

# LIFESPAN DEVELOPMENT

**Cultural and  
Contextual  
Applications  
for the Helping  
Professions**

**J. Kelly Coker  
Kristi B. Cannon  
Savitri V. Dixon-Saxon  
Karen M. Roller**

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# Lifespan Development

**J. Kelly Coker, PhD, LCMHC, NCC, BC-TMH**, is a cis-gender White female in midlife. She is a professor and associate chair of the counseling program at Palo Alto University. She is also a fierce and loyal wife, mother, sister, daughter, and aunt. Dr. Coker has been a counselor educator for more years than she can count, and as part of this work has published and presented a lot. She loves nothing more than training emerging counselors how to be their best selves, how to work with humility and compassion, and how to always strive to meet their clients where they are. As a licensed clinical mental health counselor (LCMHC) and board-certified tele-mental health counselor, Dr. Coker works with a small handful of clients in a tele-mental health private practice. She is amazed by how often consideration of phases of life enters into her work. It is for this reason that she wanted to engage in this exciting project with three other warrior women. She would love to hear from you, students and educators, about how this book informs your learning, your clinical work, and your understanding of self. Please contact her at: [kcoker@paloalto.edu](mailto:kcoker@paloalto.edu) with any queries or observations or ideas.

**Kristi B. Cannon, PhD, LPC, NCC**, is a cis-gender, white female straddling the lines of early and middle adulthood, feeling a foot firmly planted in each camp and the associated lack of balance this causes nearly every day. She is a counselor educator, licensed professional counselor, and current director of counseling programs at Southern New Hampshire University. Inspired, first and foremost, by the infinite curiosity, wisdom, and beautiful insight of the early and middle childhood years—those associated with her precious three daughters—Dr. Cannon has also spent considerable time specializing in clinical work with adolescents and women’s infertility issues. Her passion for this project came out of a desire to better reflect the meaningful variations in life experiences she witnessed in her community and clinical practice and ones not often or frequently enough named in graduate textbooks. As a woman of significant unearned privilege, it is her goal to continue learning and challenging herself every day so that she may be a better partner, parent, friend, ally, counselor, educator, and human. Her collaboration with the amazing women on this project has certainly contributed, and she hopes that you take some of this away from this book as well. Please contact her at [k.cannon@snhu.edu](mailto:k.cannon@snhu.edu) to share your reflections or to offer your life experience and brilliance.

**Savitri V. Dixon-Saxon, PhD, LCMHC**, is an cis-gender female and African American single mother, daughter, sister, and friend (her most important intersecting identities). Her roles as the mother to an emerging adult and daughter to parents in late adulthood have fueled her passion for this book. Through workshops, speaking engagements, and articles, Dr. Dixon-Saxon has provided her expertise on a variety of topics related to diversity, grief, positive body image, single parenthood, and intergenerational workplace dynamics. A counselor educator and licensed clinical mental health counselor, she has a 30-year career in higher education in student and academic affairs and is currently a vice provost at Walden University providing oversight to the Colleges of Nursing, Social and Behavioral Health, and Allied Health. She is grateful for what she has learned from this co-author sisterhood and listening to the experts who have provided their perspectives from the field. It is her hope that readers will commit to a lifetime of learning because people and society are dynamic and require constant study. She is also hopeful that more helpers will embrace working with those in late adulthood. They have so much wisdom to offer. Please contact her at [savitri.dixon-saxon@waldenu.edu](mailto:savitri.dixon-saxon@waldenu.edu) to share how you are using this book to enhance your practice and research.

**Karen M. Roller, PhD, MFT**, is a cis-het, White, temporarily able-bodied tomboy whose body increasingly reminds her she is now in midlife. Born into the middle class and raised Catholic, she aims to retain the service orientation of that tradition’s true Teachers while she spends her adult pennies traveling the inhabited world unlearning the colonial aspects of it, and learning how the rest of the world embodies connection with the Divine; this makes her a yogic Sufi with an environmental conservation bent. She is an associate professor of counseling at Palo Alto University, and clinical coordinator at Family Connections, a parent-involvement preschool serving low-resource migrant families in the San Francisco Bay area. As a bilingual marriage and family therapist and supervisor who has been primarily field based, she has spent a lot of years facilitating sessions in tri- and quad-generational homes, foster homes, hospitals, and community-based settings; this has made her a trauma-informed, cross-cultural attachment nerd. Humbled by the impact of how oppression, cultures, and quality of caregiving relationships inform the sense of self across the lifespan, she has been blessed to learn from babies, children, teens, and adults through each phase of life to death. She is a fortunate daughter, sister, grandchild, niece, cousin, coworker, friend, and (now most importantly) mom. Collaborating with this wise and inspiring writing sisterhood has enlivened her to more deeply embrace what life may send her way. Please contact her at [kroller@paloalto.edu](mailto:kroller@paloalto.edu) with any questions or suggestions.

# Lifespan Development

## Cultural and Contextual Applications for the Helping Professions

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*The authors wish to dedicate this book to the caregivers of the world,  
those in the holy and thankless work of doing everything possible  
to meet the needs of those they can while trying not to need  
too much themselves.*

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# Preface

When the authors of this textbook got together to brainstorm what to include in this book, we collectively and immediately agreed we wanted to offer a different framework for understanding human development. As a mental health professional in training, you are most likely required to take a course or two in lifespan or human development. You may have even taken a class in human development in your undergraduate psychology or sociology or human services or social work programs, so you might be thinking, “Ugh, not *another* class learning about tired old developmental theories!”

## OVERALL GOAL OF THE BOOK

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As the authors of this textbook represent women of different ages, cultural backgrounds, professional identities, and experiences as clinicians and professional educators, we felt that we could work together to try to bring to life, in new ways, the theories and models of lifespan development to benefit you, the future mental health professional, in applying them to your real-world work with future clients. Whether you are training to become a professional counselor, psychologist, social worker, marriage and family therapist, or other mental health professional, you will engage with clients/patients across the lifespan. As humans navigate the different ages of life, they pass through different stages of development. Mental health professionals rely on various theories, treatment modalities, and ongoing research to inform their best practice; we hope this text will support you to do so in a culturally responsive, humble, self-reflective way, in order that your clients will be ethically and effectively served across the lifespan.

## DISTINGUISHING FEATURES AND LEARNING TOOLS

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This textbook is organized in a way that we believe makes it interesting, entertaining, and relevant. In Chapters 1, 2, and 3, we introduce important concepts related to lifespan and human development, discuss foundational models and theories of development that serve as the roots of the field, and discuss how theories and models of development should be viewed through contextual and cultural frameworks, and updated, empirically based research.

In Chapters 4 through 13, we talk about different ages and stages of development, but we do this a bit differently than what you might normally see in a textbook of lifespan development. We first introduce you to a case study that will be a client or client family representing a particular age and stage. In the first chapter for each

age and stage, we start with cultural and contextual considerations, and then in the subsequent chapter, we focus on two to three developmental theories that help us to conceptualize this age/stage of development. By having you *first* consider how cultural frameworks and models of development and understanding of people from different backgrounds and experiences move through their lifespan, and how this movement is facilitated or hindered by other relevant contextual factors, we can begin to understand the developmental process in a richer, more dynamic way. You will be challenged to critically analyze the theories that are presented, and to seek and understand new information and research that help to consider how theories of lifespan development are either limited in their abilities to describe development, enhanced by more current research that considered a broader cultural and contextual framework, or sometimes even both.

Take Erik Erikson, for example. Erikson, a German-born American psychologist, is considered by many to be one of the key framers of one of the best-known theories, Psychosocial Development. Erikson developed a stage model of development, initially based on a very narrow set of personal experiences in his own practice. In addition, he developed his eight-stage model of development, where children, adolescents, and adults resolve key conflicts at each stage, based on normative experiences of White males in Western, industrialized society. Does this mean that we should disregard Erikson's contributions to our understanding of development? The short answer is no, because we also can learn from subsequent research and writing from other theorists (and in this case, from Erikson himself, who continued to refine his theory, with the help of his wife, Joan, well into his 90s). The answer should also be, "It depends." Just because Erikson gets a lot of play in lifespan development textbooks, like this one, for example, does not mean we just indiscriminately embrace his theoretical tenets and what they mean for clients. So, we encourage you to take a "both/and" approach to this material. Learn what you can about the theorist and theories themselves—the roots, if you will—and then evaluate them against cultural and contextual factors, recent and relevant research, and your own critical thinking skills to make informed choices about their utility in your future clinical practice.

## INTENDED AUDIENCE

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This text aims to (a) prepare emerging mental health professionals for licensure exams and an understanding of foundational developmental theories by introducing you to some of the White, Western, industrialized, male-centered developmental theories that have dominated medical model mental health practice for the last century, and to (b) take a critical look at limitations of those theories, introducing you to updated research and more inclusive, diverse, culturally responsive, relational, collectivistic, trauma-informed approaches to lifespan development and its place in clinical care. We hope to inspire you to be lifelong learners as scientists–practitioners, with ongoing openness to revising what you "know," even as you become more clear about what appears to be self-evident.

The Latin etymology of *psychology* is the study of the *psyche* (the soul, mind, or spirit). Psychology has come to be interpreted as the study of the mind and/or behavior; however, Greek philosophers were only beginning to categorize and differentiate the mind from the body from the soul or spirit. It was Rene Descartes's reductionistic split of mind as superior over matter that underlies much of White, Western, industrialized male philosophy and psychological theory today, leaving the spirit or soul out

altogether. This schism seeks to be remedied in the West now through integrative, holistic, sometimes feminist practices of medicine, therapy, and counseling, as well as allied healing arts that belong to unbroken lineages rooted in collectivistic cultures around the world. Insurance-funded government agencies are beginning to employ acupuncture to reduce juvenile recidivism, and mindfulness-based stress reduction for a panoply of medical and psychological diagnoses; insurance money generally goes where there is expected to be a return on the investment, and integrated approaches are showing measurable improvement when proper methods are employed. It is our hope that clinicians of all stripes will behold their clients' inherent wholeness, and support their clients' ability to pick up pieces they may have lost along the way, using methods that honor their sense of belonging just as they are, rather than compared to expectations within the dominant cultures in which they must find a way to survive and thrive.

Instead of filling up the reader with information to memorize which will not really serve you or your clients, the authors wish to engage in the Latin etymology of *education*, "educare" or "educere"; "e" is the prefix for *out* as in *e-gress* or *e-xit*, while *du-ca-re* means *to mold/train* and *du-ce-re* means *lead*. We want to balance these efforts of training and leading out; we wish for these words to reach inside and connect with your own lived experiences, help pull them out to be considered, appreciated, nurtured, honored, mourned, challenged, questioned, and held in their complex context as much as possible. We intend to help you explore your own cultural conditionings, to see where your experiences with subjugation, power and privilege, gaining and losing, being centered or marginalized, connected or estranged, come together to make meaning throughout your development. Because we aim to write from a trauma-informed perspective, we invite you to let go of judgments about "what is wrong" with people to act the way they do, and to instead be curious about "what happened" to them, in the spirit of collective healing and liberation.

To breathe a little life into these developmental theories, we provide case studies which are amalgamations of clients we have served over the years. Many details that one would eventually hold as a time-tested and trusted clinician have been left out of these vignettes in service of showing you how hungry the brain will be to know more, to have certainty, to complete the puzzle and be done not knowing. As people's stories are complex and mysterious and cannot be fully known, and good trauma-informed care means one must prioritize secure relationship-building over obtaining data bits, we have left many questions unanswered; we think that it is in the best interest of your future clients for you to come to peace with the time and patience it takes to earn client trust enough that they choose to volunteer more details in the timing that is right for them and their healing.

We enrich our case studies through podcasts with cross-disciplinary pioneers and leaders in their specializations who share their experience and insights into how they might work with the client systems presented; we hope these voices give you a taste of how various clinicians apply developmental theory in a culturally responsive manner, and inspire you to work as a supportive member of interdisciplinary teams. We further hope that no matter the license you pursue, no matter the systems you report to in exchange for secure employment and the opportunity to be of meaningful service, that you foster your own compassion satisfaction by developing rich, nourishing relationships with clients, colleagues, supervisors, and beloveds in your personal life all across your lifespan. Human beings know themselves through relationships, and are sustained across the lifespan through healthy relationships. The podcasts may be accessed at <http://connect.springerpub.com/content/book/978-0-8261-8279-1>.

## INSTRUCTOR'S RESOURCES

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For instructors considering adopting this textbook, we want to provide you with dynamic and supportive teaching tools to facilitate engagement with your students and to promote deeper experiences of your students. Each chapter is accompanied by PowerPoints that can be used to frame interactive discussions with students on the material presented including suggested activities to bring the reflections in each chapter to life as classroom-based interactions. We also provide a test bank for each chapter consisting of a combination of multiple-choice, true-false, and essay questions. This test bank will be able to be easily integrated into learning management systems (LMSs) for use in online learning spaces.

## CONTENTS

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This book is organized into two parts. Part I covers the topic, What Is Lifespan Development? Part I of the textbook uses three chapters to provide an overview of lifespan development (Chapter 1), theories of human and lifespan development (Chapter 2), and theories of intersectionality and identity development (Chapter 3). These chapters provide the foundation from which to explore relevant developmental concepts as they apply to people at various ages and stages of development.

Part II covers different ages and stages of development. Each age and stage is presented in a two-chapter sequence. The first chapter in each sequence introduces a case study of a client belonging to a particular age group. Once the case is introduced, relevant contextual and cultural factors are identified as students consider the lens through which to examine each stage. A podcast is included as a resource from an expert in the field who will discuss the case study from their discipline and perspective applying at least one theory of development to their conceptualization of the case. Students have opportunities for reflection on the case through sidebars and additional instructor resources and activities. The second chapter in each age and stage anchors specific theories, models, and clinical interventions to working with the identified case presented in the previous chapter. New and relevant research is included to further contextualize the application of the theory.

It is our hope that by anchoring our discussion of different theories of development to a specific case after having noted relevant cultural and contextual factors, you will be able to conceptualize these cases in a rich and robust manner. Reflections, podcasts, and suggestions for additional resources and information will round out the content of this book. Happy reading, and we hope to break the stereotype of lifespan development being just one of those topics you “have to” learn about, and instead that it becomes for you one of the favorite topics you “get to” learn about!



A robust set of instructor resources designed to supplement this text is located at <http://connect.springerpub.com/content/book/978-0-8261-8279-1>. Qualifying instructors may request access by emailing [textbook@springerpub.com](mailto:textbook@springerpub.com).



