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'How does that itsy bitsy spider do it?': Severely traumatized children's development of resilience in psychotherapy

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'How Does that Itsy Bitsy Spider Do It?':

Severely Traumatized Children's Development of

Resilience In Psychotherapy

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Abstract

This paper explores the ways in which traumatized children make use of a treatment relationship to develop their resilience. First, the concept of resilience is deepened by synthesizing elements from two theories: 1) Self-Determination Theory's emphasis on the importance for a person's well-being of her/his choices of goals of relatedness, autonomy, and competence (Ryan & Deci, 2008), and 2) Hope Theory's formulation that central constituents of hope are the ability to conceptualize pathways towards goals and a conviction of competence in goal attainment (Snyder, 2002). Applying this understanding of resilience to long-term child-centered psychotherapy, this study describes how the therapist and eight children in long-term psychotherapy co-identified treatment contracts and goals. By listening to children's presentation of their concerns, the therapist communicated to the children her understanding of the children's priorities. The children affirmed and/or revised the goals. This process continued throughout treatment, as goals were attained and children and therapist co-identified subsequent goals. The co-identified goals included sustaining a trustworthy, pleasurable alliance with the therapist, responding adaptively to disappointment, being able to think clearly, regulating violence towards self and/or others, developing friendships, caring for their bodies, mastering the challenges of learning and athletics, and optimizing their caregiving relationships (with parents and therapist). The goals could be categorized according to aspects of self-determination, specifically autonomy, relatedness, and competence. The therapeutic relationship can help children experience pathways towards attainment of their constructive goals and affirm their self-reflective competence, thereby awakening and confirming the hope that, with self-determination, is essential for children's resilience.

Introduction

"Down came the rain and washed the spider out… out came the sun and dried up all the rain, and the itsy-bitsy spider climbed up the spout again…"

This story is beloved of children from a very early age: by 18 months most children understand it and, expressing their thirst for meaningful symbols for their goal-directed activities and persistence, will repeat it and want it repeated over and over again. Also by 18 months, children have experienced many setbacks to their goal accomplishment, from the pain of teething to falls as they stand up and learn to walk. Hopefully, children have experienced plentiful affirmation from attuned caregivers, and internalize that support to develop the resilience betokened by the itsy bitsy spider.

Unfortunately, severely traumatized children commonly do not acquire resilience and instead pursue self-abnegation, hostility, or other symptomatic patterns, especially if they encounter impenetrable barriers to attaining their constructive goals (Cook, Spinnazola, Ford et al., 2005; van der Kolk, 2005). Hopefully, treatment makes it possible for them to acquire resilience, but further understanding of how that occurs is needed. This study explores how severely traumatized children acquire resilience in treatment, and also sheds light on children's capacity to be active, voluntary partners in treatment, focusing on two questions:

1) What is an up-to-date concept of resilience as an outcome of psychotherapy with children?

2) As part of understanding traumatized children's acquisition of resilience in psychotherapy, how do children co-create their treatment contracts and goals with their therapists (including in a long-term treatment context where clients typically have multiple goals, progressively accomplish them, and co-identify new goals with the therapist)?

Two theories are applied to deepen the understanding of resilience: 1) Snyder's Hope Theory (Snyder 1994, 2002; Snyder et al., 1997) and 2) Deci and Ryan's Self-Determination Theory (Deci and Ryan, 2000; Ryan and Deci, 2002, 2008), which posits that human well-being occurs as people have the experience of choosing and fulfilling their goals of autonomy, relatedness, and competence.

Theoretical background:

Resilience as Hope-laden Self-Determination

Resilience

The "itsy bitsy spider" is a model of resilience, pursuing her (or his) goal despite the adversity of the rain and having been temporarily "washed out." It takes the benevolence of the sun, which dries up all the rain and often is portrayed with a smiling face, as a context for the spider's resilience to be activated. Children's capacity for constructive goal pursuit in the face of obstacles can be conceptualized as a form of resilience, and perhaps the therapeutic relationship functions in part like the sun: a benevolent support affirming that the child can fulfill healthy goals, and shedding light on obstacles so they can be surmounted.

Resilience has been defined as the ability to thrive despite adversity or, psychologically speaking, the capacity to experience trauma and loss and yet sustain intact adaptive functioning, including inner well-being (Sroufe et al., 2005). It has long been recognized that persons can be exposed to similar traumatic stressors yet react differently, so the keys to resilience have been tantalizing human development researchers for decades. Werner and her colleagues (1968) demonstrated that children exposed to community stressors and poverty were resilient if they experienced consistent loving support from their families. In studying the risk for PTSD in Palestinian children exposed to the sustained violence of

the Intifada, Garbarino and Kostelny (1996) posited an "accumulation of risk" model. Parents' stable, healthy marriages and emotional availability to their children immunized the children to post-traumatic stress reactions from exposure to warfare.

More recently, in their pathbreaking longitudinal study of human development with at-risk children in Minnesota, Sroufe et al. (2005) documented how social services build resilience by supporting parents' and children's healthy attachment capabilities (or working models of attachment, following Bowlby). Sroufe and colleagues also emphasized the importance of learning more about how social services can nurture resilience (Ibid, p. 44-45).

Ungar (2006) reported on the International Resilience Project (IRP), which has been studying resilience in children and adolescents cross-culturally in 14 communities, using participatory action and mixed methods so as to maximize fidelity to diverse, culturally-specific constructs. According to his team, resilience is: "the capacity of people to navigate to the resources they need to overcome challenges, and their capacity to negotiate for these resources so that they are provided in ways that are meaningful" (IRP, 2013). It is, "a multidimensional construct, the definition of which is *negotiated* (italics theirs) between individuals and their communities, with tendencies to display both homogeneity and heterogeneity across settings" (p. 219). Following the IRP's definition, it is important to conceptualize resilience in terms of children's subjective experience of meaningful support in the face of obstacles.

Two contemporary theories are especially relevant for deepening the understanding of how children acquire resilience in treatment because they focus on persons' subjective experience of goal formation (intentionality) and choice, and have a significant empirical base: Deci and Ryan's Self-

Determination Theory (2000; Ryan and Deci, 2002, 2008), and Snyder's Hope Theory (1994, 2002; Snyder et al., 1997).

