply understand their impact. Because it is a concrete activity with specific themes, the Family Cycle gives parents and children a focus and structure to help organize disturbing and potentially disorganizing material. In the next section, we describe the process used to set the stage for the administration of the Family Cycle with parents. We follow this with a case illustration. As noted previously (Stob et al., 2019), while the Family Cycle was developed within the framework of an intensive home visiting program for high-risk families, we believe that this activity has the potential for broader implementation in a range of clinical settings with parents and children.

Administering the family cycle

In IICAPS there are five interrelated stages in the administration and clinical use of the Family Cycle: 1. The clinically guided and paced administration of the ACE-Q; 2. The creation of the Family Cycle based on a parent's description of their childhood; 3. The parent's predictions regarding their child's Family Cycle; 4. The child's Family Cycle presented in a family session; 5. A comparison of the child's and the parent's Family Cycles in a parent session. In this way, we aim to engage in a careful and supportive discussion of each item endorsed on the ACE-Q, and then use this information to narrate both parent and child childhood experiences using the Family Cycle. The parent clinician (that is, the clinician working with the parent) scaffolds each session by identifying the activity and providing a brief explanation of its purpose.

Administering the ACE questionnaire

The administration of the family cycle begins by completing the ACE-Q with a parent. In IICAPS, this takes place 8–10 weeks into treatment to ensure that a therapeutic relationship has been established. The ACE-Q is administered after crisis management has successfully stabilized the family system and the parent clinician has assessed and supported a parent's capacity to regulate their emotions. Prior to completing the ACE-Q, the parent has begun the process of reflecting on their lives using a three-generational genogram; they will also have created a safety plan to address the child's unsafe behaviors. The parent will have provided consent and been prepared for the nature of the questions. Together the clinician and parent identify a time and place that the session can be private. The ACE-Q uses a yes/no format that in and of itself does not promote discussion. Therefore, the parent clinician is encouraged to integrate questions from the Adult Attachment Interview (George et al., 1984, 1996) to flesh out the ACE questionnaire's yes/no format. For example, after the ACE-Q question about verbal abuse, the parent clinician might insert *When you were upset as a child, what would you do?* Or, after the ACE-Q question about feeling unloved, the parent clinician might insert *How old were you when you first felt this way, and what did you do? Why do you think your parent did those things-do you think he/she realized he/she was rejecting you? Were you ever frightened or worried as a child?* Or, after the ACE-Q question about physical abuse/verbal abuse the parent clinician might ask – *How old were you at the time? Did it happen frequently? Do you feel this experience affects you now as an adult? Does it influence your approach to your own child?"* At the close of the ACE-Q, the parent clinician may include probes about the parent's current relationship with their parents. *Do you have much contact? What would you say the relationship with your parents is like currently?* Or *Is there any particular thing which you feel you learned above all from your own childhood?*

The parent clinician can also ask the parent whether any specific memory comes up for them with an answer of "yes" to each question. As might be expected, it is often necessary to extend a session beyond 60 minutes, or to break up the ACE-Q into two sessions to thoroughly process each item. At the end of each session, the parent clinician reflects with the parent on what it was like to recall such difficult memories and how often those memories intrude into their daily life. In some cases, a parent

may appear to be flooded by negative affect. If acute intervention is needed, proper referrals are made. In most cases, the parent clinician can help reduce the parent's distress by teaching and practicing grounding skills that assist in managing overwhelming and intense feelings of sadness, anger, and/or anxiety. Their purpose is to help bring someone back into the present and regain their mental focus from an intense emotional state. Examples include talking a brisk walk with the parent, doing a sensory activity – identifying 5 things she can see, 4 things she can feel, 3 things she can hear, 2 things she can smell, and 1 thing she can taste, or simply guiding the parent to tense and un-tense her body while taking deep breaths.