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# Podcast List

Organized below by chapter, the *Lifespan Development* podcasts are available as support and provide explanatory information. The majority of chapters include a podcast. The first presented podcast, the author discussion in Chapter 2, helps contextualize the framework for the textbook. In Chapters 4 through 13, Perspectives From the Field podcasts are short conversations between the textbook authors and experts who share their perspectives of the presented case studies, the relevant cultural and contextual factors of the age and stage of development, and developmental theories attributed to the presented age and stage. Access the podcasts at <http://connect.springerpub.com/content/book/978-0-8261-8279-1>.

## Chapter 2

Podcast Chapter 2: Why Did We Write This Book?

*Author discussion among Drs. Kelly Coker, Kristi Cannon, Savitri Dixon-Saxon, and Karen Roller*

## Chapter 4

Podcast Chapter 4: Cultural and Contextual Considerations of Early Childhood: The Case of Xquenda

*Dr. Karen Roller conversation with Dr. Judyth Weaver: Perspectives From the Field*

## Chapter 5

Podcast Chapter 5: Developmental Perspectives of Early Childhood: The Case of Xquenda

*Dr. Karen Roller conversation with Dr. Judyth Weaver: Perspectives From the Field*

## Chapter 6

Podcast Chapter 6: Cultural and Contextual Factors of Middle Childhood Through Adolescence: The Case of Dev

*Dr. Kristi Cannon conversation with Dr. Stacey Reicherzer: Perspectives From the Field*

## Chapter 7

Podcast Chapter 7: Developmental Theories of Middle Childhood and Adolescence: The Case of Dev

*Dr. Kristi Cannon conversation with Dr. Stacey Reicherzer: Perspectives From the Field*

## Chapter 8

Podcast Chapter 8: Cultural and Contextual Factors of Emerging Adulthood Through Early Adulthood: The Case of Bi'lal

*Dr. Savitri Dixon-Saxon conversation with Dr. Brian Ragsdale and Dr. Emmett Roberts: Perspectives From the Field*

**Chapter 9**

Podcast Chapter 9: Developmental Theories of Emerging Adulthood Through Early Adulthood: The Case of Bi'lal and Mystic

*Dr. Savitri Dixon-Saxon conversation with Dr. Stephanie J. W. Ford and Dr. Chenobia Webster-Hill: Perspectives From the Field*

**Chapter 10**

Podcast Chapter 10: Cultural and Contextual Factors of Middle Adulthood: The Case of Ellen

*Dr. Kelly Coker conversation with Dr. Donna Sheperis: Perspectives From the Field*

**Chapter 11**

Podcast Chapter 11: Developmental Theories of Middle Adulthood: The Case of Ellen and Clark

*Dr. Kelly Coker conversation with Dr. Donna Sheperis: Perspectives From the Field*

**Chapter 12**

Podcast Chapter 12: Cultural and Contextual Factors of Late Adulthood: The Case of Rose

*Dr. Savitri Dixon-Saxon and Dr. Kelly Coker conversation with Dr. Stephanie J. W. Ford and Dr. Ramone Ford: Perspectives From the Field*

**Chapter 13**

Podcast Chapter 13: Developmental Theories of Late Adulthood: The Case of Rose

*Dr. Savitri Dixon-Saxon and Dr. Kelly Coker conversation with Dr. Nina Nabors and Dr. William Barkley: Perspectives From the Field*



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# Instructor Resources

A robust set of resources designed to supplement this text is located at <http://connect.springerpub.com>. Qualifying instructors may request access by emailing [textbook@springerpub.com](mailto:textbook@springerpub.com)

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  - Accreditation Mapping
  - Learning Objectives
  - Key Words
  - Multiple Choice Questions
  - Activities/Homework Assignments
  - Additional Resources
- Test Bank
- Chapter-Based Power Point Presentations
- Podcasts - Organized by chapter, the supporting podcasts present perspectives from experts in mental health disciplines to expand on chapter content.

# CHAPTER 4



## Cultural and Contextual Factors of Infancy Through Early Childhood

### LEARNING OBJECTIVES

Upon completion of this chapter, students will be able to:

1. Describe the perinatal and early childhood periods of human development.
2. Identify risk and resiliency factors for infancy and early childhood.
3. Recognize contextual factors that may merit therapeutic attention for early individual and relational healing.
4. Describe how cultural humility and trauma-informed care may be applied for early developmental needs in families, as well as longitudinal effects from this foundational period.

### CASE STUDY 4.1: THE CASE OF XQUENDA

Meet Xquenda (aka “Miguel” at school), a 5-year-old child assigned male at birth, currently presumed to be cisgender based on self-referential pronouns and gender presentation such as, “Yo soy el único que juega con la camioneta” (I am the only one (male) who plays with the truck). Xquenda is referred to you, a mental health practitioner at a public elementary school, in a migrant rural residential suburb surrounded by strawberry fields. The teacher’s chief complaint is that Xquenda regularly disrupts the kindergarten classroom with tantrums and potty accidents, and has difficulty with transitions. Recently, Xquenda hit a classmate in the head with a toy truck, and then did not show any apparent remorse for the hurt caused, which greatly concerned the teacher.



Xquenda’s parents, Inda Jani and Surem, speak enough Spanish to negotiate for commercial goods and interface independently with local professionals, but their mother tongues are Zapotec and Yaqui in origin. Their children have become fluently Spanish speaking in the shared home, and their daughter Nayeli is now also fluent in English due to bilingual immersion in school.

Through the interpreter, you learn from the parents that after 6 years of slowly losing their family lands due to corporatization of agriculture in their sending country (Oxfam, 2016), the parents discovered they were pregnant again and decided to liquidate their

meager holdings in search of more potential security for their growing family. They migrated from their land to a local town, where there was no consistent work, then to the nearest city, where there was no real opportunity to find affordable housing in a safe area (Garcini et al., 2019). They eventually realized they would have to keep moving to find steady work and be able to send some money to their parents and grandparents, who were all struggling to pay rent in the local town.

As trust develops with the parents over the next several months, they share further about the stress of traveling north for many weeks while pregnant, caring for their young daughter while on foot and hitchhiking, and carefully alluding to some mysterious event they suffered at the hands of the *coyote*, or smuggler who carried them across the border (Cleaveland & Kirsch, 2020; de Arellano et al., 2018). They were so grateful to finally arrive at the busy home of their neighbors' cousins in this farm laborers' community, where they have both found seasonal work in the fields and canneries in order to rent one room, provide for their children, and send a little money home to help sustain their now uprooted elders (Pew Trust, 2016).

Since you have consistently demonstrated that you are not an authority figure focused on their documentation status, the parents reveal to you that 3 months after they crossed the border, Xquenda was born with a difficult temperament (Thiel et al., 2020). He was not as easy to soothe as his older sister, did not latch well or nurse to satiation. He was colicky and had a more reactive startle response, and his long hours of frustrated crying caused tension in the household providing hospitality for the family. The parents admit that they had a hard time enjoying Xquenda's infancy, and that taking turns caring for him took a toll on their marriage even more than folding their firstborn into their lives. They also acknowledge that they had a hard time managing the pressure of this while trying not to upset their new housemates, and that they feared they would need to find an apartment, which was beyond their means.

The family has been to the doctor for regular check-ups, but they could not afford preschool, did not know about Head Start, and are all now suffering chronic upper respiratory ailments that seem never to abate (Mamane et al., 2015; Tarmure et al., 2020). They are concerned for Xquenda's behavior and well-being, and very much want to know how to help him.

## INFANCY THROUGH EARLY CHILDHOOD

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This stage of life is focused on pre-conception through about ages 5 through 8, depending on the theory to which one most ascribes. Most Western child development theories start development at birth; however, as developmental science is becoming more diversified and inclusive, early childhood and ongoing lifespan development is now acknowledging that pre-birth experiences must be included for clinical assessment and intervention (Evertz et al., 2021; Mckee et al., 2018; Seng & Taylor, 2015; Stephenson et al., 2018; Verny, 1984, 1989, 1996, 2014, 2021). Of particular concern are the neurological, emotional, behavioral impacts of in utero *teratogen* ("malformation-causing") exposure (Chasnoff, 1989; Chasnoff et al., 1990, 1998, 2005, 2015, 2018; Latini et al., 2006; Ragusa et al., 2021; Ross et al., 2015) and innumerable other forms of trauma and toxic stress that impact medical and mental health (Danese & Lewis, 2017; Fleming et al., 2018; Gilliland et al., 1999; Goldstein et al., 2021; Schwarze et al., 2013; Herzog & Schmahl, 2018), even trans-generationally

(Jawaid et al., 2018; Lehrner & Yehuda, 2018; Perroud et al., 2014; Serpeloni et al., 2017). This chapter introduces the reader to theory and research related to early childhood development, including the bi-directional developmental impact children and parents/caregivers have on each other (Crouter & Booth, 2003; Gouze et al., 2017; Schrock & Woodruff-Borden, 2010; Simmons et al., 2021).

## STUDENT REFLECTION 4.1

Looking at Xquenda's experience of conception and gestation compared to his older sister's, his parents were in a much less stable lived experience when he was growing in utero. They were probably grieving the inevitable loss of ancestral land as corporate agriculture moved in around them (Garcini et al., 2019). Depending on their water source, they may have been exposed to fertilizer and/or pesticide runoff, made to have toxic effects on living organisms (Asghar et al., 2016; Beyond Pesticides, n.d.; Roberts & Karr, 2012). The painful decision to leave the home they'd known and loved for generations likely led to waves of grief and fear as they looked for viable solutions nearby, only to be forced to accept that they would need to keep moving further away from home and family. Losing access to critical buffering relationships of beloved elders and peers to help provide emotional regulation and practical support, the parents would have to increasingly rely on each other for empathy, encouragement, and role tasks (Garcini et al., 2019); this can increase the pressure on a couple to contain stress and attune effectively under growing duress, which can often result in conflict or withdrawal when one is overwhelmed in adult attachment relationships (Johnson, 2019). It is also likely that food security and necessary rest to break down stress neurochemistry was intermittent, and sometimes insufficient, to mitigate their impact on the developing fetus (Barker et al., 2018; Monk et al., 2012; Evertz et al., 2021; Hasanjanzadeh & Faramarzi, 2017; McGowan & Matthews, 2018; Nelson, 2020; Thiel et al., 2020).

While his sister gestated in a mother who was surrounded by loved ones, on land they knew and loved, with cohering rituals and relative emotional ease due to consistent support, enjoying food and housing security, Xquenda's mom would have been more inflamed with stress neurochemistry (Talge et al., 2007; Liu et al., 2017) from being sad and scared for much of her pregnancy with him, and letting go of much that regulated her in search of future stability in a time of upheaval and loss. The sense of focus on Xquenda's well-being would have been shifted to survival needs of the family, sending neurochemical signals of distress to the developing fetus (Lobmaier et al., 2020). While this struggle and suffering could not be avoided, and is clearly not mom or the family's "fault," her elevated heart rate and inflammation of stress pathways may have set Xquenda's baseline in a more activated state, and grown his reptilian brain to be more reactive, even taking up more real estate in the finite container of the fetal skull (McGowan & Matthews, 2018; Thayer et al., 2018); this would likely be the case for anyone in this family's shoes.

While we cannot know for sure the quantity or impact of these variables, clinically, the family may need focused time and clinical support to process, digest, and release the stored survival neurochemistry generated before, during, and after Xquenda's gestation, to slowly

let go of past overwhelm that still colors their reactions to stress, which will be ongoing in the acculturation and assimilation experience in a White supremacist culture. Additionally, in utero substance exposure, whether accidental, recreational, or due to addiction, can interrupt the optimal development of the reptilian and lower mammalian layers of the triune brain, both of which regulate sympathetic neurophysiological responses such as fight-flight-freeze-fawn, and parasympathetic responses of rest-and-digest (Fisher et al., 2012). Xquenda may therefore need deeply attuned support to complete the stress and potential toxic exposure of this critical developmental phase, where he was literally fused with his mother, experiencing the stress and toxins she was experiencing, but he will need ongoing trauma-informed care to build the trust necessary to do that more vulnerable work.

Clinically, initial trauma-informed, open-ended prompts to learn from the parents (first away from the kids) about how they perceived stress and support during pregnancy can help unpack unresolved overwhelm and begin pointing to themes that need completion for the well-being of the family, which can then be done together, being mindful not to activate too much stress at one time (Andrighetti et al., 2017). Working through an interpreter who does not specialize in this phase of life or the circumstances the family has lived through will require slower pacing and thoughtful timing so as not to rush the parents through their emotional processing; therefore, lots of space around the questions would likely be indicated.

What components of intake and assessment with this family would you need supervision and consultation to perform skillfully?



## SESSION EXCERPT 4.1

**Mental health professional:** Can you tell me what it was like for you to be pregnant?

**Inda Jani:** Well (exhales audibly, and pauses, looking at Surem with a small smile), we weren't really planning for Xquenda the way we were with Nayeli. With Nayeli, we had been together a few years, and we were ready to start our family, and things were pretty easy with all our family around. And she was such a happy baby, ate so well, always affectionate and ready to play. But then as the big farm started encroaching on our lands, and we were finding their trash in our river, the whole community was trying to figure out what to do. We tried talking to the bosses, but nothing. Then the woods started getting clear cut, and we knew we couldn't stay much longer. And that's when I missed my moon (period) again, with Xquenda. We knew it would be harder to find a new living situation with a baby, we knew finding work in the city would be harder ... we knew no one. We just didn't know how far we would have to go to find a place we could be. And the money to live (tears well up in her eyes).

**Surem:** (Swallows audibly, looks at Inda Jani with warmth.) My wife has worked so hard for our family. We did not think it would be this way. (Places his head in his hands, looking at the floor.) I am so tired and wish there was more I could do to help. My son needed to be on our land. If only we could have stayed there, he would be learning to help my father and his cousins, and I know he would be happier. My wife, the things that she's been through to get here, none of that should have happened.

**Mental health professional:** You've both lost so much help, and support ... and maybe even hope? I want to know more about what you've been through, so we can help some of that stress finish for you. And when you feel ready, we can do that with Nayeli and Xquenda, too.

## STUDENT REFLECTION 4.2

Validated assessment of perinatal stress and resilience can follow a variety of qualitative and quantitative methods (Banti et al., 2011; Evertz et al., 2021). A basic semi-structured interview could begin with some of the following:

- What were you hoping for during the pregnancy?
- How did you experience support throughout your pregnancy?
- What helped you feel better when you were worried or stressed?
- Who did you turn to with your needs?
- What did you need that you didn't get during the pregnancy?
- Which of those unmet needs are still present today?
- How have you grieved those unmet needs?
- How would you describe your child's temperament while the child was growing inside you?