Self-Determination Theory

Ryan and Deci (2008) define self-determination as an experience of inner freedom to pursue goals that one regards as most important, satisfying, and vitalizing. In application to psychotherapy, Self-Determination Theory proposes focusing on a flexible, as opposed to manualized, process of treatment, and ensuring treatment offers clients the experience they are actively responsible for change (Ryan & Deci, 2008). Self-Determination Theory offers one explanation for why child-centered treatment, which allows child clients to co-create the treatment contract and goals, has such a powerful impact on children's motivation to change: People are most motivated when they have the experience of being able to freely choose their goals for their own intrinsic satisfaction (rather than for external rewards such as complying with an agenda set by the therapist).

Three essential types of goals -- competence, autonomy, and relatedness – when chosen freely and satisfied, bring about the well-being of self-determination (Ryan & Deci, 2008). Specifically, competence is a person's assessment of her/his capability to successfully complete a task, a "felt sense of confidence and effectance in action" (Ryan & Deci, 2002, p. 7). Autonomy concerns perceived internal locus of control related to choices, acknowledgment of feelings, and opportunities for self-direction (Deci & Ryan, 2000). Relatedness refers to "feeling connected to others, to caring for and being cared for by those others, to having a sense of belongingness both with other individuals and with one's community" (Ryan & Deci, 2002, p. 7).

Hope theory

According to C.R. Snyder, "hope is defined as the perceived capability to derive pathways to desired goals, and motivate oneself via agency thinking to use those pathways" (2002, p. 249). Hope Theory assumes that human behavior is goal-directed (Snyder, 1994). Hope involves pathways thinking, or the planning of ways to achieve goals (Snyder et al., 1991). Hope is also comprised of agency thought, which is one's self-assessment of one's capacity to carry out the paths to goal attainment (Snyder, 2002). When one encounters obstacles, a conviction of agency creates motivation to generate alternative pathways (Snyder, 1994, as cited in Snyder, 2002). Snyder posited that hope provides resilience, enabling persons to believe they can achieve their goals despite adversity (Snyder, Hoza et al., 1997).

Towards a synthesis relevant for child treatment

Building on previous definitions, in this study, resilience is regarded as a capacity for making use of available support (in this case, a treatment relationship) to respond to adversity with re-awakened hope and the pursuit of constructive goals (autonomy, relatedness, and competence, associated with self-determination per Ryan and Deci, 2002), rather than maladaptive goals (or symptoms).

Severely traumatized children come to therapists with multiple symptoms and long histories of having been maltreated in their families, and/or having suffered terrifying events such as life-threatening asthma or exposure to community violence. Recently, the term complex or developmental trauma has been advanced as a nosological category, superior to PTSD because it captures the multiple types and long duration of trauma that such children have unfortunately endured (Cook, Spinnazola, Ford et al., 2005; van der Kolk, 2005). When development is distorted by traumatic experiences, children's pursuit of constructive goals is thwarted (Lieberman

& van Horn, 2011; Perry, 2002, 2009; van der Kolk, 2005). Instead, trauma and crushing opposition compel children to substitute destructive goals for their constructive goals. Examples are the prematurely sexualized behavior of children forced into child prostitution, or long-lasting temper tantrums, head-banging, destruction of property or violence against others, suicidal efforts, eneuresis or encopresis, resistance to learning, etc. Children may be so terrorized that they give up their own goals, organize themselves around a goal of complying with abusive parents' goals, or develop goals of dissociating ("going numb" to avoid extreme emotional or physical pain). Neglected children tend to present with disorganization (Sroufe et al., 2005) or emptiness (Perry, 2011) rather than age-appropriate, constructive goal-directed activity.

Child therapists commonly find that traumatized children "reenact" traumatic experiences in various ways, either by playing out stories of the traumatic events (Gil, 2010; Sugar, 1988), or by relating with the therapist in ways that communicate clearly what the child has endured (such as cursing at the therapist or trying to grab the therapist's genitals). Outside of treatment, such re-enactments can provoke further trauma. Fortunately, in a treatment context re-enactments are opportunities for mourning and represent children's efforts to enlist therapists' help in attaining mastery over traumatic experiences and their psychological aftermaths.

Complexities in Inquiries about Child Treatment

Potentially, a more complete picture of child treatment and children's development of resilience can take shape if knowledge includes children's perspectives on their treatments. Many commentators recognize children's relative disempowerment and potential to be silenced by adults. They urge the importance of including children's points of view in knowledge about

services for them (Bellefeuille & Ricks, 2010; Ben-Arieh, 2005; Garbarino and Stott, 1989; Petr, 1992). However, this is not so easily done.

It is challenging to present psychotherapy process in a systematic inquiry in part because while therapists readily perceive in the child's communications several layers of meaning about the child's context, the child's inner life, and the child's relationship with the therapist, scientific data presentation necessarily reduces those multiple dimensions to a few (depending on the theories selected). In other words, child clients can communicate multiple layers of meaning in any given moment, giving rise to the question about which layer(s) of meaning is salient for scientific purposes. For example, at the end of a session seven year old Mia approached the door holding a toy mother doll behind her back and, aware of the rule that toys stayed in the therapy room, said, "I don't have anything with me." Her demonstration of her wish to take the therapist with her at the end of the session, and yet her conflict about straightforwardly communicating it ("I can't just say I wish you could come with me, I have to hide it") took precedence in how I understood her. Yet, one could argue she was demonstrating her ability to "lie," or her ability to represent another's mind and then try to shape the other's understanding of her, or she just wanted the doll because she was deprived, etc. How one interprets any given client communication will be shaped by one's theories, values, and prior experiences. Even therapists using the same theory may do very different things and understand the same vignettes very differently (Kazdin, 2003).

The multiple ways of understanding Mia's communications opens a window into the realm of intersubjectivity – a term referring to knowledge that exists between two or more minds, or is consensual. In psychotherapy, intersubjective knowledge refers to meanings created in the context of the

therapist-client relationship, and assumes the ability to enter into and reliably verify another's inner experience, generally via empathy (Kohut, 1959; Atwood & Stolorow, 1993).