The family cycle

Completing the ACE-Q with a parent provides the foundation for creating the Family Cycle, as it allows them to consider the ways adverse childhood experiences contributed to their state of mind as a child, (and now adult), and how these internal states were and are expressed through their behavior. Each step in this process aims to enhance the parent's capacity to reflect first upon their own experiences, and later upon those of their child. The parent clinician can explain the activity and its utility by saying something along the following lines:

> Now that we've talked a little bit about your childhood I'd like to do an activity called the Family Cycle. It's a drawing that tells the story of how your experiences affected you and how you learned to cope with your feelings.

The number and nature of ACEs endorsed along with the more in-depth questions about the parent's childhood incorporated from the AAI guide the parent clinician in beginning the Family Cycle. To start, the parent is asked to reflect on their experience of the ACE-Q and the number of adverse experiences they endorsed. If a parent has not described any adverse experiences, the clinician can focus more on the parent's emotional experience as a child. This could include feelings of alienation, rejection, conditional love, or disappointment. For example, a parent might report having always felt very disconnected from their caregiver or report that their caregiver was psychologically intrusive. The parent is then asked to choose a phrase that best describes the pain or loss of their experiences. On the template of the Family Cycle this is called their *Unacknowledged Loss/Pain* (i.e. adversity in the context of a problematic parental relationship (Stob et al., 2019)); in session, however, it is often simply referred to as *Loss/Pain*. The act of naming, processing, and reflecting on it means that it is no longer *Unacknowledged*.

At this point the clinician can suggest a phrase the parent has already used that was particularly poignant, or work with the parent to identify a phrase that they feel captures their experience. A parent may choose "I was completely alone" or "No one took care of me" or "Violence and Fear." Once the *Unacknowledged Loss/Pain* is named, the parent clinician can begin to explore how the parent internalized this as a child, perhaps by pulling threads from statements the parent has already made. The parent clinician can ask the parent to close their eyes and try to remember how they made sense of their experiences as a child. They might also ask how the parent's experiences of their own parents changed the way they saw themselves, their relationships, and/or the world. If a parent is struggling, the clinician might offer their own reflection. For example, if the parent describes a childhood divorce that felt like abandonment and their mother's subsequent depressive episode, the clinician might guess – "it sounds like you started to believe you were invisible and powerless." Once the parent identifies the *Unexpressed Belief*, the clinician can begin to explore how their day-to-day home life further confirmed the negative belief. The parent clinician can ask the parent to describe an average weekday or weekend. For example, a parent might state "My Mom was never around", or "Absolute chaos", or "My Dad was always drunk." Sometimes it's helpful to narrow the description down to a specific age range. The description the parent chooses is used for the *External Dynamic*, which the parent clinician can describe simply as "At home." The parent clinician then explores with the parent how they coped with chronic stress – how it was expressed behaviorally and how they felt – *Expression*

of the Internal Buildup. This can be an opportunity to help a parent understand her behavior in light of underlying feelings. For example, a parent who felt intense shame might have used casual sex and substances to cope.

Next, the parent clinician asks how the parent's caregivers responded to their *Build Up*. For instance, some parents overreact to their children's behavior without reflection on its meaning, whereas others can underreact. Both feel invalidating to the child, because – as in the example above – their shame is unacknowledged. Lastly, the parent is asked whether they ever came to a point of *Crisis* and how they identify that moment or experience. Sometimes it's better to rephrase *Crisis* as a time of intense difficulty. Then the clinician can explore with the parent how the *Crisis* ultimately leads to more *Pain/Loss*. As will be demonstrated in the case example, often the extensions of the parent's *Crisis* can be found on their child's *Unacknowledged Loss/Pain*. Finally, the parent clinician asks the parent to sit back, take in the completed Family Cycle and reflect on the process of creating it. One of the concrete goals of the activity is to generate a visual narrative for the parent that makes meaning of, and stimulates mentalization about, their own adverse and traumatic relational experiences.