## CULTURAL FACTORS: INFANCY THROUGH EARLY CHILDHOOD

Humans are sexually reproductive mammals, born into family systems, whether or not they will stay and be raised within those family systems, given to another family system, and/or be surrendered to some form of institution. Family systems and those who procreate in them, and/or raise others' offspring, are shaped and formed by multicultural identities, experiences, and expectations. Conception, pregnancy, birth, bonding, child rearing, parenting, and caregiving are therefore relationally and culturally embedded experiences. Research shows that one way culture is sustained is through parenting practices; therefore, let's explore some relational and cultural considerations of infancy through early childhood.

### Infancy

Development in the first year of life outside the womb—infancy—continues to be marked by a high degree of physical dependency to have all of the baby's needs provided for by caregivers (Evertz et al., 2021). At birth, a neonate's only available defenses are to close its eyes, turn its head, and shut out overwhelming sensation by



falling asleep (Brazelton & Nugent, 1995); from a pre- and perinatal perspective, this is also when dissociation starts as a short-term coping mechanism to shut off overwhelming, disorganizing sensations (Lyons-Ruth et al., 2006).

As social mammals, human babies are born equipped with physical and behavioral traits that have evolved to hijack healthy caregiver attention, elicit caregiving, and increase chances the baby's needs are tended to (Kringelbach et al., 2016). Smelling a baby generally reduces testosterone, lowering aggression and the need to roam; it also increases estrogen, oxytocin, prolactin, and leads to dopaminergic surges associated with reward-based learning—even more so in experienced gestational parents (Lundström et al., 2013). When this does not happen for biological and/or social-emotional reasons, there is increased risk of postpartum depression, and aggression, for parents (University of Southern California, 2017).

Newborn babies need the womb re-created for the *fourth trimester* outside (Karp, 2002). They stay regulated with skin-to-skin contact, being held with their ear against the heart so they can hear it beating, on-demand breastfeeding, shooshing white noise and swaying movement like they experienced all throughout gestation (Cleveland et al., 2017); this is especially critical for pre-term babies, though is widely beneficial for all babies (Campbell-Yeo et al., 2015; Heidarzadeh et al., 2013; Sharma et al., 2018). *Baby-wearing*, or carrying the baby against the caregiver's body in a sling, papoose, or other material wrap, is common in Africa, Asia, and among the First Nations of the Americas to facilitate co-regulation of these needs while caregivers simultaneously tend to other responsibilities, and Western researchers have found babies do stay regulated for higher portions of time when tended to with sensitive care in this proximity (Hunziker & Barr, 1986; Reynolds-Miller, 2016). A longitudinal study has found 20-year benefits for babies who were worn compared to those who were not (Charpak et al., 2017). There are safe and unsafe ways to wear a baby, or multiples, so consulting with experienced baby-wearers is recommended to make sure the baby's head is properly supported while allowing for ease of breathing and access to the caregiver's face (Marcin, 2019).

According to Dunstan, babies around the world have about five distinct recognizable sounds of discomfort that will escalate into cries that issue from related areas in the abdomen or chest cavity to signal their various reasons for being distressed (Iftikhar, 2020). When caregivers can accurately assess these sounds to deliver the needed comforting and care (e.g., change diaper, help pass gas or poop, feed, burp, wrap and soothe for sleep or otherwise address temperature regulation), the baby will down-regulate and be settled again (Iftikhar, 2020). Preliminary research shows caregivers experience less stress compared to controls if they know how to recognize and respond to these early sounds of distress (Pineda et al., 2016), and parental caregiving aptitude is correlated with conferring secure attachment in children (Hong & Park, 2012; Lewis et al., 2001).

Babies who are born pre-term, or with other medical or physical difficulties, may have a lot of invasive intervention occurring at this fragile developmental stage. Where the evolutionary mandate would be for a long *lying in* to rest and allow the baby to stick to the caregiver so both can gather strength physically and emotionally (Dennis et al., 2007; Murfin, 2012), advances in medical technology in industrialized societies can now lead to life-saving interventions for babies that would otherwise die, but that are likely overwhelming for baby and parents (Porges et al., 2019). There are also

myriad decisions to make, balancing personal, familial, and cultural beliefs and expectations with professional opinion regarding immunization, sleep training and arrangements, feeding and elimination habits, visitation, shared caregiving, exposure to the outer world, and so on.

Infants spend much of their time sleeping (decreasingly so across the first year), but when they are awake, they want caregiver proximity, attuned interaction, physical and emotional comfort, facial mirroring, reliable empathy, cooperation, support, mutuality, and regulated emotional and attentional stimulation (Porges et al., 2019). These elements together operationalize *contingent responsivity* of the caregivers to baby (Dunst & Kassow, 2008). The more of that they have, the more regulated they will stay, and the more they will trust that their caregivers will provide what is needed in good timing (Beebe & Steele, 2013). Cultural preferences for functional interdependence in collectivistic societies will support ongoing proximity and relatedness as the infant develops toward toddlerhood (Behrens, 2010; Crittenden & Marlowe, 2013; Dawson, 2018; Jin et al., 2012; Lai & Carr, 2018; Rothbaum & Kakinuma, 2004; Sagi, 1990); cultural preferences for independence in individualistic societies result in a push toward increasing infant attention on objects and projects, with an emphasis on infants to explore the world around them independently with growing physical capacity and mental curiosity (Alcock, 2013; Bowlby & King, 2004; Fox, 1977; Keller et al., 2005; Kratzer, 2019; Main, 1990; Mesman et al., 2016; Strand et al., 2019; van Ijzendoorn & Sagi-Schwartz, 2008).

As their strength grows, if they have no medical difficulties that interrupt or delay the next phases, babies evolve from needing to always be on their backs in order to breathe safely, to being able to hold their heads up for several moments during *tummy time*, which allows them to strengthen their backs in preparation for eventually crawling (Hewitt et al., 2020). As they get ready for crawling, they start strengthening the muscles to roll over from their back to their tummy, and begin little pushups, which then allow them to get up on knees and hands, rocking back and forth.

Crawling is a midline movement that connects the left and right hemispheres of the brain across the corpus callosum for better neurological organization; forsaking crawling to begin walking early has been linked with learning difficulties, and thus extending crawling through daily interactive floor games can be protective and preventive for neurological organization (Stiles & Jernigan, 2010). As physically able babies gain strength through crawling, they begin to pull up on available supports, developing the muscles of the legs to hold up their disproportionately big heads (Adolph et al., 2011). Bouncing while holding on leads to side-stepping with hands on supports, known as *cruising*, to lifting hands up to stand freely, to taking first unstable steps somewhere close to the first birthday. These wobbly, top-heavy first launches into the world are the beginning of *toddling*, and result in lots of falls in the learning process; real injury can occur if the surroundings are not appropriately protective for these first walks (e.g., steps, stairs, concrete, bodies of water, startled pets, cars all can be life-threatening; Peden et al., 2008), and caregiver response to the bumps and bruises can be experienced on a spectrum from neglectful to dismissive to minimizing to regulated and soothing (Koralek, 1992). The baby's brain continues to throw on grey matter at a rapid pace here; receptive language is being encoded as an infant also verbalizes with coo's, discernable cries, intentional sounds, and often their

first caregiver titles and favorite object neologisms by the end of the first year (Mayo Clinic, 2021, March 25).

In the diminishing hunter-gatherer tribes around the world today, the way all of our ancestors lived until agrarian and then industrial societies arose (very recently in human history), babies co-sleep with parents and nurse until at least 3 years—but often up to 6—when the *milk teeth* fall out (Diamond, 2012; University of Notre Dame, 2010), and toddlers are known to handle knives and fire-related tools to meaningfully assist in food preparation for the greater good (Apicella & Crittenden, 2015). Safely co-sleeping regulates the baby's heart rate variability and breathing patterns, and also eases breastfeeding transitions to enhance bonding and co-regulation of the parent-baby dyad while reducing exhaustion for the breastfeeding parent (Burbidge, 2017; Weissinger et al., 2014). Though there are innumerable physical similarities and developmental milestones that inform what is normative for early human development within any given culture, there are perhaps as many variants on how those evolutionary potentials are prioritized across societies, which continue to shape how individuals within those cultures develop.

### STUDENT REFLECTION 4.3

While his sister's zero-to-five years experience was all contained within the community embrace of multigenerational family members looking after her when her parents needed to work, with on-demand breastfeeding because her mom was able to work in the fields nearby and either wear her or take breaks when she needed her, Xquenda had to tolerate long hours away from his mom while she worked away from the home during his infancy. In fact, because mom had delivery complications with Xquenda, she ultimately had an unplanned C-section, and was hooked up to a bag of antibiotics in the hospital for 3 days after Xquenda's birth, which interrupted their bonding processes (Pilch, 2015; Sakala et al., 2020; van Reenen & van Rensburg, 2013). Xquenda had difficulty latching and the parents could not afford a lactation consultant, so he was given formula in the hospital and the parents were not encouraged to keep trying breastfeeding (Jenco, 2020). Xquenda was also given broad spectrum antibiotics in the hospital, which upset the fragile development of the intestinal microbiome environment necessary to begin digesting comfortably, resulting in chronic colic (Azad et al., 2013; Leung & Hon, 2019), and though he was able to room-in with his mom, she was not allowed to have visitors for more than 1 hour at a time.

Xquenda's mom recalls this period with tears in her eyes, saying how lonely and overwhelmed she felt while her husband and daughter could not be with her and the new baby, and that she could not soothe him with breastfeeding as she had been able to do with her daughter (Mlynek, 2019; Mueller et al., 2015; Murray, 2020; Putignani et al., 2014; Walker, 2010; World Health Organization, 2011; Yang et al., 2016). Though she doesn't "know" it, the oxytocin she generated while naturally birthing and breastfeeding her first child helped bond them emotionally to block out much of the pain and exhaustion of this massive undertaking; she did not generate as much of this bonding neurochemistry with her son due to the interrupted birth and breastfeeding experience (Feldman et al., 2013; Kim & Strathearn,

2017; Kim et al., 2017; Mah et al., 2015; Scatliffe et al., 2019). Where the difficult time she had during the pregnancy and birth could have been partially mitigated by support to successfully breastfeed, as well as rest more deeply when the baby slept, the built-in support she had with her community and family was not available to her with her second child. This increased the risk of postpartum depression, potentially resulting in diminished patience, enjoyment, and contingent responsivity with the baby (Office of the Surgeon General, n.d.; World Health Organization, 2021).

What do you know about your own birth and bonding experience? Are there any patterns that run in your family that might be worth exploring and resolving through personal counseling?

## TODDLERHOOD

Subsequent development of the toddler to young child is also relationally and culture bound. Indeed, even if a young child spends time away from primary caregivers and *allo-parents* (kin or non-blood-related, chosen and trusted members of the family), to attend a formally structured day care or preschool environment will inform what developmental milestones (such as toilet-training and tolerating shoes) must have been achieved to be considered “normal” by pre-determined ages. Whether or not a child is born in a state society will inform what caregiving and disciplinary practices are permitted, sanctioned, required, or litigated (Jonson-Reid et al., 2017); this has implications when mental health professionals are serving migrant families who may not have been informed of all the local rules and consequences of the dominant culture, and merits supervisory support to ensure ethical informed consent and clinical care.

Toddlerhood is generally considered to start at 1 year of age, and last until about 4, though there is no official upper limit that is widely recognized (Barker, 2001). Toddlers suddenly go from being relatively easy to contain, because the adults are faster than they are, to quite capable of getting themselves and others into physical danger quickly. Coupled with the fact they have very little appreciation of the risks they can run with their newfound freedom to walk, run, and wield increasingly heavy objects, toddlers create a whole new demand for caregiving supervision (Barker, 2001). To compensate for this risk, Nature imbued us with shame, which acts as a psychic leash with just a look and a shout; when a caregiver notices we are about to hurt ourselves or someone else, they can yank that leash and stop us in our tracks, even at a physical distance (Terrizzi & Shook, 2020). This yank gets us to drop our chin and roll our shoulders forward, turning our attention inward and shortening the breath, in addition to emotional rumination on this ostracized state (Schore, 1991). While effectively stopping us from what we were doing, this state can be difficult for toddlers to self-regulate for too long, and requires that we be soothed and brought back into the tribe with forgiveness and encouragement, along with the lesson delivered (Barrett et al., 1993; Herman, 2018).

Toddlerhood’s explosive neurological development can lead to a lot of busy projects, many of them imitating bigger people and their skills, even if the skills don’t make sense (Tellis, 2010). Receptive language acquisition is increasingly evident in the daily expressive language that begins to pour forth, often in delightful ways (Mayo Clinic, 2021, March 25). Gross motor skills such as climbing, tumbling, and dancing,

as well as interest in manipulating adult tools for daily living, all come online in varying rates among toddlers and preschoolers (Kid Sense, n.d.). Biological males have the highest ratio of testosterone-to-body weight at age 3 (Vesper et al., 2015), which shows itself in sheer energy level, as well as quickness to anger. Fine motor skills are slower to graft on at this stage, but greater dexterity begins to unfold, and handedness becomes clarified (Occupational Therapy for Children, n.d.). Toddlers' emotions continue to be felt very strongly, with frustration tolerance typically low and resistance to boundaries being enforced too often (Schore, 1991). However, toddlers who have a history with responsive caregivers tend to be amenable to soothing and redirection toward what they are allowed to touch and do, and generally want to please loving caregivers (Dennis, 2006). In cultures where young children are incorporated into the whole group activities, imitation leads to procedural learning of adult behaviors, with ongoing desire for proximity, physical contact, and shared attention to the task at hand (Krassner et al., 2017; Rubin et al., 2006).

Socially, young toddlers in same-age cohort groups or drop-in public settings such as parks commonly engage in co-ed *parallel play*, next to each other, where they are often doing their own solitary play in proximity to peers (Brigano, 2011). Through a combination of natural and socialization processes, they may slowly develop reciprocal and increasingly gender-based play as they age through toddlerhood, and increasingly show interest and skill at collaborating in cooperative play, while also showing strong preferences for types of materials and activities that define with whom they play (Änggård, 2011). Younger toddlers tend to have more fluid gender-based play, and increasingly show more consolidated gender identity by the time they reach school age (though social pressure can thwart this for gender non-conforming children) (Kung et al., 2018; Rafferty, 2018, September 18). Strong peer loyalties and alliances can be formed at this age, as can bullying, and imaginal play can alternate between practicing adult roles, and engaging in fantastical, larger-than-life abilities (Holmes et al., 2015). Delays in movement toward collaborative and cooperative play, age-typical language capacity, or emotional regulation tend to garner concerned attention, and may become a focus of early clinical and educational assessment based on this author's experience.