When it comes to scientifically verifying and presenting intersubjective knowledge, including children's perspectives, a dominant philosophy of social and behavioral sciences termed positivism has held one could and should eliminate subjectivity from scientific knowledge (Scriven, 1969; Slife, 2004). As positivism dominated the social and behavioral sciences from the 1920s through 1980s, subjectivity and even client opinions about services became taboo ontologies (Tyson [McCrea], 1995; Campbell, 1969). Under positivism, empathy was regarded as inherently unverifiable and unreliable as an epistemology for generating scientific knowledge.

Fortunately, since 1979 numerous efforts have been made to develop postpositivist approaches to knowledge for the social and behavioral sciences (Baert, 2005; Danziger, 1988; Manicas & Secord, 1983; Saleebey, 1979; Tyson (McCrea), 1995; Slife, 2004). Postpositivist researchers emphasize that even the most seemingly pristine studies reflect profound influences of the research method on participants and the data obtained (Danziger, 1988; Hall, 2010; Manicas & Secord, 1983; Slife, 2004; Tyson [McCrea], 1995). Researchers and all participants in research are changed by their research processes (Baert, 2005), including readers (Gadamer, 1975).

In the context of these more up-to-date philosophies of science, standards have been developed, such as trustworthiness and credibility, that emphasize articulating the assumptions comprising the lenses and processes used to generate scientific knowledge (Denzin, 2005; Guba & Lincoln, 2000; Tyson [McCrea], 1995). Embracing social constructionism (Gergen, 1985; Witkin, 2010), pragmatist (Baert, 2005), or critical realist

philosophies of research (Manicas & Secord, 1983), researchers wade into the messiness of intersubjectivity, leaning on reflectiveness about standpoint and impact, and including as many perspectives in findings as possible (triangulation). Studies of psychotherapy from a postpositivist standpoint unabashedly use empathy (Atwood & Stolorow, 1993; Kohut, 1959). Client opinions about services are restored to a position of importance for scientific knowledge. No longer is it necessary to reduce client communications to behavioral observations or responses on standardized scales in order to carry out informative inquiry: It is possible to scientifically value the unique dialogue that occurs in psychotherapy, in which therapist and client create shared meanings. Their dialogue is deeply personal and yet at the same time potentially open to careful scientific study.

Accordingly, the treatment contracts and goals described below include children's perspectives but more accurately represent processes of co-development, calibration, and mutual recognition between therapist and client (Warshaw, personal communication, July 24, 2013). The therapist strives to create an atmosphere of safety and respect so the child can present concerns, and enables the child to arrive at a mutually agreeable formulation of the child's wishes and goals for their work. Their ongoing collaboration continually modifies these mutual understandings. Following postpositivist standards in this inquiry, I have included the therapist's communications in the examples provided to offer readers a window into the therapist's impact on the children's communications. The child-centered, humanistic approach to treatment is described here, as well as the lenses used to interpret the clinical material (Self-Determination and Hope Theories).

To preserve confidentiality and anonymity, in accord with statutes and codes of ethics, all identifying information and specifics of dialogue have been disguised. Data disguise is a very important issue scientifically, as clinical researchers aim to meet contemporary standards of trustworthiness in contemporary research (Guba & Lincoln, 2000) and of necessity make decisions about disguise in order to meet ethical and legal standards as well. Decisions about the elements of the treatment process to disguise and which require presentation without disguise are complex and require a paper for adequate discussion. One cannot do what Freud did, which is have a systematic key for the disguising process, because people figured out his key and then his clients' identities. What can be said here given space constraints is that potentially clinical researchers can meet scientific and ethical standards by disguising those data that are not central to their research questions, while preserving the data pertinent to their questions. Accordingly, for any one case I disguised identifying data and some specifics of the treatment process, but preserved treatment contracting and goal formation data. Thus, contracting and goal identification processes occurred as presented below. However, no child clients would recognize themselves in the cases presented below.

Treatment Model

The clinical interactions presented below were generated in the context of a child-centered treatment relationship. There is now ample evidence that non-directive (also called humanistic) child-centered treatment is an effective treatment model (Bratton, Ray, Rhine, & Jones, 2005; Gil, 2010; Landreth, 2012). The child-centered treatment relationship prioritizes helping children communicate their wishes in treatment, and affirming children's opinions about treatment focus, pacing, and duration. It avoids adultcentrism (Petr, 1992) and implicitly carries a human rights point of view into the child treatment relationship. In contrast, in

directive models of child psychotherapy, while therapists consider children's contributions, the therapists' agendas take precedence over children's agendas.

Contemporary child-centered and trauma-focused theorists draw from the extensive legacy of psychodynamic treatment approaches offered by pioneers such as Anna Freud, Melanie Klein, and Selma Fraiberg (1987), and from client-centered treatment models advanced by Virginia Axline, Dorothy Baruch, and Clark Moustakas. More recent theorists have applied Kohut's self psychology to child treatment (Elson, 1986). Because this paper focuses on treatment contracting and progressive goal formation (relatively conscious processes), it leaves out of focus (more unconscious) psychological processes such as defense mechanisms, dissociative states, transference and countertransference (including the self-object transferences identified by Kohut). The focus here does not imply that preconscious and unconscious dynamics do not play a significant role in child treatment (and did in the case examples provided below).

While most child-centered treatments reported in the literature (notably by Landreth, 2012) are relatively short-term (15-50 sessions, which is not short-term by adult standards of course), this study focuses on treatment with children who needed many years of treatment to attain a normal developmental course. Some of the children wanted to continue treatment into adulthood (and did, since in child-centered treatment children have a strong voice in determining treatment duration).

The focus on individual child treatment does not imply that treatment of the family and interventions with the child's school are unimportant. In fact, since children who do not receive treatment develop their most fundamental self experience in the context of parental caregiving relationships, all parents whose children received the treatment described

here were encouraged to participate in individual psychotherapy or parental counseling. However, unfortunately some of the parents of the children described below refused treatment for themselves (Felipe and Roger), and others pursued treatment with other therapists very ambivalently (Selina and Auggie). Accordingly, the data below also address whether psychotherapy can have positive effects, even under the suboptimal conditions of parents refusing or participating intermittently in treatment for themselves.