Linking the parent's family cycle to the child's

The next step is to ask the parent to try and predict or imagine their child's Family Cycle (which the child has been creating separately with the child clinician). The child's Family Cycle is never shown to the parent without the child's consent. In most cases, the child will present their Family Cycle to the parent in their own words; however, it is often helpful for a parent to anticipate their child's Family Cycle first. This decreases the likelihood of defensive and invalidating responses.

To begin, the parent clinician asks the parent to think about loss and pain in their child's early experience. Here the parent clinician can ask the parent whether the child has had experiences of abuse, neglect, or other adversity, and how the parent thinks their child will remember their childhood and their childhood experiences as an adult. In some cases, the parent clinician can bring back the ACE-Q and ask the parent to consider how their son/daughter might respond to each of the items as an adult. Another way to help a parent consider the *Unacknowledged Loss/Pain* for their child is by completing a timeline. When creating the timeline, the parent clinician should keep the ACE-Q items in mind and get a sense of how often and at what developmental stages the child's trauma or adverse events took place. Again, if there is no obvious trauma or adversity, the parent clinician should focus more on strain in the parent/child relationship. Throughout the process, the parent clinician should try to create an atmosphere of curiosity. That is, the parent is asked to *imagine* what the child's experience *may have been*. It is essential that the parent clinician pull from their own observations of the child and not rely entirely on the parent's ability to imagine their child. The parent clinician then helps the parent reflect on how it feels to imagine their child's losses and pain, and asks how they think they will respond to the child's Family Cycle. At this point the parent clinician can provide pointers about validating responses and role-play with the parent what they might say or do.

After the family session in which the child presents their Family Cycle to the parent with the assistance of the child clinician and the parent clinician, the parent clinician can bring both the child and the parent Family Cycles to a parent session and process the parallels. The goal is to help the parent make connections between their Family Cycle and the child's. This process begins by the parent clinician placing the parent's Family Cycle *inside* the child's Family Cycle in order to create a visual comparison. This is then presented to the parent by the parent clinician, who allows time to observe and then probes about similarities and differences. The parent clinician may ask, *What do you notice that is similar? . . ..how about differences? Do you feel the experience of your Family Cycle affects you now as an adult? . . . . how about as a parent?* The parent clinician can then ask how the parent would have wanted their parents to respond to *them. As a child, how would you have wanted/needed your parents to respond to you? What things could have shifted your Family Cycle? How do you think we can shift your daughter's/son's? If you were responding to your child's belief/feelings instead of their behavior,*

what would you do differently? Inevitably, parental guilt and shame will surface with the awareness of the ways they have played an integral role in their child's experience. It is important that the clinician frame the Family Cycle as an activity to increase understanding versus an attempt to find fault or blame. Once reflection on the two Family Cycles is complete, the clinician and parent can begin the process of identifying and practicing new responses to the child. This first requires the parent being aware of how they are triggered by the child's behavior, what their dysregulated response is; they can then think together with the clinician of ways of regulating themselves before responding to the child.

Monique

Monique was a 29-year-old mother whose son, Elijah, had been referred to the IICAPS program after an aggressive outburst at home led to an inpatient hospitalization. The parent clinician began to engage Monique in an exploration of her childhood experiences after having established a reasonably strong and trusting therapeutic relationship with her over the course of several months. Initially visibly uncomfortable and reluctant to describe her childhood, Monique frequently asked the parent clinician why talking about her past was going to make her son "act right". At first, she was vague in response to open ended questions about her relationships with her parents; as the questions became more direct, however, she began to describe a childhood marked by her father's alcoholism and violence. She had vivid memories of being put down and, at times, hit by her father. She recalled one incident as a teenager in which she ran away from him through the streets in stocking feet and hid in a bush for hours. She described feeling intensely helpless as she watched her mother get threatened and beaten on a regular basis. She recalled discovering – as an adolescent – that the mother who had raised her was not her biological mother and her resulting feelings of betrayal, shame, and a sense that no one loved her. Her birth mother had died in Monique's infancy from a drug-overdose and her father quickly moved on and married her step-mother. Her step-mother's symptoms of depression and withdrawal made her feel even more alone. She told the parent clinician of being sexually abused (digitally penetrated) by her paternal uncle at the age of 13 and being afraid that her father would blame/hurt her if she told anyone. She watched her brothers get in trouble with the law and subsequently become incarcerated, compounding her feelings of being alone in the world. The two adverse experiences she did not endorse were not having enough to eat/dirty clothes and her parents divorcing/separating.