## STUDENT REFLECTION 4.4

While Xquenda's sister's toddlerhood would have been focused on life skills specific to survival and contribution within her local community (with likely more than one regulated adult available for line-of-sight supervision at all times), spending lots of free time outdoors and developing gross and fine motor skills based on her interests, Xquenda's toddlerhood in the shared home of his parents' acquaintances was not as free and self-directed, as the family was trying not to impose or annoy the hosting family. Xquenda heard "No" a lot more than his older sister at this same age, and his impulse to run and climb was often interrupted because there was no fence around the suburban house making it safe for him to discharge his wild young energy outside. Xquenda was often told to be quiet and not touch other people's belongings, and the host family's kids would sometimes tease Xquenda by playing with their toys near him, but then taking them away when he tried to play with them.

What aspects of Xquenda's early experience are similar to yours? What aspects are different, and how? If you were to take one key question to your supervisor about how to best proceed serving Xquenda's family thus far, what would it be? Clinically, what repairs do you think would be helpful to better bond parents and son?

## Early Childhood

For our purposes here, we will define early childhood from about 4 or 5 years old until kids go on to become fully *school-aged* at 8 (Committee on the Science of Children Birth to Age 8, et al. 2015). Early childhood, as opposed to toddlerhood, is commonly marked by medically capable neurotypical children being reliably potty-trained unless a rare accident occurs, because they finally have sphincter control (Clifford & Gorodzinsky, 2000); increasing ability to verbally self-report needs such as hunger; having the ability to follow simple multi-step directions, and understand many consequences for not doing so; and increasing interest in connecting socially with others outside the family-of-origin (Committee on the Science of Children Birth to Age 8: Deepening and Broadening the Foundation for Success; Board on Children, Youth, and Families; Institute of Medicine; National Research Council, 2015). If the entrance to an aged-cohort day care or school setting has not yet occurred, preparations to do so often begin at this age in industrialized societies. Cultural preferences for ongoing relational closeness in collectivistic societies often result in high regard for teachers as significant and respected authority figures worthy of reverence and the right to influence one's offspring, with high expectations of children to treat teachers with deferential respect, like a family elder (Klassen et al., 2010). Repetition of experience begins to show itself in relative mastery compared to peers in social settings; thus in patriarchal societies, a general acceptance and tolerance between most young preschool-aged peers begins to give way to competitiveness and power-over dynamics, as cohort members vie for authority and attention (Andersen et al., 2013).

The physical, emotional, and cognitive leaps made by young children year-over-year are remarkable to caregivers as they look back during this young stage. What a neurotypical 5-year-old of relative privilege can try to do is vastly different than what a neurotypical 8-year-old of the same relative privilege can reliably do. If given the opportunity to engage in hours per day of free off-screen play, movement, and quiet time, the integration of gross and fine motor skills for medically capable children typically begin to translate into stronger and more graceful movement, while expressive language expands into colorful story-telling, and the ability to imagine into others' experiences increases exponentially (Beaudoin et al., 2020; Madigan et al., 2019). Preferences for school subject matter may begin to result in exploratory imitative play, and as children begin to read in addition to drawing and creative expression, their excitement about fictional storylines and non-fiction subject matter can turn into dramatic performances and science experiments (McNaughton, 1997; Rhodes et al., 2020). Tolerance and stamina for non-preferred academic and life-skill activities typically begin to increase for neurotypical children, with fewer tantrums and more willingness rooted in growing understanding about the need for good hygiene, safety, and some semblance of justice and responsibility (Crosby et al., 2019; Li et al., 2016). Many traits on a spectrum start to consolidate here, such that relative extraversion-introversion,

easy going–slow to warm–difficult temperament, and cognitive processing speed become less likely to change much with each passing year (Roberts et al., 2000).

## CONTEXTUAL FACTORS: INFANCY THROUGH EARLY CHILDHOOD

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In industrialized societies, in utero substance exposure, chronic medical needs, other Type II relational/developmental trauma (Terr, 2003), and neurological or chromosomal learning differences or delays will become a focus of parental involvement with child development professionals as children this age become more involved in public and private educational settings, and those professionals (who have often spent decades in direct service to this age and stage) make recommendations and referrals based on variations from typical age cohort patterns (Crawley et al., 2020; Shonkoff & Phillips, 2000). If caregivers have been suffering in silence; are rooted in cultural groups that are more marginalized, private or even insular; are avoiding authority figures out of fear of reprisal or legal implications; or for other contextual reasons have more rigid boundaries around the family system, the young child with special needs' growing ability to assert and express themselves may result in families being forced to interface with mental health and allied professionals, even if they would rather not (Berger & Font, 2015; Ellis, 2019; Sudland, 2020). Our sensitive empathy and care for the disenfranchised grief and rational fear often held here can help families begin to engage in services while their children's neuroplasticity and identity development are more receptive to beneficial change (Kolb & Gibb, 2011; Novak, 2019). The following topics are primary reasons socially just mental health services are needed for young children and their caregivers, with prevalence rates when they are known.

### Discrimination

Being systematically targeted or overlooked due to any identity feature that is marginalized causes toxic stress and is among the causes of Types II and III trauma, which have the highest incidence of becoming complex PTSD (Solomon & Heide, 1999, 2005). Racism, misogyny, ableism, homo and transphobia all fall on young bodies, severing them from a sense of safety and inherent goodness as they find themselves stuck in belittling or life-threatening interactions in their families or out in the widening world. Suicide rates for young children have only recently begun being studied, but patterns show that suicide for young Black boys is increasing, and suicide rates for LGBTQIAA + kids is 7 to 9 times higher than heterosexual and cisgender youth (Sheftall et al., 2016; Youth.gov, n.d.b).

Systemic White supremacy, ableism, cis- and heteronormativity play themselves out in which services and opportunities are available to whom, where, and how, as well as what attributions are made regarding why a child is behaving the way they are, including among highly educated healthcare workers (Ellis, 2019; Trent et al., 2019). In this way, adults in positions of authority often wield access and make split-second decisions about who gets supportive versus punitive intervention when a child is acting out or just happens to be in the wrong place at the wrong time.

Fear of police brutality and murder can result in Black, Indigenous, and other People of Color (BIPOC) parents using corporal punishment to try to teach their children how seriously they must not bring attention to themselves in certain places due to the

deadly risk, and requires that BIPOC parents have *the talk* with their kids about protecting themselves from the police, usually while still in elementary school (DeGruy, 2017). The number of police murders has led to the civilian development of 10 survival tips for children of Color (Atlanta City Review Board, n.d.). Black children are six times more likely and Latinx children are three times more likely to be killed by police than White children overall (Badolato et al., 2020). About one in 1000 Black boys will be killed by police, while American Indian/Alaska Native boys are about 1.5 times more likely, and Asian/Pacific Islander boys are only slightly less likely to be killed by police than White boys. Black and American Indian/Native Alaskan girls' rate of being shot by police is about twice that of White and Latina girls, while Asian and Pacific Islander girls' rate is currently the lowest (Edwards et al., 2019). That parents even need to consider the risk of their children being killed by police as a component of their effective child-rearing is a predominantly American phenomenon, though it is also a significant factor in many migrant-sending countries (McCarthy, 2017, January 18). Further considerations regarding the risk of children dying by gun violence follows below.

## BULLYING AND PEER ABUSE

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Bullying starts in preschool (Saracho, 2017). It can often begin as kids just grabbing toys from each other and not showing remorse for sadness caused when they are small, which is normal for young toddlers, given the limits to their neurological development and therefore ability to sublimate personal desires in preference for respectful peer relationships. However, if left consistently unaddressed as neurological development unfolds and *Theory of Mind* increasingly allows for empathy regarding how others feel (Beaudoin et al., 2020), that can escalate to hitting and name-calling, and kids outnumbering targeted individuals to threaten and torture them emotionally and physically. Cross-cultural research is beginning to show that access to sufficient shared materials and emotional support appears to be implicated in preschooler aggression, and that cultural variations for how to interact with same-age peers has demonstrable difference by preschool age (Metin Aslan, 2018). The risk for discrimination being played out with bullying and peer abuse increases with more marginalized identities and capacities, particularly when the kids targeted are more introverted and less likely to stick up for themselves or have peers who help them find safety (Repo & Sajaniemi, 2015). Kids can also become quickly savvy about finding places away from adult view to enact their abuse on peers, including low-visibility areas such as behind sheds on school playgrounds, bathrooms, buses, and behind closed doors at home (Levine & Kline, 2008; Levine & Tamburrino, 2014).

Sexual abuse between young peers can and does happen in buses and schools, as well as in homes (Levine & Kline, 2008; Tremblay-Perreault & Hébert, 2020). All children involved in either side of this peer abuse may potentially be referred for clinical care if the abuse or resulting trauma behaviors are identified, and it is also possible they go untreated for a long time. Erin's Law is a prevention-oriented child sexual abuse program that is on its way to being enacted in every state (Erin's Law, n.d.), but much sexual abuse happens before children reach the elementary school age at which this program is being delivered (Singh et al., 2014).

Bullying and peer abuse, which tend to escalate as children move through elementary school, are known to increase the risk of suicidal and homicidal behavior in



children once they hit 10 years old (Centers for Disease Control and Prevention, 2019). Though schools often publicize they have a zero-tolerance policy for bullying, there can be a lack of operationalization for how intervention will be implemented; this merits supervisory support and meaningful advocacy for school-based mental health professionals, particularly to uphold social justice ethics re: how the children are treated by various authorities. I (Roller) have seen mental health professionals place aggressor and victim in dyad counseling without reporting back to caregivers any updates, while bullying continued unimpeded by school administration.

Gang recruitment and affiliation (2%–5%), begins in elementary school (Youth.gov, n.d.a). When children are born into situations where their role model options are limited, the appearance of protection and belonging a gang initially provides can be quite compelling (Sharkey et al., 2011). Affiliating begins with simply wearing colors, flashing numbers, *mad-dogging* and talking trash to opposing members, but once kids go through the rite of passage of getting *jumped in*, they must begin to avoid certain territories and people in fear for their life, as well as perform prescribed acts to prove their loyalty and worth (Dmitrieva et al., 2014).

Kids who cannot avoid gang affiliation due to family involvement will find it nearly impossible to extricate themselves once they've been jumped in (Dmitrieva et al., 2014). Officially leaving the gang requires another rite of passage of accepting another gang beating, but this time there are truly hard feelings, rather than just one having to prove their courage and loyalty (Dong & Krohn, 2016). Training in diversion and restorative justice approaches is necessary for mental health professionals attempting to penetrate this chain of command to build up the "pulls" away from gang involvement (Young & Gonzalez, 2013), in addition to highly nuanced joining and family therapy with the influential adults to help support the children's differentiation and safety from these subcultural pressures. Success rates for leaving a gang are highest when the family and/or other prosocial enticements help cut ties, which can sometimes require relocation (an option not often available for the working poor; Young & Gonzalez, 2013).

## Civilian Gun Violence

Gun violence in the United States has consistently been on the rise over the last several decades with increased gun ownership; there are now 120 guns for every 100 people in the United States. According to the Center for Violence Prevention at Children's Hospital of Philadelphia:

gun injuries are the second-leading cause of death among U.S. children and teens and the leading cause of death among high school students.... Among younger children (ages 0–12 years) ... 85% are killed in their own home (Children's Hospital of Philadelphia, 2020, December).

There have been 237 school shootings and 403 related deaths or injuries since the Columbine shooting in 1999 (Rowhani-Rahbar & Moe, 2019). Drive-by shootings do not have reliably accurate reporting, but best estimates suggest they result in hundreds of U.S. shootings every year, with 18% of those being children, and 46% being at home (Children's Defense Fund, n.d.).

## CUSTODY

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About 50% of children in the United States will find themselves in a shared custody situation before age 18, and up to age 13, will not be included in the court's decision-making about their living arrangements unless there are liability-causing determinants the court gives merit (e.g., substantiated child protective services [CPS], DUI, or DV reports on file; Chen et al., 2021). Parents in prison often retain legal custody, even though they cannot provide physical custody, and thus can block children from accessing mental health services unless a judge overturns and mandates that service, which requires the custodial parent have legal representation to get that instituted, which is a privilege (Tuthill, 2021). Mental health agencies sometimes have intake paperwork requirements to reduce legal risks related to split custody, but those who have not yet had to manage an aggressive or threatening parent may not be prepared for this eventuality.

Children caught in high conflict separations, or who are experiencing significant chaos due to changing custody arrangements, may have great fear about voicing their needs and feelings related to a situation where their core safety and security are at risk. The emotional turmoil of this disenfranchised grief and loss requires great sensitivity to navigate successfully, and children can find themselves bouncing between two very different worlds, with multiple challenges and demands placed upon them, while holding their attachment needs for when they can get met (O'Hara et al., 2019). Developmental disruptions are predictable with this ongoing interruption, and require both child-centered and family therapy to resolve as well as possible (Chen et al., 2021; Gil, 2006).

## UNACCOMPANIED MINORS AND DACA

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According to the Migration Data Portal, "the U.S. Border Patrol (USBP) apprehended nearly 69,000 unaccompanied children in 2014, 40,000 in 2015 and 60,000 in 2016. In 2016, 61 percent of apprehended unaccompanied minors in that year were from El Salvador and Guatemala" (USBP, 2016), and "in recent years, the number of children migrating unaccompanied by guardians has increased. In 2015–2016, there were five times as many children estimated to be migrating alone than in 2010–2011" (UNICEF, 2017b). The number of unaccompanied and separated children applying for asylum in countries other than the European Union increased from 4,000 in 2010 to 19,000 in 2015 (Migration Data Portal, n.d.). These trends make it clear that mental health professionals need to be prepared to effectively serve children whose families may not be traced or available, and try to appreciate the incomprehensible loss such a survival move represents, while helping children navigate the labyrinth of local requirements for them to obtain their education and have a pathway toward self-sustainability.

Deferred Action for Childhood Arrivals (DACA) is a legal policy currently protecting about 800,000 children (Boundless, n.d.) who may or may not have families with them. Recent policy changes aim to uphold these protections and provide support to the 1.8 million children currently eligible for DACA. While the supports are intended for high school graduates or GED-holders, steps need to be taken when children are

young to maintain their eligibility. Supervision and advocacy are necessary to protect this opportunity for childhood arrivals.