While the clinical material below cannot represent long periods in which the therapist did not speak, there were many, many sessions in which the therapist said very little, sometimes nothing more than variations on "hum" or "wow." The therapist's patient, gentle listening can signify safety, acceptance, and liberation for children who have not yet experienced the joy of a relationship in which they could feel truly free and deeply valued.

Treatment Contracts

Many researchers studying child treatment have said that child clients are inevitably "involuntary," including Selma Fraiberg (1987). Yet, Selma Fraiberg herself described a child client who of her own accord knocked at her door, asked if she helped children, and then if she could get help. In fact it seems that whether or not children are voluntary is strongly related to the treatment approach used: Kazdin (2003) emphasizes a cognitive behavioral approach in which the therapist sets the agenda and the key issues addressed are determined primarily by the therapist. He describes children as invariably involuntary. By contrast, the many therapists who use child-centered approaches report that child clients are eager participants (Gil, 2010; Landreth, 2012). This issue is extremely important, in that therapists of adult clients have found change is best accomplished when clients feel intrinsically motivated to bring it about

(Ryan & Deci, 2008). There is no reason to conclude it should be any different just because the clients are children.

All the child clients described in this paper were voluntary. In the first session (or shortly thereafter) they said they would like to come for help and they identified what they would like to work on together. For the great majority of sessions the parents found the children came readily (some children even reminded their parents when it was time to come to treatment). Most children came to treatment once weekly. Mia, Charisse, and Auggie requested increases in treatment frequency to twice weekly. As they attained self-regulation, treatment frequency was gradually reduced.

The elements of treatment contracts typically used with adults (problem and goal identification, role clarification, confidentiality with the caveat of harm prevention) can be included in child treatment, as is evidenced in the first interview with Carl:

T: Hello, Carl, my name is X. I help children with their feelings. We're going to spend some time together today and you can let me know how you feel about what we're doing, and then I'll take you back out to your mother. I'll keep what we say and do private unless someone is getting hurt, then I'll have to try to stop that.
C: oh. okay. what's this? (pointing to doll house)
T(therapist): a house
C: (takes the dolls and identifies them) this is the father. This is the sister. This is the boy. She's older. The mother is over here (outside the house) - in her car. She went away for a while. Then the mother comes back and the father leaves for work (has him drive away) The sister and brother fight (beating them up).
T: I wonder what they are fighting about?
C: sister to him: you're just like dad I can't stand you...
T: wow I wonder what that's like for him?
C: he doesn't care. Now the sister and the boy go to sleep...he's dreaming about school.
T: uh huh. what about?
C: teacher ... he has a test. oh no. now the phone rings.
T: uh huh, what happens.
C: (out of the story momentarily, asks therapist directly) do you have a rubber band?
T: yes - how's this?
C: fine. (puts it around the father's neck - father is hung)
T: wow. how did that happen?
C: he did it
T: who did it?
C: the father did it to himself.

T: how come?
C: now the mother wakes them up. She's crying
T: what about?
C: stop crying mom (boy doll says to mother). Now he makes the dinner. She's still crying.
T: Gee that looks hard. I wonder how he's feeling about what happened?
C: okay. Well worried. not really.
T: um hum. Can you say what he's worried about?
C: what his sister said.
T: uh huh - when she said that he's just like his dad?
C: yeah.
T: and does that worry him because his dad hurt himself and died?
C: uh huh
T: is he afraid he might hurt himself?
C: um. Let's not play this anymore. Can I color?
T: sure. It's terrific you could share those feelings here, Carl. I wonder if you're saying your father hurt himself and died, and part of you worries you might hurt yourself too?
C: sort of.
T: those are just the kind of very very painful feelings we can help you with here.
C: oh. Good.

The therapist learned later that Carl's father had committed suicide when he was three years old. His mother had remarried and brought Carl for help because he was jumping off high places in school, staff were worried about this behavior, and also thought he might have ADHD. His mother said she thought Carl did not remember his father or his death. From Carl's story it is clear that in fact, the loss of his father was uppermost in his mind, he had never been able to mourn it and was still frightened and wanted help with it.

Not all children present their central concerns with Carl's straightforward trust. Some children, like Charisse, are so tortured by separation anxiety that they come reluctantly and need help with their fears about being with the therapist. Children feared the therapist might give "shots," be psychologically hurtful (Charisse), or a murderer (Mia feared the snacks available to her at her request in the second session were "poisoned"). Even when children protest loudly initially, if they are helped with their fears and allowed to choose treatment goals, often they quickly become voluntary clients. Three year old Auggie, for instance, who

had been brought because of acute separation anxiety, prolonged temper tantrums, refusal to engage in any toileting activities, alternating intense sorrow and elated destructiveness, head-banging and other self-harming behaviors, reacted to the therapist's invitation to come in with vociferous protests and evident fear. However, as soon as the therapist said, "these are the feelings that make it hard to play with friends and enjoy yourself, and this is what we'll help you with" and showed him the play room, he turned to her and calmly said, "let's play." At the end of the first session Auggie gave his mother the therapist's card, saying "Come back."

While adult clients commonly seek help because they have some hope that a relationship might bring about change, children who have not experienced a therapeutic relationship do not have that hope. Even if parents tell their children that the therapist is a feelings doctor who can help them, children generally do not know what that means. Rarely do they express the hope that they can change what bothers them until children experience, through the treatment relationship, change occurring for them.

Children express their despair in many ways. Paolo was brought for therapy because his acute separation anxiety interfered with all normal social and educational activities, causing night terrors, temper tantrums, and self-destructive behavior. At his first session, extremely reluctant to part from his parents, he looked manifestly frightened -- his eyes downcast, his posture slumped, profoundly sad. In the office, he saw a seashell and asked if there was a dying animal inside. With exploration he shared that he too felt like he was dying and experienced continual wishes to jump out windows and kill himself (which he later shared he had never revealed to his parents). The therapist said,

T: Our relationship can help with the very painful feelings that are making you feel like dying, it's so great you could share them

P: good.
T: we can build a home in your mind together that you can choose to live in if you want, that will help you with the hard feelings and where you can be happy.