Monique acknowledged that she had not discussed her childhood with anyone in "a long time." She was visibly affected by the experience but said that she was glad to talk about it because she now realized it affected her. At the close of session, she and the parent clinician practiced deep breathing to help her feel calm and reviewed her routine for the evening. The parent clinician ended the session by reminding Monique that they would begin her Family Cycle next week.

Monique's family cycle

The following week, the parent clinician reminded Monique that they were going to do an activity called the Family Cycle. Monique's responses to the ACE-Q were then used to conceptualize her *Unacknowledged Loss/Pain*. Monique was asked to choose a few words that described the pain from her childhood or what she felt had been missing. For her *Unacknowledged Loss/Pain*, Monique offered, "no one protected me." The parent clinician described the next circle as the *Belief*. The clinician explained that the circle is meant to capture the feelings that are internalized when bad/sad/scary things happen to them – the lesson the child has learned about themselves or the world. In Monique's case it was helpful to give an example, so the parent clinician said, "For instance, if I'm put down every day by my mother I may start to believe that I'm unlovable." When asked what the lesson she learned from her experience of no one protecting her was or what it made her start to believe about herself, Monique thought for several minutes and then described a recurring thought that she had throughout her childhood, "I should never have been born." Monique went on to describe how frequently she returned to that thought when she felt hopeless, helpless, and alone. The clinician then asked Monique to describe how day-to-day life at home confirmed her negative belief. Monique described the many ways she felt that her home life confirmed this feeling: there were no adults who

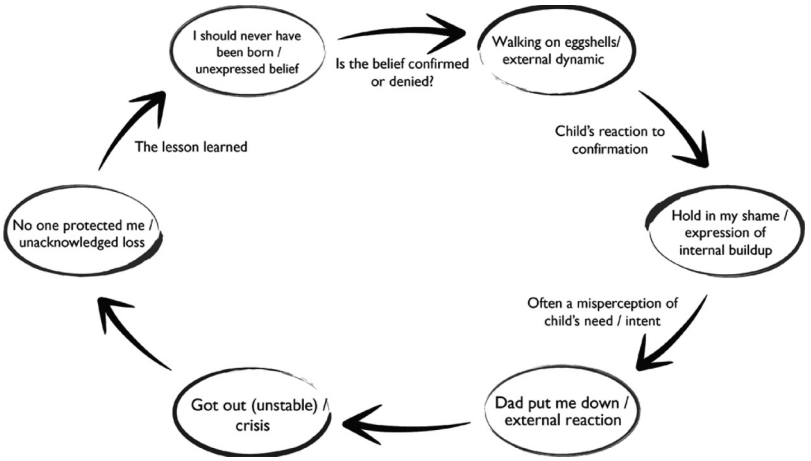

Figure 1. Monique's family cycle.