## RUNAWAYS, ABDUCTIONS, AND TRAFFICKING

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The incidence of small children running away in the United States is extremely low and not accurately known, but when a small child truly runs away (as opposed to just wandering off for a brief moment) the historical literature attributes this to serious maltreatment, which is linked with multiple increased risks as children become teens (Pergamit, 2010). According to the National Estimate of Missing Children, the incidence of abducted children over the last decade is estimated to be 18.8 out of 1000, with 11.4 reported as being missing (Office of Juvenile Justice and Delinquency Prevention, 2017). Furthermore, “9% are kidnapped by a family member in a custody dispute; 3% are abducted by non-family members, usually during the commission of a crime such as robbery or sexual assault. The kidnapper is often someone the child knows; only about 100 children (a fraction of 1%) are kidnapped each year in the stereotypical stranger abductions you hear about in the news, and about half of these 100 children come home.”

According to the Office of Child Labor, Forced Labor, and Human Trafficking (OCFT), approximately 4 million children are currently trapped in forced labor, including about 27% of them in forced sexual labor. As awareness of this widespread systemic abuse continues to grow, and children are rescued from these circumstances, it is likely that mental health professionals will increasingly need specialized training to effectively treat the complex trauma that results from such prolonged, egregious abuse (Department of Labor Bureau of International Labor Affairs, n.d.). I (Roller) served children involved in these circumstances who had to grow up in foster care; their charts revealed STIs sometimes as early as 1 year old, and the global effects on their social, emotional, and cognitive functioning were truly heartbreaking.

## FOSTER CARE AND ADOPTION

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In the United States, there are currently approximately 419,000 children who have been removed from their families of origin due to egregious or unremitting child abuse and neglect, or who were thrown away, who arrived as unaccompanied minors, or whose caregivers have been deported, incarcerated, or died in a calamitous event. They will often face ongoing loss and developmental disruption as the foster care system attempts to find stable placement for them when suitable kinship care is not available (The Imprint, 2020). It cannot be overstated how devastating the lifelong impact of such disruptions can be if a child does not find their forever family, if they are also separated from their siblings, if they are not supported to grieve all that they have lost, and if they are not given every possible stabilizing resource that helps them to experience themselves as whole, loveable, worthy, capable, resilient, connected, and belonging. Unfortunately, the compassion fatigue that plagues Child Protective Services and the foster care system means that children in it are often left to fend for themselves emotionally and behaviorally (Kapoulitsas & Corcoran, 2015; Scott, 2021). Because there are insufficient qualified foster parents to hold all the children who need

a forever home, children in care often have their wounds re-traumatized by the system to which they are handed as they get passed from temporary placement to placement.

Fost-Adopt is a bridge program, usually reserved for younger children, whose families of origin have failed *reunification*, so the children have been relinquished or placed in *permanency planning*, where hope for living with their families again must now be grieved (Barth et al., 2017). As children age through permanency planning, their chances of being adopted out of foster care reduce with each passing year. It is nothing short of miraculous when a child in foster care finds a *sweetheart placement* with a healthy and loving adoptive family that takes them in as their own, commits to keeping them for life, and takes over the reliable, enriched therapeutic and educational care that they need to recover and thrive. In lieu of that, a patchwork of paid professionals and occasionally volunteers will find themselves trying to provide some semblance of continuity without fomenting unrealistic hopes about the child's need for security, positive predictability, trustworthy and reliable adults, and a chance to finally exhale deeply and stop packing their life into one bag to be shuttled to the next temporary place.

Mental health professionals serving children in foster care will often find themselves helpless to influence many circumstances beyond the child's control, and yet must strive to provide evidence that some adults are reliable. Neurosequential organization through predictable session length, time, placement, and activities is crucial for many children in foster care; empowering children with as much choice about activities, topics, and timing of transitions also restores a little bit of safety and worth for kids who otherwise have almost no say in what is happening to them (Perry, 2006).

## NEURODEVELOPMENTAL DIFFERENCES AND DIFFICULTIES

Autism Spectrum Disorders (ASD; incidence rate 3%) are neurologically based differences with likely genetic roots exacerbated by inflammatory epigenetic events during the second trimester (Christensen et al., 2019; Madore et al., 2016). Experienced birth parents often notice immediately if their neonate appears overwhelmed by tactile stimulation and gazing when awake. Leaky gut syndrome, stereotypical movement patterns, self-stimulatory humming and neologisms, flat affect, restricted diets and fixated play interests, phobias, lining up objects, and blunted social reciprocity may occur in young children *on the spectrum* (Sivberg, 2003). The evidence-based practice for treatment of ASD is called Applied Behavioral Analysis (ABA), which is a specific paraprofessional intervention performed at home, in the community and school, not billable to mental health services (Odom et al., 2020). Mental health providers may perform auxiliary support for social anxiety in kids with ASD, as well as family therapy to help with the stress on family dynamics. Holistic interventions for building the microbiota and healing the digestive tract may also be employed by appropriate allied professionals (Ding et al., 2017; Fowlie et al., 2018; Srikantha & Mohajeri, 2019).

Fetal Alcohol Spectrum Disorder (FASD; approximately 5%–10% incidence), one of the most under- and mis-diagnosed of all neurodevelopmental difficulties, encapsulates all forms of substance exposure (not just alcohol), and applies to more children than the ones showing the recognizable facial dysmorphology typical of this clinical presentation (Centers for Disease Control and Prevention, 2021, February 4; Chasnoff et al., 2015). FASD increases comorbid risk of: sensory integration disorders (SID); reactive attachment disorders (RAD); encopresis and enuresis; receptive/expressive language

development delays; learning disabilities (LD); Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD); mood disorders; conduct disorders (CD); and antisocial tendencies (Chasnoff et al., 2015). Occupational therapy (OT) is often incorporated in the child's Individualized Education Plan (IEP) as part of their educational accommodations, with ongoing wraparound services to help with social-emotional development.

ADHD and ADD can also stand alone (9.4%) and appear to have genetic roots (Centers for Disease Control and Prevention, 2020, November 16). These diagnoses are common complaints of elementary school teachers, though teachers are not formally trained to accurately diagnose. There are ongoing discussions among mental health professionals regarding epigenetic patterns in industrialized societies that may be contributing to higher rates of ADHD and ADD; quality of involved parental caregiving, quantity of neurologically integrating body-based activities, and screen use are often implicated in these conversations (Weissenberger et al., 2017). Both tend to be treated with a combination of pharmacotherapy and behavioral interventions, with some parents conflicted about ever using medicine, while others cannot imagine trying to raise their child without it.

Psychotic process rarely blossoms fully by early childhood, even though symptoms are as common as 17% in small children (attributed to cognitive processing differences in young children) but when traced back retrospectively, eventual diagnosis of true psychotic process in adolescence or young adulthood is highly correlated with receptive-expressive language delay as early as age 2 (Klosterkotter et al., 2011; Ruhrmann et al., 2010) and a stilted, if any, transition from parallel to cooperative play. Parents of children who went on to be diagnosed with a psychotic process have stated to this author (Roller) that their child has always had a flatter affect and less interest in social interaction than their other children, somewhat like kids on the spectrum may present. Because psychotic process advances as the myelin sheath of the brain further deteriorates, early detection and treatment are paramount (Raballo et al., 2020). For young children exhibiting early *negative* symptoms (e.g., poverty of thought, delayed speech and language, flat affect, low social reciprocity), this is done with a combination of specialized assessment, family therapy, and behavioral interventions to develop skills of daily living; as children age and demonstrate more *positive* symptoms (e.g., sensory hallucinations, paranoia, delusions, word salad), pharmacotherapy and further wrap-around mental health service are added to protect access to education and developmentally appropriate skills of daily living (Polanczyk et al., 2010).

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS, possible incidence of 1 in 200) can result in tics and other behaviors associated with Obsessive-Compulsive Disorder (OCD) and Tourette's syndrome; ongoing research is pointing to up to 25% of OCD cases being caused by PANDAS (PANDAS, 2018). Pediatric OCD (2%–3% prevalence) can also stand alone, not caused by strep, and has genetic roots, exacerbated by epigenetic stress (Adams et al., 2018). If caught early, PANDAS can remit with antibiotics, but both PANDAS and OCD can become all-consuming if not treated effectively, and both often go undetected or misdiagnosed (Lewin, 2019). Early signs tend to be hand, head, and/or vocal tics; distraction due to cognitive rumination; avoidance of stressful stimuli associated with phobias; compulsions such as handwashing or repetitive yet not fruitful habits (e.g., checking doorknobs, lining up objects, washing until skin bleeds; Adams et al., 2018).

Mental health professionals serving families with young children exhibiting any symptoms of these clinical presentations need to seek supervision quickly; insist on medical, psychiatric, and neuropsychological referrals to perform adequate rule-outs; utilize indicated validated measures to assist with differential diagnoses; do thorough genograms to help assess for genetic risk factors; and optimize early neuroplasticity for therapeutic benefit (Lewin & Piacentini, 2010, April). A combination of occupational therapy, pharmacotherapy, family play therapy, parental and teacher psychoeducation, and skillful collaboration with collateral professionals is often necessary to effectively support families whose children have neurodevelopmental difficulties.

## COVID-19

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During the COVID-19 pandemic, families who were living in industrialized societies found themselves overseeing their children's online schooling in some format. Young students were regularly required to sit at a computer for 4 to 6 hours per day, often while parents blessed with professional jobs were simultaneously working from home and not able to provide the quantity or quality of social support, play, or pedagogical skill as their children would have normally received at school (Fontenelle-Tereshchuk, 2021). Further complicating this was how children whose parents did not have the luxury of working from home, or who did not have reliable access to the internet, were required to adjust and compensate without the stable structure of a school community to normalize the stress and developmental needs that continued to unfold for over a year. Low-resource families were devastated by the demands placed upon them (Montenovo et al., 2020). Accessing medical and clinical care was largely facilitated by telehealth, if at all, and the vast majority of developmentally appropriate embodied enrichment in the community was intermittent at best, or fully evaporated.

While the long-term effects of these widespread adjustments will not be known for some time, it is clear both parents and children experienced a tremendous sense of stress during the ongoing losses and demands of this global crisis; hundreds of thousands of families lost members without being able to hold them and say goodbye, which complicates the grief even further. Substance abuse was reportedly on the rise, and loss of jobs led to loss of medical insurance, housing, food security, and relational cohesion (Russell et al., 2020; Van Lancker & Parolin, 2020). The circumstances giving rise to child abuse and neglect only increase under times of great duress, and yet children's access to mandated reporters and respite care was nearly completely cut off. At the time of this writing, posts on listservs for mental health professionals were predicting a tidal wave of counseling referrals and CPS interventions once children began returning to in-person school (Torjesen, 2020).

## Clients in Infancy and Early Childhood and Their Families: Clinical Considerations

While Xquenda's sister grew up within a consistent group of diverse-aged caregivers and playmates in an attachment network who had known her since conception up until her family moved away, giving her more fluid access up and down the developmental spectrum depending on her needs at the time, Xquenda made an earlier transition to outside society. Xquenda's launch to kindergarten was marked by being handed off to

non-relative professionals who have not been part of his family or community while he was a baby, where he also has to become part of a large group of same-age peers overseen by one or two regulated adults, who don't necessarily "love" him or speak his preferred languages, and being directed to spend a bulk of time learning fine motor and reading skills, with only short breaks for child-centered gross motor discharge and development. Furthermore, the pressures felt by Western public school teachers to uphold externally determined standards for achievement and behavior in their outnumbering charges tends to result in stress-based feedback when children are non-compliant or falling short of expectations, without the luxury of time to repeatedly demonstrate and scaffold toward the preferred behavior in a patient way (Klassen et al., 2013).

As a kindergartener, adjusting to the emotional demands of being one among 24 in a group of 5-year-olds expected to sit still and attend academically, and transition willingly, an early assessment and intervention conversation with a mental health professional might look something like this:



## SESSION EXCERPT 4.2

**Mental health professional (who also meets with family regularly):** Hola, Xquenda... I'm so glad to see you today ... (Calm and welcoming tone, soothing prosody, gentle smile, watching Xquenda's facial expression and body posture to quietly ease into his awareness without overstepping his personal space, letting him determine proximity so long as mental health professional and child are both safe.)

**Xquenda/Miguel:** Ruben took my truck and teacher won't give it back to me! (Anger in voice.)

**Mental health professional:** Oh, you must be so frustrated ... (Validating, gently modeling 6-count exhales to soothe the nervous system.)

**Xquenda/Miguel:** Rah! It's MINE!! He can't take it from me!! (Signs of sympathetic arousal in flushed face, tight jaw, wide open eyes.)

**Mental health professional:** So frustrating ... you feel mad right now ... (Intentionally soothing tone, maintaining 6-count exhales to down-regulate child's nervous system, not rushing to shut down safe expression of activation.)

**Xquenda/Miguel:** It's MINE!!!! Ruben always takes mine!

**Mental health professional:** That mad is all in your chest and fists ... I can see how mad you are feeling right now ... (Intentional soothing tone, staying focused and present, not trying to shift child out of activated feeling state with words, as he is not able currently.)

**Xquenda/Miguel:** I never get the truck! He always takes it from me! And teacher lets him!!!

**Mental health professional:** I would be so sad, to want something so much and have it taken away (Normalizing and modeling being with sadness, softening ground for addressing grief and processing/differentiating from past grief and traumatic loss in upcoming family sessions.)

**Xquenda/Miguel:** (Showing anger through stomping, banging fist, giving way to downturned mouth and fleeting signs of sadness in downcast eyes and breath catching in throat.)

**Mental health professional:** Sometimes what helps me is to go outside and throw clay ... would you like to go let your mads out with me? (Gentle redirection to channel discharge of anger and make space for vulnerable sadness underneath protective anger.)

**Xquenda/Miguel:** (Moves toward door so mental health professional gets up and leads the way to trees outside, brings plywood rectangle, ground sheet for front of target, and block of clay kept for this purpose.)

**Mental health professional:** Here, let's break off a chunk of clay for you, and you roll it up into a strong ball, while I go put the target up for you. (Empowering with healthy outlet for directing reactive energy, supporting age-appropriate impulse control through successive approximation with engaging alternative for aggressive discharge.)

**Xquenda/Miguel:** (Throws clay before mental health professional is out of way of target.)

**Mental health professional:** Oops, we both have to be safe, remember? (Calm, neutral tone, not giving too much attention to the unpreferred act having predicted the mild testing would occur). Ok, now I'm far enough away for your strong arm ...

**Xquenda/Miguel:** (breaks off more clay chunks and throws at target silently for several minutes while mental health professional calmly encourages, assists only when client bids for attention).

**Mental health professional:** Look at you, so in charge of yourself! You're focusing... (Ten minutes of client-centered outdoor play, much time non-verbal, being an empathic presence, providing strength-based feedback for what is expected of him in school setting, while giving his body and brain necessary time to break down adrenaline and cortisol generated when he lost something he deeply wanted, again.) Ten more minutes, and then we'll go back to class ... (Gentle preparation for transitions is crucial for young children, and most clients processing overwhelm.)