Even the possibility of hope can have a significant impact on a child overwhelmed by despair. Towards the end of the session,

Paolo got two puppets; he took one and gave the other to the therapist, saying, "You say the words and then I'll say the words.
T: Can you tell me what you'd like them to talk about?
P: About building the home. You start.
T: It's really great you could share all the different feelings here, the happy and the sad and the mad feelings—it will really help to build that new home in your mind.
P: Then it can be easy.
T: Yes, when you feel good about yourself, then everything is easier.
P: Say some more.
T: And you have lots of different feelings to share.
P: Sometimes it's easy, sometimes it's hard.
T: Maybe you're saying that for part of you it feels easy and good to share your feelings, but for another part it feels terribly hard.
P: It was hard out there when I didn't know you.
T: Maybe you're worried that when you come back next time it might feel very hard again, and it's just the thing to do to share when it feels hard and have help with what makes it hard.
P: Good.

Parents' goals for their child's treatment may coincide with children's but often are quite different, as in the examples of Carl and Paolo above. Child therapists have varied in their approach to this issue, from an extreme view that children are completely unreliable and their reports have to be verified by parents after every session, to child-parent (or filial) psychotherapy (Lieberman & van Horn, 2011). In child-centered treatment, therapists take parents' perceptions seriously but keep the treatment process focused on what the child identifies as important (Gil, 2010; Landreth, 2012). As children get better, their parents are deeply gratified and generally agree with the child and therapist that the problems are resolving, which occurred in the cases presented here.

Co-formulated Children's Goals and their Accomplishment

"Relatedness" Goals

The goals below were co-identified by the children and therapist. Depending on their strengths, not all children needed to accomplish every goal. Charisse, for instance, came to treatment a fine athlete and a leader in her class academically. For analysis in this study, the children's treatment goals were categorized according to Deci and Ryan's three categories of "relatedness," "autonomy," and "competence." The categories below include all the goals the eight children sought to accomplish.

A secure, pleasurable alliance with the therapist

All eight children expressed a wish for a stable, pleasurable relationship with the therapist, albeit with varying degrees of ambivalence, especially in the initial phase of treatment. Children have profound needs for attachment, and secure parent-child relationships are associated with adaptive functioning in all areas (Sroufe et al., 2005). It follows that the *sine qua non* for effective treatment is helping children develop a healthy, strong attachment with the therapist, which becomes the foundation for growth in specific functional arenas (Perry, 2011; van der Kolk, 2005). Often children express their motivation for a secure attachment immediately:

> Six year old Mia's grandmother described her as experiencing chronic, prolonged temper tantrums in response to minor triggers such as having to wait for a juice. She was isolated and alienated from peers. Constant nightmares and terrors plagued her. Grandmother complained she was continually noncompliant. In her initial treatment session Mia showed, both verbally and through play, a state of chronic agitation that made it impossible for her to pursue a logical train of thought for longer than 30 seconds at a time. She described acute fear at separations from her grandmother, constant fears that she had to take care of her grandmother, painful chronic nightmares, fears of others such as a fear of being poisoned, and homicidal and suicidal feelings. Even so, in the first session Mia progressively indicated confidence that the therapeutic relationship could be a healing remedy. At the end she took the toy walkie-talkie plastic connecting line, and wound the line around her leg and the therapist's leg so that they were bound together by this symbol of communication. She said, "we're going to be together for life."

Other children indicated their attachment with the therapist symbolically, as occurred with Felipe in his 15th month of treatment:

> Felipe brought his ferret to a session. He also had brought his game-boy (a handheld computer game), and, after putting the ferret in the therapist's arms, he spent the entire session playing the game-boy, occasionally looking over at the therapist and the ferret to see what they were doing. He clearly did not want the therapist to say anything or to do anything in particular with the ferret, and so the therapist stayed silent and held the ferret gently. The ferret crawled inside the therapist's jacket, curled up under her arm, and fell asleep. Felipe looked at the therapist and the ferret periodically but said nothing. At the end of the session, Felipe looked over at the therapist and the ferret and said, "oh, look where he is – hum – " and he looked quizzically at the therapist, who said, "I wonder how he's feeling?" Felipe smiled and said beatifically, "really great."

While Felipe communicated that the ferret rather than himself enjoyed the deepest closeness, this formerly alienated child had begun to regard closeness as most desirable.

An advantage of affirming children's own treatment goals may be that the children experience deeper involvement in the treatment relationship, the engine for the therapeutic action (Barish, 2004). For example, when children can share both positive and negative affect (as did Mia and Felipe), they internalize the therapist's reflective response and develop better affective self-regulation (Barish, 2004).

Self-regulating violent motives towards others

Once Auggie and Mia felt safe with the therapist, they both demonstrated their difficulty with violent motives towards others. Violent outbursts followed moments in which they had relaxed their guard and experienced a close attachment with the therapist, or else during moments of disappointment and consequent vulnerability (the end of sessions for instance). Their violence appeared to express fear of being hurt as they had been in the past:

> Upon walking into the office, Mia got the candy and small ball of yarn that were waiting for her, and she yelled,
> M: "you take them out to my grandmother, I'm staying here."
> T: "Gee, I hear it's feeling hard to be together. It's our time though, so we can take it out together if you like, or else I'll stay here with you".
> M: tried to kick and punch the therapist.
> T: initially dodged her kicks and punches and then, when Mia was getting more aggressive, held her arms so that she was far enough away that she could not kick

her, then said, "I can't let you do that but I can see that a part of you gets angry when another part of you starts to feel good and close here."

Mia then began to arrange the candy in the form of what she called a "yummy feast," and after a minute of arranging and expressing her satisfaction, she tried to punch the therapist in the lip with all her might.