had much interest in her or her thoughts and she experienced constant anxiety and fear when her father came home. For *External Dynamic*, she chose "walking on eggshells." The next circle was described to her as her *Build Up* or how she acted when her negative feelings built up. The clinician described this circle as the way Monique learned how to cope with her home environment. Monique described keeping to herself and trying to make herself very small. She said, "I held in my shame" and went on to explain that it was too unsafe for her to act out and that there was no room for her feelings. She described later dropping out of school and spending most of her time in "the streets." Her silence at home, she said, made her an easy target for her Dad's put-downs, which she chose for the External Reaction. She struggled to identify a crisis, instead stating that she "got out", meaning she moved out of her home at fifteen years old. The clinician then explained that some parents describe their crisis as coming later in life – perhaps early adulthood – and asked whether Monique thought this applied to her? After some reflection, she said that maybe her crisis was her "fu**** up relationships" and "all the moving around and shelters." She then described having tumultuous romantic relationships with lots of arguing which led to unstable housing, as she often moved in with romantic partners and then felt that she could not return to her family home.

The clinician drew out what Monique chose for each circle and presented it to her. The clinician then narrated the story of her Family Cycle using her words. Monique nodded throughout and upon completion of the narration, she was silent for a few minutes and then stated that she had never thought about herself as a child in this way. She asked incredulously why no therapist had ever helped her make sense of this before. She then reflected on her attempts as an adult to deny the significance of her childhood experiences. She also indicated that she thought some of her childhood experiences might be related to her mental health problems as an adult. Prior to leaving, the clinician and Monique practiced her deep breathing and discussed next trying to use her own childhood experiences to better understand her son (see Figure 1).

Monique imagines her son's family cycle

In the next session, Monique and the parent clinician began a timeline of Elijah's life. The parent clinician prompted Monique to consider Elijah's important childhood experiences. The parent clinician indirectly used ACE-Q items as a conversational guide in asking Monique to recall specific adverse events (i.e. incidents of domestic violence, parental mental health problems, incarceration) and at what stage they happened in his life. In creating Elijah's timeline, Monique wondered about the impact of his never knowing his incarcerated father. She also acknowledged struggling with chronic housing insecurity and her ongoing mental health difficulties. She recalled several "break downs"

witnessed by her son, usually following tumultuous arguments with her boyfriends. When Elijah was 6 years old she was psychiatrically hospitalized for several weeks after a suicide attempt; she told the parent clinician that she had never discussed this with him. She and her clinician wondered together about how he had made sense of their separation. She talked about his exposure to several boyfriends with substance use problems – but was unsure how much he understood about their substance use. Monique talked about how she had prioritized protecting him from physical and sexual abuse due to her childhood experiences. When asked for a phrase she thought Elijah might choose to describe his timeline, Monique chose "Instability" for his *Unacknowledged Loss/Pain*.

Next the clinician asked Monique to consider how her son had internalized his childhood experiences. The clinician provided an example – *Sometimes when kids have witnessed a lot of violence, they start to believe that nothing is safe*. Monique thought for a while and then guessed that her son believes that he can't depend on anything. She stated that she worried he felt that nothing was ever going to last. This was used for his *Unexpressed Belief*. Next the clinician asked Monique to consider what happens at home that makes that feeling worse. Monique struggled here, but ultimately admitted that she was aware that he frequently got upset when she had friends over when he came home from school. When asked to think about why this made him upset, she guessed that he didn't like it when his routine was changed and that often she might have a drink and her friends would be smoking, which she knew he didn't like. For his *Buildup* she readily stated that he was disrespectful, but struggled to consider what feelings were underneath his disrespect. Here the parent clinician suggested that maybe this was something Monique could ask him about. She then admitted to losing her temper with him and yelling, which was used for the *External Reaction*, though she made it clear that this was only in response to his disrespectful behavior. When asked to describe how he responds when she yells, she stated "Out-of-control." This was used for his *Crisis*.

The parent clinician then showed Monique the visual of her predictions and narrated it back to her: *For a long time Elijah felt that everything was unstable, which made him start to believe that nothing and no one is dependable. At home, when the routine changes and he's caught off guard, that just makes him feel worse. So, all that starts to buildup and he lashes out and acts disrespectful. And when you yell at him, that makes him feel and act even more unsafe and out-of-control . . . and ultimately, that leads to more instability and the cycle repeats itself. Something like that?* Monique said that it was different to hear it presented to her in that way. She said she hadn't considered how many things were affecting

Figure 2. Elijah's family cycle.

him at once. At this point the parent clinician asked whether she would be prepared to hear his version in family session and she said yes.