**Xquenda/Miguel:** Can I play with your trucks? (Finding ways to fill up where he has more choice and less competition.)

**Mental health professional:** Of course. Do you want to throw a few more times? Or use all that time to play with trucks? (Giving a sense of agency wherever possible, as children in school are often not given choice about what happens next, and this can mount as frustration).



## STUDENT REFLECTION 4.5

**Being Differently Abled.** Xquenda has some special needs that are beginning to be identified by educational and clinical professionals, as even with his colic and difficulty being soothed and latching, the general medical professionals did not see anything they needed to offer the family. With skillful wraparound prevention and intervention, including environmental accommodations at home and school, he will be able to realize his fullest potential emotionally and academically. How might this developmental stage look if a baby's special physical or other developmental needs are identified at birth by medical professionals, for instance, with Down's syndrome, cerebral palsy, or blindness? How might this developmental stage materialize if a baby's special physical or other developmental needs are not immediately apparent at birth, but come to be realized over time, as is often the case with *failure to thrive*, deafness, Autism Spectrum Disorder, celiac disease, hemophilia, and learning differences and disabilities? What special developmental needs do you feel pretty confident you could help with? How will you use supervision, consultation, and referral to ensure families with children of differing abilities and special needs get access to appropriate support and opportunity, especially if you don't have previous training to effectively support these families?

Fetuses, infants, toddlers, and young children are minimally differentiated from the systems they inhabit. They depend physically and emotionally on the systems they inhabit to protect and provide for them, and to alter as necessary for their survival and well-being, as well as their emotional integration of a complicated and often dangerous world. Clinically, it is necessary to bear in mind and support the systems (relationships) our youngest members inhabit, in order that those systems can best provide for them. Toward that end, critically examining the interactions among Xquenda's micro-, meso-, and exosystems can support the mental health professional to perform effective client-centered advocacy and identify linkage needs, while also normalizing stressors the parents and teachers are feeling as the family is pressured to assimilate to the dominant culture. Clinically buffering where possible, using one's privilege and access to help navigate systems with more power, can help reduce the burden of stress on a marginalized family. Facilitating access to necessary resources and community support can help the family create a new network of care and continue to build resilience against the ongoing toxic stress they will likely experience. Supporting this clinical intervention is Relational-Cultural Theory, which aims to facilitate the Five Good Things: (a) a desire to move into more good-feeling relationships; (b) a sense of zest; (c) increased knowledge of oneself and the other person; (d) taking action in and outside of the growth-fostering relationship; and (e) an overall increased sense of worth (Robb, 2006).

Helping Xquenda and his family have these mutually growth-fostering relationships through our own clinical attunement and responsiveness can inspire reasonable hope that another network of support might be formed in this new place, and reduce pressure on the nuclear family to provide everything necessary for Xquenda to thrive, which in turn could help them to recover from some of what they have lost and continue their own *post-traumatic growth*, integrating their strengths and capacities to take on demands as they evolve, even while grieving (Perreira & Ornelas, 2013; Umer & Elliot, 2021). Examples include empowering the family to maintain connection to

their cultural identities and practices (e.g., asking the parents what name they would like each family member to be addressed by, rather than assuming the names used at school are preferred; Baima & Sude, 2020); inquiring about how they may connect with their spiritual practices in this new place (Koerner et al., 2013); and using time in session to connect with the family's lineage in ways that feel sustaining, to support their inherent wholeness within dominant systems (Cervantes, 2010; Comas-Díaz, 2006; Nader et al., 2013).

Children born with congenital or acquired disabilities or illnesses will need more alteration, accommodation, and consideration from their micro-, meso-, and exosystems in order to have relatively fair access to developmental opportunities within their communities. The more marginalized and subjugated identities and experiences a child absorbs, the more toxic stress they are likely to face as they develop, and the more their optimal development will likely be impinged upon due to this toxic stress. Mental health and allied professionals serving infants, toddlers, young children, and their families often need further education, training, supervision, and experience to be sensitized and effective in anticipating and providing support services needed for children with special needs and/or marginalized identities, as well as navigating oppressive systems on behalf of underserved clients. Thus mental health professionals are encouraged to maintain holistic awareness of fairness not being "same" between clients, but rather, what is needed for each client to meet their optimal potential.

## STUDENT REFLECTION 4.6

How would you support Xquenda and his family if you were to work with them at this developmental phase? What interventions would you use to try to bring balance among the limitations they are facing? How would you use supervision to process any expectations you have about how families behave at this developmental stage? How would you collaborate with preschool teachers if you were asked to provide assessment at this phase?



### PERSPECTIVE FROM THE FIELD: PODCAST

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The goal of this chapter was to provide you with an initial understanding of how infancy and early childhood are shaped by the experiences, contexts, and cultures in which they are embedded. As we prepare to move into the next chapter and dig more deeply into additional theories and models specific to this age of development, I invite you to listen to Dr. Judyth Weaver speak more directly to the developmental considerations we should bear in mind when working with a client like Xquenda. Dr. Weaver is a Reichian psychologist, practicing clinician certified in multiple somatic modalities, educator, and the founder of Somatic Reclaiming. She is also a leader in the field of pre- and perinatal psychology, facilitating therapeutic processes for groups, families, and individuals to complete unfinished business from gestational and birth imprints.

## SUMMARY

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Key cultural considerations for families experiencing pregnancy, birth, early bonding of infancy, and the transition to toddlerhood and early childhood include joining with the entire family in support of what regulates and sustains them as a system during these most critical developmental foundations, while grieving losses with the family system. The physical, emotional, and financial demands of early parenthood have historically been shared and absorbed by a greater number of regulated and devoted adults than most contemporary parents in industrialized societies can access regularly, therefore linkage, and facilitating proactive use of internal and external resources, helps shore up families who do not have sufficient support systems for the demands, and is a primary clinical objective. Contextual factors include being sensitive to the pressures placed on families due to conflicting beliefs and behaviors between their own backgrounds and any dominant system (e.g., medical care, education, law enforcement) with which they must interface, to help honor and empower family strengths in their caregiving, which ultimately serves their offspring. Using our professional access to relationships and resources to reduce toxic stress on the family can help reduce risk of prenatal adversity and Adverse Childhood Experiences (ACEs), which in turn optimizes the child's and family's development (Felitti & Anda, 2010).

Every client we serve survived their gestational, birth, early bonding, infancy, and subsequent stages; the work to do so on their part, and their caregivers', can be extraordinary, and may have left emotional residue with behavioral implications. Many clients we will serve were subject to chronic and even toxic and traumatic stressors during these critical periods, wiring their brains, nervous systems, and therefore implicit beliefs with reasons to be fearful and reactive to subsequent stressors, including the emotional complexity of another human being. The more accumulated and unresolved overwhelm a little one has to hold, the more internal pressure is there, ready to tip into emotional distress and resulting behaviors that may appear regressive. In utero substance exposure, malnutrition, violence, and loneliness are disadvantageous for the developing fetus, babies, and young children; a sense of being safe, wanted and lovable, supported, provided for, attended to, and prized all lead to a more secure base moving forward and out into the wider world. Using our trauma-informed mental health training while accessing all necessary allied services to provide socially just and regulating support to all members of a child's family optimizes that child's chances of navigating each developmental stage to the best of their ability.

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# CHAPTER 5



## Developmental Theories of Infancy Through Early Childhood

### LEARNING OBJECTIVES

Upon completion of this chapter, students will be able to:

1. Identify the stage of lifespan development known as “early childhood.”
2. Describe key theories impacting this stage of development.
3. Paraphrase key research impacting this stage of development.
4. Recognize future directions for research and understanding of children and families in early childhood.

### INTRODUCTION

Childhood development was the first area of focus for human development theorists. While development clearly unfolds across the lifespan, our earliest years lay the foundation for how our bodies, brains, nervous systems, beliefs, and expectations get set as a baseline from which we make meaning about ourselves and our place in the world. Understanding the situations in which our clients were conceived, gestated, birthed, and raised helps demystify why they react as they do in a variety of circumstances, especially when non-optimal contexts challenge access to developmental needs such as safety and belonging being fulfilled in good timing. Infancy and early childhood are also extremely demanding on caregivers, more so when caregivers are not sufficiently supported, so the relational caregiving context of early childhood is also centered in these theories.

### CASE STUDY 5.1: THE CASE OF XQUENDA

Xquenda’s family is raising two children who are 6 years apart. The elder daughter Nayeli’s gestation and early childhood were spent on family lands in a nearly homogeneous cultural environment with low conflict over values, norms, and beliefs, with shared context of experience that allowed for a sense of continuity in belonging, responsibility, role differentiation, and an available network of support for all members of the family, in addition to enjoying food and housing security throughout this earliest formative stage (though we know these last components



of security began to erode as Nayeli grew). Xquenda's gestation and early childhood have been spent force-migrating to colonized land in crowded co-housing, in a heterogeneous rural residential neighborhood with more conflict over values, norms, and beliefs, without as much shared context of experience, and without an available network of support for all members of the family, in addition to ongoing exposure to chemical and toxic stress, economic stress, and acculturation stress.

Though sharing much genetic inheritance, Xquenda and Nayeli's early childhood epigenetic experiences are vastly different, and this has implications for their physical, emotional, relational, and cognitive development. Furthermore, the bi-directional development that occurs between caregivers and their charges can be quite different between parents and their children due to a variety of impacts on goodness of fit (Newland & Crnic, 2017; Simmons et al., 2021). For instance, Ina Jani and Surem have consistently felt more successful and at ease with their first child than they have with their second based on differences in the children's temperaments and the relative demands placed upon the parents to provide for and attune to the children's needs, as they arrived in vastly different moments in the parents' life cycles. The relative stress each has had to carry in attending to each child has ongoing impacts on their relationships, which they are all navigating together as their life cycles unfold.

A major variable that is shared between the children is the cohesive relationship of the biological parents being committed to their children and doing everything in their power to ensure their children have their needs met under ever-changing circumstances, while maintaining a strong relationship between themselves and those with whom they interact. The parents' shared expectations for how they will treat each other and their children helps mitigate some of the loss and ongoing stressors they are processing, though the long adult memory still creates a tendency to compare the easier past with the more demanding current phase of life. The parents cannot help but wonder why they are having so much more difficulty with Xquenda than they did Nayeli, even when they account for how little support they have now.

## INFANCY THROUGH EARLY CHILDHOOD

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The founders of human developmental theory began with birth and the early years. They aimed to make sense of the physical and emotional needs of newborns, infants, toddlers, and young children from their frames of reference. The following early theorists emphasized sensory experience, emotions, and meaning-making that result from repeated experience in response to caregiving. While each theorist honed in on different aspects of a young person's earliest development as it influences identity formation, all acknowledged in their theories that caregivers have a tremendous, lasting impact on how babies and children experience safety, belonging, respect, connection, worth, power, and other embodied birthrights. We will explore more deeply the widely misunderstood father of psychoanalysis, Sigmund Freud, and then move on to some of his more influential successors.

### Freud's Psychosexual Stages

Freud's *libidinal phases of development*, the psychosexual stages known as *oral*, *anal*, *phallic*, *latency*, and *genital libido* phases, mostly operate beneath our conscious awareness.

They are ancient, inborn, sexually reproductive social mammal needs that give rise to bonding behaviors when they are met well, and aggressive or depressive behaviors when they are not (Freud, 1936). Having a disruptive pattern of needs from any stage going unmet leads to *fixation* on, or *regression* to, that stage, and gives rise to predictable personality traits and defenses that point to traumas and unresolved conflicts emblematic of the work of that phase. Core beliefs and somatic self-states formed about self and others during these early developmental stages give rise to *transference* and *projections* of emotion/expectation onto subsequent *objects* of potential relationship, which Freud explored through *free association* in order to increase patient insight into their root causes and bring to resolution (Brill, 1938). The general therapeutic goal was making the unconscious conscious by integrating the *id* and *superego* into the *ego*, so that one could resolve *neuroses*. Dreamwork and letter-writing were also incorporated to make sense of the unconscious symbolism pointing to the internal wishes and fears (Brill, 1938). Themes around safety, belonging, power, and fulfillment thread throughout all the psychosexual stages.

### RELATIONAL–CULTURAL CONSIDERATIONS

Bruno Bettelheim's *Freud and Man's Soul* (1982) importantly revisits the cultural context in which Freud worked with patients and wrote to share his findings and theories, while clarifying problematic losses in translation of his work from Viennese German to English that persist to this day. Victorian Vienna was a sexually repressive society within the realm of the rising Third Reich as Freud's impact was becoming more widespread and hard to control (Gruber, 1987). The meth-addicted Gestapo (Ohler, 2017) eventually arrested Freud's daughter Anna, burned many of his books, and murdered several of his sisters in concentration camps in the wake of forcing him to ex-patriate and write a statement in support of their reign (Gay, 1988; Jones, 1957; Roudinesco & Porter, 2016). In the years leading up to the invasion, a high degree of social control was exhibited by the elite ruling and professional class, and patriarchal abuse of power was normative.

Modern social media fans may consider that many of Freud's patients could have been part of the #metoo movement, and his writings had a similar effect of creating a social revolution requiring accountability and reparation (Danil, 2017). Freud's psychoanalytic patients were often the daughters of his contemporaries (what would now be considered a major conflict of interest, if not a dual relationship), many of whom were reporting molestation and incest (Brill, 1938). Freud was trying to find a way to address this scourge without getting himself killed or his financially dependent patients disowned from their powerful families, and thus his presentations and writing were delivered in a coded manner, with hints of how trauma was being perpetrated by his influential peers (Bettelheim, 1982). Empathizing with his lived experience, one may have compassion for how he veiled his controversial findings while engaged in the talking cure.

Bettelheim's linguistic understanding of Freud's original writings demystifies some of the main suppositions behind Freud's efforts to make the unconscious conscious. The *id*, that animalistic part of us driven by raw impulse to consume, fornicate, attack, and do whatever is necessary to survive, means the *it* within us, that raw body desire ruled by the reptilian and lower mammalian parts of the brain whose sole job is to keep us alive and moving forward as an individual and a species. This portion of the brain is present in the neurotypical neonate. The *ego* is the *I*, that upper limbic and

rational mammalian portion of the brain containing the reptilian/lower mammalian *id/it*; if I can tolerate it, I can let you see it, and this layer of awareness is the intermediary between what is underneath and above it, further developed from birth through about age 7. The *superego* is the *over-I*; it is the internalized parental or authority figure, exemplified by the neo- and prefrontal cortex, that watches over the *I* and governs its conduct so that my *it* doesn't take over and destroy me in society (Bettelheim, 1982). This portion of the brain also needs to be constructed from about school age through to age 26, and then is continually organizing itself across the lifespan (U.S. Department of Health and Human Services, 2021, February 22). These notions will be explored a bit more in the updated neuroscience research that follows.