T: caught her hand and said, "I can't let you punch me, but one part of you is feeling good and close about having the feast together, and then you feel mad and want to punch me…"

Later in the session, Mia asked the therapist to make drawings for her, and she was dictating the form of the drawing. While the therapist was drawing what she wanted,

M: "Move this [the lamp] over here it won't stretch."

T: "Why do you want to do that?"

M: "To put it on your head and burn you." Then, by telling the therapist, Mia also heard what she had said and said "no."

T: "Well I can't let you burn me, but I think what's happening is that one part of you is feeling good and close that we are drawing what you want to express, and then part of you feels like burning me; it's great you can tell us about those different feelings and recognize you don't agree with the part of you that feels scared and mad after you feel close."

Mia's violence gradually receded, both in and outside of treatment. Auggie's self-regulation was acquired in similar fashion.

Optimizing caregiving relationships

These traumatized children had experienced numerous disappointments in relationships with caregivers, and struggled to cope adaptively with such disappointments. They worked on understanding and handling moments when their parents were distressed. Felipe described his mother's harshness, commenting, "when I grow up and feel like yelling at my kids, can I come here for help so I won't do it?" Selina at six years old tried telling her upset mother, "Mom I think you're stressed out, you need to relax," surprising and calming her mother. While Felipe insisted on the privacy of his treatment, Roger asked the therapist to assist in communicating unmet desires to his parents. Clearly they sought in their own ways to optimize their relationships with their parents.

Disappointments can occur in the treatment relationship if the therapist makes what Lieberman and van Horn (2011) describe as "lapses in

attunement." Therapists can help children develop the capacity to evaluate the care they are receiving and communicate their need for better care:

After Auggie had been in treatment twice weekly for three years, many of his symptoms had remitted – he was using the toilet, no longer hurt himself or others, had friends his own age, talked easily and with great pleasure, made up fantastic creative stories, and his teachers told his parents he was doing well in school. After an interruption, Auggie's parents chose not to bring Auggie for the extra hour Auggie had wanted, and that the therapist had made available. Then, Auggie came in and confided that he had been terrified, with fears of a wizard who came and took away a child's parents. He was worried that a wizard might take his parents away too. The therapist's first response was that Auggie's mad feelings with his parents were feeling stronger because of the interruption. Auggie replied, "no, don't say that." The next hour he came in and said with great frankness and confidence, "It didn't work what you said about the wizard, think of something else to tell me about it."

At the beginning of the following session the therapist said she had thought about what Auggie had asked her -- to "think again" -- and wondered if he wanted to know what she thought. He said yes, and she said that perhaps Auggie's fear of the wizard taking his parents away was because Auggie was upset with them for not bringing him for the therapy, which was so important to him. Auggie smiled and said, "Maybe." After that he was no longer afraid of the wizard and spent the time with the therapist making a delicious picnic lunch together that they could share.

Auggie could respond to failure in attunement by telling the therapist when she had missed the boat, and seeking a better reflection and the resulting comfort from the therapeutic relationship.

Resilience in response to separations

Children's acquisition of resilience can be evaluated by examining how they respond to inevitable separations in the treatment relationship, such as the session ending or the therapist's vacation, as Mia exemplifies.

In the fifth month of treatment, when the therapist said they were going to have to end in a few minutes, Mia tried to scratch her and, when the therapist held her hand, she said, "I'll sharpen my nails and scratch your eyes out…" "I'll break glass and kill myself and you." By the 10th month of treatment, as the therapist was saying they would end in five minutes, Mia lay on the floor, clearly refusing to go. The therapist told Mia she could see Mia was communicating how terribly hard it was to have to stop their session. Mia screamed, trying vehemently to kick and punch the therapist, who stopped her by holding her in a hug while saying she understood how hard it was to stop and that she could not let Mia hurt herself or the therapist. After a few minutes, Mia then said, "let me go, let me go I can walk, I can walk." Mia got her notebook and walked out bravely with the therapist.

With two years of gradual progress, Mia could handle the end of sessions with reluctance communicated verbally rather than physically.

Peer relationships

In her first session, 3/12 year old Selina lamented, "All the rocks are sad," and said forlornly, "My mom gets mad at me." She showed one doll hitting another doll while playing, and said "yes" when the therapist wondered whether Selina felt bad and felt like hitting other children. Right away she demonstrated the problem of interpersonal aggression that had caused her to be dismissed from preschool and caused her parents to bring her for help. At the end of that first session, when the therapist said, "we can keep meeting and helping you with these hard feelings," Selina immediately said, "I want to."

For other child clients, the goal of improving peer relationships came up only later in treatment. For example, Felipe's parents had said he had a problem bullying vulnerable children. Felipe himself began tackling this problem only after he worked on his life-threatening asthma, fits of rage that caused him to break his bones, and suicidal thoughts (more important priorities which his parents had not identified). Mia began to work on friendships in the fourth year of treatment, after she tackled her aggressive behavior and difficulty sustaining logical thought. Charisse worked on friendships in part by asking the therapist to help her call friends and plan play dates and parties.

"Autonomy" Goals

Responding adaptively to current disappointments and serious loss

Autonomy can be understood as the capacity for sustained self-regulation, or volitional choice of constructive goals, regardless of external constraints or rewards (Deci & Ryan, 2000). One sign that traumatized children in treatment are becoming more autonomous is that they can continue to pursue constructive goals when faced with disappointment and even serious loss (rather than responding with symptomatic behaviors).

Traumatized children can have devastating reactions to even the slightest disappointments. For instance, towards the beginning of her treatment Mia wanted to enter a contest offered on a candy wrapper but cried, "I won't win, I never win at anything!" (The therapist arranged for her to experience a "win"). Auggie said, "I never get what I want," and Paolo complained about a disappointment, "I knew it would happen, things like that always happen." Furthermore, trauma can cause children to engage in re-enactments (Gil, 2010; such as Carl jumping off high places), which then cause children additional losses (alienated friendships, injuries, bad grades, etc.). The therapist has the critical task of helping children become able to respond to disappointment and even serious loss adaptively, so as to develop their autonomy. This process is a cornerstone of resilience.