Elijah's family cycle in family session

The child clinician and Elijah had completed his *Family Cycle* over the first 10 weeks of treatment throughout the time the parent clinician had been preparing Monique to hear it. Monique, her son, the child clinician, and the parent clinician all came together for the session to present Elijah's Family Cycle to Monique. With the child clinician's assistance, Elijah described why he chose "Ups and Downs" for his *Loss/Pain*. He described that he was referring to both frequently moving and becoming homeless and his Mom's moods. He reflected that when things were good they were really good, but that he never knew when it would get bad again. The parent clinician asked for a few examples of when it was really bad – at which point Elijah brought up his mother's psychiatric hospitalization and his separation from her. Monique was prepared and told him that she regretted never talking about it with him and validated how frightening that must have been. With the parent clinician's help, she explained that she had gone to the hospital to get help for her sadness. He seemed satisfied with this explanation. Elijah then described the lesson he learned from his childhood: "Everything is crazy." The child clinician rephrased this as "nothing is predictable, or nothing lasts." Elijah said that, at home, the feeling was "Never knowing what you're gonna get." When asked by the parent clinician for some examples he brought up not liking it when his Mom was "hanging out" with friends or "in a really bad mood." He then described his *Buildup* as frequently a response to what was happening at home – if things seemed calm and stable he would have a good attitude, if things were loud and Mom was moody he would have a bad attitude. The child clinician asked, "And what's Mom's response to the bad attitude?" He nervously wrote, "Mom disrespects me" placing a smiley face next to the words in an attempt to diffuse his Mom's anger. Again, Monique was prepared for this and said, "I know I lose my temper and yell." To which her son responded, "And that makes me go crazy!" which was used for his *Crisis*. The parent and child then prompted both Monique and her son to process how this leads to more "Ups and Downs." At the close of the session Monique and her son were asked to reflect on the session and what thoughts and feeling it had brought up (see Figure 2).

Reflecting on the parallels

After the family session in which her son presented his Family Cycle, the parent clinician created a new visual placing Monique's Family Cycle inside of her son's Family Cycle. The parent clinician began the session by explaining the concentric cycles and asking Monique for her observations about similarities and differences. Monique immediately noticed the similarities between her and her son's description of the *External Dynamic* and the *External Reaction*. She stated, "He feels the same way I did about my home life." Referring to Monique's Family Cycle, the parent clinician asked whether the Unexpressed Belief ever resurfaced in parenting. Monique reflected on her ongoing struggles with her self-esteem but said that being a mother gave her purpose. When her son "acts out", however, it made her feel he was doing it on purpose to exert control over her. She stated that when things were "really bad" between her and her son, she would often go back to the thought that she should never have been born. When asked if she still thought her son was acting out on purpose to control her, she said that she now understood that it was how he was dealing with his own feelings, but that this would be hard for her to remember in the moment. The parent clinician asked whether the shame she had identified in her childhood was still with her and whether she still dealt with her feelings by holding them in. She thought for a while and said that she thought her shame had changed into anger as an adult and that she was more likely to fight back. She identified her repulsion at the idea of ever being a victim again and always being on the defensive if she perceives someone is trying to "put her down." The clinician wondered if this was related to her experience of her father and Monique immediately said yes. The clinician then asked if her son ever put her on the "defensive." With some help, Monique made the connection that sometimes her son was triggering her experience of her father from childhood, and that her reaction was often an over-reaction in the here-and-now.