As Freud's developmental and cultural context necessarily informed his identity and meaning-making, he could not imagine what early childhood development might be like in cultures that were more collectivistic, healthfully sex-positive for all genders and consensual adult relationships, focused on emotional proximity, and including children in the group's daily activities. Furthermore, because he was inadvertently uncovering relational and developmental trauma in his early patients in an abusive patriarchal society (Brill, 1938), and presumably comparing their functionality to his own children's experiences, his observations were specific to a group that was largely culturally homogeneous, but may have been demonstrating some in-group variance around early relational/developmental trauma (assuming his own children were not abused and/or neglected).

Looking at birthing and early parenting practices around the world, we know that Victorian Vienna was a comparatively uptight and individualistic culture compared to many others, in a prodromal transcrisis on the verge of a massive collective trauma when Freud was discovering unsavory realities about the behavior of some of his intellectually elite peers and trying to make sense of how to help without putting himself, his family, or his patients in greater danger (City of Vienna, n.d.). With that in mind, let us remember that all human babies are social mammals born with the same universal needs for safety and belonging in proximity and soothing, nourishment and attention, positive predictability and encouragement (Otto & Keller, 2014). What tends to vary between cultures and individuals is not the needs themselves, but the strategies to get those needs met (Main, 1990; Puddledancer press, 2021). If the strategies to meet needs are well attuned and delivered in good timing, the end result will be more time spent in positive affect, which is beneficial for both individuals and their relationships (Johnson, 2019). Much mental health intervention is prescribing specific strategies to get needs met; culturally responsive intervention requires that clinicians be sensitive to what strategies work for whom, when, how, and why (Seponski et al., 2012).

For instance, if we look to various countries in Asia, the Middle East, Africa, and Latin America, as well as among the U.S. Amish, it is common whenever possible to have a *lying in*, or postpartum confinement process for the birth parent and newborn baby, ranging from 30 to 100-days. During *lying in*, the birth parent is protected to heal from being ripped open in giving birth, and is not expected or encouraged to go out into the world, but rather to focus on bonding with the baby and building up their immune systems before interfacing with the world outside while receiving "mothering" from mostly female elders within the family and trusted community (Dennis et al., 2007). Such an endeavor means birth is a highly social and organized event for a family and community, which can reduce the risk of postpartum depression and

overwhelm in an otherwise too-isolated birth parent. Such practices, if truly well supported, can increase the likelihood of a baby getting their initial needs met without having to scream in protest or collapse in despair during the early oral phase, thus facilitating greater ease, calm, and well-being as byproducts of early biological and emotional needs being co-regulated in good timing. This would theoretically lower the risk for disruptions to oral gratification, assuming the birth parent has access to the help necessary to meet the demands of this phase, resulting in a general sense of trust within the babies. Conversely, when babies' needs are not responded to quickly, when they must expend a lot of energy protesting to get the nourishment of attention, holding, and food, the negative affect and resulting stress neurochemistry generates embodied tension and a sense of mistrust, which appear in factor analysis research on Freud's oral phase to create "a heightened preoccupation with being supported and nurtured and with seeking oral gratification in terms of over-eating, the abuse of alcohol, and verbosity" (Fisher & Greenberg, 1996, as cited in DelMonte, 1998, p. 39), and can also manifest as depression (Desmet, 2013).

## The Oral Phase

### CASE STUDY 5.2

Inda Jani and Surem were surrounded by family and friends when Nayeli was born. Inda Jani was able to lay in and rest for weeks after giving birth to Nayeli, and she was tended to by her mother, grandmother, aunties, and lifelong friends, in addition to Surem during breaks from the fields throughout the day. Because Inda Jani was not solely responsible for managing the household, or an outside job, and she had this support network helping welcome the new member, she was able to get some self-care during this demanding phase, which helped with mood stability amid the new stressors. When Nayeli *rooted* on the breast as an infant, or fussed, she was able to nurse for as long as necessary, while Inda Jani sang songs that had come through the family line for generations. When Inda Jani needed a break to bathe, nap, or go for a little walk by herself, she had multiple willing caregivers she trusted to hand the baby to, who would swaddle and sing to her between feedings, and Inda Jani was able to return to bonding refreshed and ready to engage. She recalls this time with a wan smile: "It was the happiest time in my life. Tiring, but happy, hopeful." From a Freudian perspective, Nayeli would presumably not be fixated on getting support or nurturing, or filling up physically and emotionally; Nayeli would presumably trust that her basic needs will be met if at all possible, in good timing, and the result is a basic sense of ease about ingestion and trust in connection.

Xquenda's sister Nayeli was naturally home-birthed and worn by her mother in the first year of life, enjoying on-demand breastfeeding and the comfort of physical and emotional proximity during this vulnerable formative period. Nayeli spent the majority of her infancy soothed and relaxed, with ease of access to her needs being met in a timely manner, without having to compensate with unpreferred substitutions, and this allowed her nervous system and brain to develop optimally, with soft muscles and an emotional openness to connect with attentive others, while not needing to seek attention from overly burdened, distracted or dismissive caregivers. From a Freudian perspective, further developed by Melanie Klein into *object relations*, Nayeli would be expected to perceive her parents as *good objects*, who were

physically and emotionally available and responsive to her, allowing her to avoid splitting her perception of her caregivers as good versus bad (Petot, 1991; Westen, 1991).

Xquenda's gestational experience primed him for more prolonged experiences of elevated heart rate when upset, and more difficulty bringing his heart rate back down to a resting baseline (Chiera et al., 2020; Lobmaier et al., 2019); overwhelm can be experienced as shocks to the electrical rhythm of the heart, and these shocks can be held as a "freeze" response in the heart, which needs to be sobbed, trembled, and touched/caressed through the skin to resolution (Heller & LaPierre, 2010; LaPierre, personal communication, Feb. 2021; Stupica et al., 2019). The emergency C-section and subsequent antibiotics further upset his fragile digestive tract; the resulting colic, difficulty latching, and the hospital's protocol of not offering a lactation consultant coalesced in Xquenda being put on formula in the hospital, and thus he did not get the same skin-to-skin contact, baby-specific enzymes and immune-boosting antibodies (Kotlen, 2020; Mlynek, 2019; Murray, 2020; Walker, 2010; World Health Organization, 2011), and relaxed access to immediate, cozy, holistic nourishment as his sister, which may have left him more frustrated and aggravated around being able to receive and take in what he needs from the world, in addition to simply not developing the microbiome necessary to optimally digest stress neurochemistry and rest in a positive baseline mood (Mueller et al., 2015; Putignani et al., 2014; Robertson et al., 2018; Yang et al., 2016).

Furthermore, because his parents suffered multiple stresses and were relatively unsupported emotionally during Xquenda's first year, their ability to respond with ease to his basic first year needs was much more intermittent than for his sister (Stupica et al., 2019). His oral phase development led to much frustration, with long hours of crying, shorter and shallower naps, and a quicker startle response that was tougher to soothe. Both his parents spent much of this year wishing he would sleep better, be more calm and quiet, and be satisfied with the attention they could give him; they also secretly worried about what was "wrong" with their second child.

Inda Jani and Surem were in a new and alien place, without their beloved support system to help them, when Xquenda was born. There was no time for a laying in; Inda Jani took 2 weeks unpaid leave off work, as she had no paid family medical or maternal leave with her fieldwork job. Though the housemates did offer to share food and help with some laundry, Inda Jani and Surem were concerned about becoming a burden, so Inda Jani managed household responsibilities and the baby, and tried not to bother anyone with the crying. Xquenda's difficulty latching and gastrointestinal reflux disorder made him loudly uncomfortable and cranky; he did not root or suckle for comfort, as Inja Jani's milk dried up from not nursing in the hospital. Sometimes Xquenda could settle enough to take formula from a bottle, but sometimes he refused it angrily, reducing Inda Jani to tears. Very much against her wishes, she returned to work 2 weeks after Xquenda was born to keep her job on which the family depended, and left him with a neighbor lady who ran a daycare out of her apartment. Xquenda often refused the bottle there in frustrated, crying protest, and sometimes cried himself back to sleep. From a Freudian perspective, Xquenda would presumably be fixated on oral gratification due to the pattern of disrupted satisfaction in this first psychosexual phase. It would be expected that he would be concerned with getting support and nurturance, getting his turn and attention, getting comfort through food, and being heard. It is also expected he would be at higher

risk than Nayeli for falling into depression when relationships aren't going the way he wants, even though their shared genetic and parental inheritance affords them some significant similarities.

### THE ANAL PHASE

Subsequent focus around the world on toileting practices suggests that the further from the Equator one is raised, the more toilet-training is delayed; climate, economics, and maternal educational attainment all appear to impact the amount of time babies are permitted to simply follow organically arising biological rhythms rather than assert some discipline and self-control over urinating and defecating in a particular place at a particular time (Howard, 2017). Medical data show that about 99% of all people achieve and maintain continence until about 60 years old unless trauma, medical, and/or developmental difficulties interrupt it, and so toileting practices around the world work for the vast majority of us who are medically capable (World Health Organization, 2017). From a Freudian perspective, the main question would be how much stress, tension, and shame one carries because of the messages and even punishment one received about how well we met the parental and societal expectations placed upon us while trying to gain mastery over toileting functions, and to what degree the power and control dynamics inherent in the socialization of our toilet training continue to have a deleterious impact on our day-to-day functioning (Brill, 1938). As stated by Fisher and Greenberg (1996) in relation to their factor analysis, power struggles between the developing toddler and their caregivers over toileting appears to increase risk for “the anal triad—consisting of orderliness, parsimony, and obstinacy. The anal personality is thus confirmed of being concerned with issues of control” (DelMonte, 1998, p. 39).

### CASE STUDY 5.3

Nayeli moved through the anal phase living closer to the Equator than her brother, but her parents did not come from a culture where there was pressure to do consistent *elimination communication* in order to teach babies to control urination and defecation on a schedule (Xu et al., 2021). Because she was in arms during so much of her infancy, her cues to go potty were often noticed, and she was supported to go potty in a bowl or outside, but not required to do potty training early. She spent little time uncomfortable in a diaper, and as she became a toddler, was free to run around undiapered much of the time, self-directing to appropriate places to go potty without much stress (Dewar, 2020; Jordan et al., 2020). From a Freudian perspective, Nayeli did not experience power struggles through the Anal Stage. She did not have to assert herself obstinately as she became capable of more continence and decided whether or not to make a mess adults would have to clean, so presumably, she is not overly concerned (“fixated-regressed”) about how much control she has in a situation, represented by imbalances or reactivity around personal assertion, personal productivity, tidiness issues, and general movement toward a focus on others, rather than herself (Combalbert et al., 2006; Juni & Cohen, 1985).

Xquenda moved through the Anal Phase living farther from the Equator, where cultural norms do not generally allow for elimination communication due to work requirements away from home (Dewar, 2020). Because his caregivers were not realistically able to have him in arms most of the time during his infancy, his cues for needing to urinate and defecate were not tracked as closely, and he lived in a diaper to

make general care and cleanliness more manageable. When he became a toddler and was physically able to remove his own diaper, he sometimes did so out of frustrated desperation to get focused attention at daycare and, realizing this worked, he began to do it at home on occasion, too. His parents became very concerned he would defecate on the host family's furniture or carpet, and began to monitor him with more stress as he asserted his budding independence. From a Freudian perspective, Xquenda's oral fixation bled into an anal fixation, where his unfulfilled need to be nourished and nurtured was then exacerbated by power struggles around where, how, when, and even why he eliminated when and where he did. This was experienced as obstinacy by his caregivers.

## STUDENT REFLECTION 5.1

What would your clinical judgment suggest would be a natural difference between Nayeli and Xquenda with regard to their sense of ease around holding and letting go as developmentally appropriate? How do you think the parents and school can best help Xquenda navigate these pressures at home and school? How would you use supervision, consultation, and collaboration with school-based community partners to come up with satisfactory strategies to empower Xquenda so that he is not embarrassed by accidents at school? How could you use child-centered and family play with preferred activities and objects to empower him to hold and let go with more facility, and help anchor those gains to his ego development in relationship?

### The Phallic Stage

Sociological research on child-rearing practices of preschool-aged children also reveals meaningful variation in how much young children are incorporated into the daily rhythms of the family of origin, extended kinship, and community, which would theoretically have an impact on emotional and relational integration of developmental needs and changes during Freud's Phallic Stage (Kulic et al., 2019; Roopnarine & Davidson, 2015). Sleeping arrangements, bathing practices, errands, food preparation, how much access to which caregivers, expectations to perform academically, which impulses and emotions are permissible to express (plus when and how) are all culturally informed, and children must learn to survive and cope within the systems where they find themselves.

While language, gross and fine motor skills, cognitive, and gender identity development all explode on the scene for most children during the Phallic Stage, it is not as clear across the globe that all children are universally having to navigate a deep-seated desire to eliminate their rival parent to have sexual access to their preferred parent, or that fear of losing one's genitalia is common outside of cultures where genital mutilation is widely practiced or a realistic concern (Campbell et al., 2009; Mpinga et al., 2016; Wilson & Roehrborn, 1999; World Health Organization, 1997). What is evident is that preschool age children are generally aware of their genitalia, what that means about their assigned sex, possibly whether or not that accords with their subjective sense of gender, some expectations of gender roles within the society where they live, and



whether or not they are safe in their bodies at home and outside (Healthy Children, 2019). Traumatology would suggest that precocious overtly and accurately sexualized behavior may very well be a trauma response, while innocent curiosity and questions of peers (e.g., “playing doctor”) and adults are normative and not necessarily something to worry about (Levine, 2003; Rady Children’s Hospital, 2014).

#### CASE STUDY 5.4

Both Nayeli and Xquenda were affirmed in their need for affection and attention from both their parents through the Phallic Stage, leaving both of them free of fixation or regression on the Oedipal/Electra complex and resulting residue of a phallic personality (Brill, 1938). Neither was exposed to dismissive or invasive attitudes about their self-expression with regard to inborn sexuality or gender identity, nor forced to submit to sexual attention or touch. Both have enjoyed uninterrupted and safe co-sleeping in the family bed, and the parents have been organized about how and when to privately maintain their sexual relationship without over-stimulating or rejecting the children in their developmental needs. While Nayeli was nestled in kinship care with beloveds who honored her body boundaries and self-expression, Xquenda also was blessed with non-kinship caregivers that fundamentally respected his body and identities, and allowed him free expression without over-stimulating him or requiring his affection in exchange for his needs to be met. Nayeli’s name is strictly feminine, derived from a Zapotec phrase that means “I love you,” but also the word “open,” in addition to the Nahuatl word for “princess”; thus far, her name appears to be syntonic with her identities, and not a subject of resistance. Xquenda’s name is androgynous in Zapotec for “spirit, soul, essence,” which signals his parents’ culturally syntonic openness to fluid sexual and gender identity and expression (at least for Xquenda), in resistance to missionary colonialism (Estrada, 2003; Indian Health Service, n.d.; Nicolas, 2018; Ristock et al., 2010); no matter where Xquenda lands on the gender identity spectrum, the name is gender-fluid.