Tragically, Charisse had to make use of the support of the treatment relationship to respond constructively to a profoundly threatening loss:

> She was brought for treatment at the age of 8 by her (single) mother, because her debilitating separation anxiety and chronic tearfulness interfered with her school attendance and concentration and having any normal socialization with friends. Both Charisse and her mother described the extremely painful event of the death of Charisse's aunt (who had raised her along with her mother) when Charisse was 4 years old. Charisse's aunt had fallen while the family was visiting a church together, sustaining injuries to her head that resulted in her death. Charisse saw her aunt after the fall and had extremely painful memories of the experience.
>
> In the first session of therapy, Charisse complained her sister (who was younger than she) beat her up, and that she was "afraid of getting in trouble with my Mom." She was worried about losing things that she liked, and as the session progressed showed through pictures that she felt others (including the therapist) lied to her. Despite that profound mistrust, she was very motivated for treatment. The first session ended with the therapist commenting, "Things can feel good sometimes but really hard sometimes too and coming here can help with what's feeling so hard." Charisse said, "I want to come next week and think about it." Expressing her hope and idealization of their work together, she asked the therapist to organize a treasure hunt for her, commenting, "we're finding buried treasure!" As treatment progressed, Charisse shared intense fears of being locked in dungeons and tortured, and in those fantasies the reason for the torture was always her own misdeeds and inadequacies. She often portrayed those in helping roles as wounding or killing children. Gradually, Charisse mourned the loss of her aunt. She shared painful feelings of self-blame, for instance that she should have been able to prevent her aunt's fall or save her life once she had fallen. Then she could address other goals, such as feeling more comfortable asserting herself in games and speaking up in school. Her anxiety began to diminish and she clearly began to feel more confident in her world.

But just as this occurred, in the third year of treatment, Charisse's mother needed treatment for heart disease beginning with a hospitalization. She asked the therapist to call her between sessions. Subsequently, for the entire two years her mother was undergoing treatment and rehabilitation, Charisse was almost always the person who answered the phone when the therapist called at their scheduled time, and she used the phone calls to sustain her resilience in the face of this serious loss.

Choosing physical self-care over physical self-abuse

The following interview provides an in-depth look at the process of goal-setting in the middle of an ongoing treatment.

Felipe's parents said he had suffered from severe temper tantrums at a very early age. At five years old he had been physically and sexually abused by relatives for over a year before his parents knew about the abuse and began to protect him. When he started treatment at 10 years old, he had broken several bones, was setting fires at home and in parks with friends, had life-threatening asthma and despite that would smoke cigarettes, and was chronically in trouble in school for misbehavior. Felipe had rarely seen his father during the two previous years when his father had been put in jail for a white collar crime.
The following interview occurred in the sixth month of treatment, and indicates how Felipe, who had successfully surmounted his suicidal ideation and stopped smoking cigarettes because he perceived they aggravated his asthma, now began to co-develop a goal of getting help with his self-injury. He showed the therapist an injury, saying, "That's when I hurt my knee."
T: What happened?
F: I was riding my bike and doing wheelies. I pushed down too hard and the handlebars bumped against my knee.
T: Gee, that must have hurt.
F: It still hurts…
T: "It's great you're sharing about how you can make decisions that hurt your body."
F: No I don't. (He looked at candies the therapist had for him and asked about them, and the therapist responded to that question, also saying)
T: I can understand it feels that you don't, but you're also telling me about part of you that caused you to push too hard on the handlebars; and that has caused you to break your arm twice and your foot once...
F: Its just bad luck.
T: I can hear it feels like just bad luck but it's actually something we can help you do something about, and it would make things a lot better for you.
F: (continuing to deny that his motives were self-destructive): I'm just a daredevil.
T: Maybe it feels to part of you like just how you are, but I think you're also hoping we can help you make decisions so you don't feel so much pain.
F: But I know lots of other kids who broke their arms.
T: Maybe they need help too.
F: I've done this ever since I was three.
T: What do you mean?
F: When I was three I would bang my head against the wall. I've always done that.
T: Uh huh. Well, that makes sense that the part of you that can make these decisions was there even then. But we can still help you to change it.
F: But pain doesn't bother me.
T: Well, you've had a lot of pain for a long time and I think you've had to get used to it and tell yourself it doesn't bother you. But I think there's another part of you that would rather not be hurting.
The therapist stayed silent while Felipe got the candy that he had asked the therapist to have for him, and he started to enjoy it.

After a few months of working on how he hurt his body, in one session Felipe, when inclined to hurt himself, instead of carrying out that intention showed the therapist his inclination and said "that hurts." The therapist affirmed his self-care. In another few months Felipe had stopped trying to hurt himself altogether and expressed thoughts about hurting himself only in a bantering game with the therapist.

Another aspect of physical self-care, using the toilet, was a problem for only one child, Auggie. He began to address this problem after tackling his aggression against himself and others. Having been too terrified to use the toilet in any way, Auggie began sharing his feelings, one day pointed to the toilet, and then took a toy airplane and crashed it into a toy building (this occurred prior to the September 11 terrorist actions). When the therapist inquired about whether Auggie was worried that using the toilet could mean a crash, Auggie vehemently said, "yes if I poop in there it will knock down this whole building!" He progressively worked on those fears until he had the pleasure of competence in using the toilet.

Coping adaptively with physiological symptoms

Paolo and Felipe struggled with life-threatening bouts of asthma. Both used the treatment relationship for support so they could attain better self-regulation over that symptom, and also for help with the terror that the acute episodes induced. The following example shows how Paolo initiated this goal.

Almost two years after he started therapy, Paolo initiated a game of soccer with the therapist. His asthma was greatly exacerbated by exercise. He was unable to participate in gym class or other athletic activities for longer than the briefest periods of time. When Paolo initiated the soccer game, it was with a compelling intensity. Whereas previously he had delighted in the therapist letting him win games, now he requested that she "play your hardest," and then played without comment until he was breathless. After resting for several minutes to catch his breath, while watching the therapist intently, he resumed. After several cycles of intense playing, breathlessness, rest, and resumed play, it became clear to the therapist that Paolo sought to use the treatment relationship to develop regulatory control over his asthmatic reactions. Sure enough, within a few months of this work together, Paolo became able to play soccer and basketball, and he began to enjoy gym class with the other children.