Using her son's Family Cycle, Monique began to observe that her immediate and hyper-aroused response was to react to him as though he were going to hurt her, without understanding the anxiety underlying his behavior. In this case, her son's aggression had taken on a meaning outside of his individual characteristics. This meaning had come to dominate and distort their relationship. She connected this back to her unwillingness to be a "victim", particularly in moments where she feels out-of-control herself. She acknowledged her sensitivity to feeling out-of-control and connected this back to her childhood experiences. She also noted that she hadn't realized that he did better when he could predict what he came home to after school.

With this groundwork complete, the parent clinician and Monique could identify habitual non-mentalizing, connect it to her difficulties with self-regulation when triggered, and begin a conversation about how she could intervene to shift her son's Family Cycle. In this way, they focused less on Elijah's behavior, and more on his and her experience. For Monique, this meant that to respond differently she would need to take space and calm herself prior to reacting to her son, so as not to escalate his anxiety, anger and distress. As she began to take space and calm herself prior to responding, her son escalated less frequently and stabilized. Soon there were fewer Emergency Department visits and inpatient hospitalizations due to out-of-control aggression (See Figure 3).

Discussion

The Family Cycle was designed to help vulnerable parents and their children begin the process of mentalizing trauma: identifying thoughts/feelings/beliefs and connecting them to painful and traumatic experiences. What this means concretely within the context of parent-child treatment is that – through the process of completing the Family Cycle – the parent deepens their understanding of themselves and of the child, and in this way is better able to hold and contain the child's experience. While the Family Cycle was developed for use with high-risk families who have experienced multi-generational adversity and are unlikely to consistently attend outpatient treatment, we believe that this method, and particularly its emphasis on helping both children and parents mentalize, is readily transferrable to work with lower risk families seen in a range of outpatient settings.

No two Family Cycles are alike, and much falls to the clinician and their ability to mentalize and make sense of what are often very painful and chaotic experiences. A parent's readiness to complete the activity is often variable, with some parents requiring a full six months to only uncover and process their *Unacknowledged Loss*, whereas other parents move through the entire sequence outlined above over the course of six months. Completing the activity is not an end in itself. Rather, it provides an opportunity to

Figure 3. Monique's family cycle inside of Elijah's family cycle.

create a visual representation to reflect upon, consider, and return to. And, once created, the narrative can shift over time with awareness, understanding, and practice. It is neither static nor closed. Thus, it is important that the clinician not treat the Family Cycle as a worksheet; rather, it should be thoughtfully administered at a pace that meets the family where they are and allows them to choose language that is meaningful to them. In this way, the task of addressing child and parent self-regulation and ongoing self/other reflection becomes the work of follow-up sessions and ongoing treatment. Ideally, reviewing both the child's and parent's Family Cycles in supervision will further deepen the work.

Despite the fact that parental childhood trauma has repeatedly been linked to a range of psychiatric and behavioral problems in children (Schickedanz et al., 2018; Steele et al., 2016), few mental health interventions provide guidelines for making this connection explicit to parents in treatment. We believe that articulating the relationship between a parent's history and the child's struggles is critical to clinical progress, even though this can be challenging for both parents and clinicians. Parents struggle enormously with the idea that they have anything to do with their child's difficulties; the child is, after all, the "identified patient", and, in fact, they are often present with acute behavioral problems. Many parents have little reason to trust those in the mental health profession, and can readily feel blamed, shamed, or criticized. Clinicians themselves can struggle with clear, direct explanations as to how a parent's childhood experience is related to child behavior and psychopathology. These conversations can be very difficult, and require patience, compassion, and finesse. However, as we hope we have made clear here and in our earlier paper (Stob et al., 2019), when integrated into both child and parent work, the Family Cycle scaffolds and organizes dialogue, reflection, and, ultimately, transformation.

Notes

1. We will use the term "complex trauma", although the other terms are equally descriptive and appropriate.
2. Reflective functioning is an overt manifestation (typically in language) of the underlying psychological processes involved in mentalizing.

Disclosure statement

No potential conflict of interest was reported by the authors.

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