Competence Goals

Learning

Once Mia had addressed her violent behavior, she then began to work on the trouble she had with sustained, logical thinking, asking for the therapist's help with sequential tasks and clearly wanting reflections for the agitation that made it hard for her to solve problems. She tackled very challenging drawing tasks that required focused attention and sequential following of instructions, such as paint-by-numbers. She became acutely frustrated when she made mistakes or was confused, enlisting the therapist's comfort. Eventually she became able to soothe her frustration herself.

Auggie tackled his learning problems by talking with the therapist about how painful it was to feel like a "loser" (when he could not figure things out). One of Felipe's final goals was learning, and he brought in his homework for support. Selina enlisted the therapist's help with her feelings about learning by playing school. She was a strict, humiliating teacher and wanted the therapist to express a student's feelings about such treatment and how to cope with it. She clearly wanted the therapist to model resilience in response to excessive self-criticism and the stressors of teachers' critiques.

Managing Competition, Winning and Losing: Games

While games have been used for some time as part of child treatment (Swank, 2008), from the perspective of helping children form a deep therapeutic attachment, games suggested by the therapist can give the message that the therapist seeks a competitive, adversarial relationship. However, when children decide they want to play games, they may be wanting to develop their resilience to the losses that invariably occur in competitive situations. Roger, for example, had such fragile self-esteem that when there was even a threat of losing at games he felt compelled to

cheat, then concealed his action, but then felt intense shame about the entire dynamic (he looked at the therapist's 'secret' scorecard in Clue on his way to the bathroom, for instance, and then elaborately feigned ignorance). As treatment progressed (and after he experienced many wins), Roger became more and more able to tolerate loss. He could express losses openly with the therapist without shame. This paralleled his ability to manage the hurly-burly competitiveness of boyhood friendships.

Conclusions

Every child in this study except one was able to surmount the symptoms of complex trauma and resume a normal developmental course. Roger made an initial recovery, but his parents (believing he was "cured" and no longer needed help) terminated his treatment before the therapist and Roger thought he was ready to stop. It was especially important to seven-year old Roger to have a private relationship of his own with the therapist, as he commented "My mother can make it rain in my room," and despite his pleas the judge adjudicating his custody arrangements did not listen to his preferences. When the therapist said in the initial session, "Here you can talk about what's happening with your parents, it's a place just for you so you can share the sadness and anger and find ways to not hurt yourself and care for yourself," Roger commented, "Good." Within a year of therapy, Roger's teachers reported significant improvements in his behavior. By 18 months of treatment, Roger had made use of the treatment relationship to help himself with feelings about his parents' conflicts and divorce, picking scabs until they bled, fighting with peers, and depression. When his parents decided to prematurely end his treatment, Roger shared his dismayed shock with the therapist, "How could they do that, this is the beginning of

life!" He enlisted the therapist's comfort for his passionate feelings of loss and anger and left determined to come back.

Nine years later, Roger, at 18, called the therapist, saying that finally he could drive himself to the therapist he wanted. Roger poured out the events of the last nine years, primarily disappointments and betrayals in relationships that were important to him, including with every member of his family. He also said, "There was one person who never let me down." He reiterated his wish to restart treatment and described how the treatment relationship had been a beacon of hope through all the difficult years.

Far from being involuntary clients, the severely traumatized children described above made treatment contracts and co-identified important goals for the treatment to accomplish. Then as treatment progressed, children continued to co-develop goals, working on one goal after the other so as to acquire competence in learning, athletics, care for their bodies, friendships, and family relationships. A stable attachment with the therapist was the foundation for this profound change.

The child clients described here communicated their treatment goals in many ways: at times directly and verbally, other times through the symbolic media of play. They counted on the therapist to recognize that they were sharing their anguish in the hope that the therapeutic partnership could help them understand and remedy their distress. Unlike adults, children cannot possibly know that help for their inner anguish is even possible. As treatment progressed and children acquired confidence that working jointly with the therapist could indeed help them feel better and accomplish goals they identified, the way children shared their goals became more reflective and openly determined. Older children could even say, "can you help me with…?"

Traumatic experiences appear to cause children to substitute for their healthy goals a goal that is (from an observer's point of view)

destructive, but, from the child's point of view, achievable. In other words, to preserve some form of self-determination, children find goals that cause symptomatic behaviors, such as picking scabs to ease the numbness brought about by dissociation, head-banging to ease self-hatred, not trying to ease fear of failure, becoming bullies or joining in aggressive gang activities to handle feelings they are boiling over with anger, suicidal attempts to try to end despair. With therapy, children can become reflective about their goals and able to formulate and choose adaptive, rather than maladaptive goals.

As treatment progressed, children chose goals that could be readily categorized into the three areas comprising self-determination: relatedness, autonomy, and competence. Resilience as understood herein is not a passive experience or a personality trait. Instead, resilience is a capacity discovered and developed through relationships, including a treatment relationship. Resilience is deepened as children have a reflective experience that their goals will be recognized by an important partner, they can formulate their goals, attain those goals, and receive affirmation of the well-being associated with that process.

The clinical examples noted above illustrate the profound importance of the treatment relationship in building children's hope. The therapeutic relationship made it possible for children who had previously been swamped by despair to discover pathways for attaining their goals. Because the treatment relationship also supported them in persisting in their goal attainment despite obstacles, children gradually acquired the sense of competent agency Snyder regards as an essential ingredient of hope.

The children's use of treatment clarifies some central features of resilience. The children practiced activities that were difficult for them, using the support of the therapist to push through frustrations and making mistakes. As the therapist's comforting care became familiar and

internalized, children came to naturally expect that the therapist would help them with small disappointments ("owies") and major losses (illness of caregivers). Rather than responding to disappointment with maladaptive habits, the children became able to respond to disappointment with a wish for comfort from caregivers (including the therapist). The ability to respond to disappointments adaptively, combined with their ability to co-identify and attain constructive goals, betokened the children's hope and self-determination, and their acquisition of resilience.

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