From a Freudian perspective, both Nayeli and Xquenda appear to have navigated the Phallic Stage without circumstances adding tension regarding their developing sense of gender and sexual identity, inborn attractions, need for parental love and affection, or safety in their developing sexual self. Had sexual boundary violations, emotional rejections, or other significant traumas occurred during the Phallic Stage, it would be expected there would be added acting out or acting in related to body boundaries and expression of affection and attraction, possibly resulting in eventual sexual compulsivity and/or promiscuity (Jerkovic & Berberovic, 2012).

### Updated Research

Neuroscience has become the new darling of modern psychological research, and *neuropsychoanalysis* is revisiting Freud’s original suppositions with the benefit of

## STUDENT REFLECTION 5.2

When children have been molested directly or over-exposed to sexual behavior, it is not unusual for them to demonstrate precocious sexualized behavior with peers or adults. How do you think this might show up in the classroom or play yard, and how would you use supervision and consultation to navigate these sensitive issues therapeutically?

technologies unavailable in his day (McGowan, 2014). Neuroscience power brokers Antonio Damasio, Joseph LeDoux, Jaak Panksepp, V. S. Ramachandran, and Eric Kandel have all taken Freud's theories to investigative task. Kandel, a Nobel Prize-winning neuroscientist, affirmed in *The Age of Insight* (2012) Freud's view that the majority of our mental and emotional life,

is unconscious at any given moment...(and) that the instincts for aggressive and sexual strivings, like the instincts to eat and drink, are built ... into our genome....normal mental life and mental illness form a continuum (Owen, 2017, para. 7).

Multiple imaging techniques of the last decades have differentiated the triune (three-layered) brain, with various types of scans demonstrating that the three layers do not always talk to each other fluently, but work in neural networks, and develop in response to repeated experience, thus creating functional variance between individuals (Music, 2018; Turnbull et al., 2019). Traumatology neuroscience shows that rather than an elevator smoothly moving up and down between the layers across the lifespan when under duress, our blood flow and electricity tend to drop from the upper layers, once they have been built in adolescence and early adulthood, way down into the basement of the reptilian brain when our attempts to use the social-engagement system do not resolve a threat, or when we are otherwise presented with rapid threat stimuli that trigger a historical trauma response (Kozłowska et al., 2015; Schimmenti & Caretti, 2016). Furthermore, when "we are placed under extreme stress, the memory-forming hippocampus is bypassed, and experience registers in the fear center of the amygdala, creating what LeDoux in 'Psychoanalytic Theory: Clues from the Brain' (1999) called an 'unconscious memory'" (Owen, 2017). Much of modern traumatology works with these implicit, embodied memories as they show up in repetitive holding, movement and behavior, sometimes working to make them explicit, but sometimes not (Schimmenti & Caretti, 2016).

Neuroscience is now corroborating much of Freud's conceptualization of how our various developmental capacities as a species are brought online and made dominant in response to maturation within circumstances, what is now called *experience-dependent learning*, and that with consistent patterns, our grey matter thickens and synapses neurologically wire together in response to the demands and gifts of the environment (Costandi, 2014; Fields, 2020). Thus, for babies and small children who are well-supported and whose developmental needs are met consistently, the early-developing lower layers of the brain do not need to grow larger or more reactive for survival, and the blood flow and electricity can afford to go up the elevator, focusing growth on the later developing cortex and neocortex, and resulting organization of higher executive functions as those developmental capacities naturally unfold (Lewis et al., 2000). However, for babies and small children who are exposed to toxic stress, including neglect and/or abuse, the blood flow and electricity must necessarily stay focused on the survival activities mediated by the reptilian brain, and thus a more reactive fight-flight-freeze-fawn-flop response is a predictable outgrowth of that lived experience, as can be blocks to explicit recall of overwhelming events that initiate a self-protective or aggressive reaction to stress (Bracha, 2004; Hambrick et al., 2019).

Neuroscience is therefore normalizing the biological and physiological underpinnings of psychological beliefs and resulting behavior under both calm and stressful developmental (trait) and momentary (state-specific) conditions, aligning with Freud's

*Project for a Scientific Psychology*, with various approaches being more or less reductionistic, more or less focused on the brain (objective material) versus the mind (subjective meaning-making; Bassiri, 2013; Khalsa et al., 2018). This ongoing research highlights the nature of nurture, that epigenetic exposure turns on or off inherited genetic potentials, resulting in both individual and cultural beliefs, with free-floating anxiety being channeled in ways that can be both culturally syntonic or dystonic (Campbell & Garcia, 2009; Lende & Downey, 2012). So while Freud's theories are not all universally applicable, they are not all universally inaccurate, either. As Cieri and Esposito (2019) note, the free energy principle is:

*the royal road* in the dialogue between neuroscience and psychoanalysis, *the bridge* between mind and brain (as an) adaptive biological system, connecting psychological sciences, neurosciences and related fields in perfect confluence and synergy with psychoanalytic concepts. (para. 12)

Subsequent developmental theorists who built upon Freud's foundation sometimes needed to jackhammer open a few holes to go underneath it, as well as cantilever out from it before erecting their walls; that they were able to do so meaningfully is owed to the solid slab he laid down for them.

### STUDENT REFLECTION 5.3

From an updated Freudian lens, what would your budding clinical judgment tell you regarding how much tension versus ease each child of Inda Jani and Surem has had to hold and process? Since it requires biological and emotional labor to digest stress neurochemistry and body-based tension, which of the two children is likely to be spending more time and effort stressed? How do you imagine that stress might show up behaviorally as the children move through developmental stages? How might that stress affect the family, educational professional, and peers around the child? How would you as a mental health professional soothe yourself to regulate reactivity to that stress?

### CASE STUDY 5.5

Xquenda is having difficulties incorporating the developmental tasks of the Oral and Anal Stages during the entry to school, with echoes of the unresolved work showing up in frustrated aggression when he is not able to access what he needs, or when he can't control an interaction with relaxed ease that it will resolve in his favor. Luckily, he does not have added anxiety, inhibition, and shame from traumatic interruptions during the Phallic Stage, thus there is some holding capacity to work through earlier frustrations and grief as he moves toward formal school entry and the latency phase. Because he is not also caught up in fight-flight-freeze-fawn-flop from ongoing traumatic interruptions in current time, and he is supported by a secure base in his parents, it is possible to do titrated exposure to that which causes him small amounts of stress and work to build his window of tolerance with that activation, while aiming to deliver the emotional and physical supplies he needed but did not always get as a fetus, neonate, infant, and toddler to down-regulate that activation in increasingly age-appropriate ways.

Clinicians aware of the subconscious stress that may be held over from gestation and birth through to school entry may gently assess through the parents how baby's ingestion and toilet training was navigated, listening for themes of tension, negative affect, or other parenting difficulty, and helping to process through age-appropriate child-centered and family play therapy (Ray & McCullough, 2016) the patterns that show the child is stuck trying to gain mastery yet from those phases, while also working with holistically oriented medical practitioners to help build the biological health necessary for positive mood and easeful behavior. Freud's *repetition compulsion* (Brill, 1938) of stuck patterns that need working through can help clarify what stage of early development has been thwarted and merits therapeutic attention, and family counseling with sensitivity to perinatal and early developmental themes can facilitate the processing of grief and relational disconnection from behavior that arose out of overwhelming emotions (Lieberman et al., 2020).

### Reich (c. 1920–1957)

Wilhelm Reich was a star pupil of Freud's, both having medical and psychoanalytic education to inform their ongoing studies of the mind–body connection, in a shared cultural experience, developing their theories among the Vienna Psychoanalytic Society before having to escape the Nazis. Reich took Freud's psychosexual work one step further (Reich, 1927) and stirred up even more controversy and professional ostracization in the process, as he migrated over Europe looking for a safe place to research and practice out of the reach of the Gestapo. Reich's life work of experimentation and research was originally centered on White, European, presumably cisgender, heterosexual adults, resulting in his development of sexual health policies he was trying to extend down into adolescence through public health clinics, to his own peril (Sharaf, 1983, 1994). Homosexuality was much maligned under fascism, and socialist reactions to fascism (Gruber, 1987; Reich, 1933b), and thus much that might have been written about same-sex relationships and psychological development was likely burned (Kinsey Institute, 2017, Nov. 28); however, Reich appeared to be a product of his environment in his belief that homosexuality was a neurosis or aberration to be aligned with Nazism (Oosterhuis, 1995). He ultimately emigrated to America in hopes of finding a more receptive environment for his research, but suffered an even worse fate of ex-communication than Freud, ultimately dying of heart failure in prison shortly after his books were burned in the United States (Hale, 1974; *Today in Civil Liberties History*, n.d.).

Reich is credited with being the godfather of a sexual revolution in his day (Bramwell, 2018). His student Fritz Perls went on to found the most widely recognized body-inclusive modality, Gestalt therapy (Fischer, 2012; *Totally History*, n.d.), while many other modern body-inclusive therapies also root their origin stories in Reich's work (Marlock et al., 2015). The Beat Generation artists often referenced Reich's experimental devices and their experiences in them (Antonic, 2019), thus he enjoyed an influential following at his peak.

Biographical research on Reich (Sharaf, 1983, 1994) suggests that he likely had a significant Type II and III trauma history; specifically, a sexual abuse history with a trusted nanny; exposure to his mother's sexual relationship with his private tutor; his mother's suicide upon discovery of the affair by her husband when Reich was 12; surviving life in the trenches; and living under the pressing specter of fascism throughout

his early childhood and early career. In reflection on losing his mother, he wrote the “joy of life [was] shattered, torn apart from [his] inmost being for the rest of [his] life!” (Sharaf, 1983, 1994, p. 43); his tutor was sent away, and then his father soon after died of unceasing pneumonia and tuberculosis. Reich spent his late teens in the trenches in a horrendous war, his family home destroyed, family fortune vanished; he arrived in Vienna shell-shocked, penniless, and without family (Reich, 2005). The details of these suppositions are acknowledged in his private journal entries (Reich, 2013), and if taken at face value through a trauma-informed lens, normalize some of the ways he reportedly comported himself sexually and relationally across his lifespan (Barnum & Perrone-McGovern, 2017). As formal codes of ethics were still in the formative stages during the early development of psychoanalysis, modern reflection on the boundary blurring and abuse of power that occurred between practitioner and patient highlights how the projected trauma of toxic patriarchy informed the need for laws and regulations with regard to patient rights; Reich became sexually involved with a patient whom he later married, and may have aborted his child with another patient (New World Encyclopedia, n.d.).

### ORGONE AND VEGETOTHERAPY

For the purposes of this chapter, we will focus on the components of Reich’s *orgone* and *vegetotherapy* theory that are relevant for young children’s development (Reich, 1983, 1984), while situating his work in the larger cultural milieu and resulting theory development. Reich’s investigations into the inborn lifeforce, which he dubbed *orgone* (derived from *organic* and *orgasm*, similar to Freud’s *libido*) (Reich, 1942, 1973, 1963), led him to further incarnate Freud’s and Jung’s depth psychology theories on how chronic social impingements and threats infringe upon the embodied being, both individual and sociocultural, breaking down our ability to love fully and resulting in the rise of evil and violence (Reich, 1933b, 1953).

### CHARACTER ARMOR

Rather than just affecting how we think and emote in the moment in response to our internal desires versus the expectations placed upon us by family and society, Reich posited that the stress of these assaults on our natural needs for empathy and embodied connection and expression left behind residue of muscular tension defenses he called *muscular* or *character armor* (1933b), that shows in how one holds oneself in, up, down, or back; blocks against emotional or physical exposure; and aims to protect from future hurt. This character armoring expanded clinical body-based awareness from Freud’s erogenous libidinal zones to the muscles we use to fight or flee, freeze, fawn, or flop (aka fright or faint; Bracha, 2004; Kozłowska et al., 2015), while Reich’s work on adolescence and adulthood encouraged the healing powers of complete orgasmic release both as a measure of how free one’s lifeforce was flowing, and as a way to heal these historical embodied blocks (1942, 1973).

### CHARACTER STRUCTURE AND ANALYSIS

Reich considered character armor to be our subconscious defenses erected to protect us when we were too young and small to do so effectively with other behavior, and this muscular tension was theorized to organize itself in particular segmented body patterns based on survival and coping mechanisms, which he categorized into *character structures*. The tension can result in a depletion of energy, resulting in a slumping,

## FIELD NOTES 5.1

From a general practice standpoint, I (Roller) have found that at least some components of Reich's character armor theory are self-evident when comparing two very disparate groups of infants. As a volunteer holding babies born addicted to crack while their birth parents participated in recovery treatment, this author has felt the stuck holding and tactile withdrawal from touch that is common in babies with this form of in utero substance exposure and neonatal abstinence syndrome (Addiction Center, 2021, 2021, March 24). Their arching of the back, rigid bellies, clenched fists, and general inability to relax from prolonged unsootheable crying makes these babies' muscles very tense, and the diaphragm particularly reactive to rubbing. Their movement patterns are thus gripping and sharp, and their lower weight simply does not rest down comfortably into the support of being held. They simultaneously need, but cannot be soothed by touch. It is clear the nervous system is more highly reactive and less easily down-regulated, and that contact with the world is generally overwhelming due to the lack of endogenous painkillers and feel-good neurochemistry they generate.

However, in many other babies without in-utero exposure I've held as a babysitter, family clinician, allo-parent, and parent, particularly babies who are breastfeeding and being worn a lot, those babies tend to allow their heavier weight to sink down trustfully into the supportive holding arms, lean heavily against the caregiver's torso, melt their muscles in relaxation when it is time to rest, and demonstrate more fluid, easeful movement when they are awake, while being peacefully responsive to both soothing and playful touch. These safer, calmer, happier babies don't generally resist touch, or hold defensive tension in their bodies, but instead engage in mutual enjoyment of touch and proximity.

withdrawn, flaccid stance on one end of the spectrum, and an uptight, rigid, aggressive stance on the other end. Reich experimented with touch and pressure to release this held over muscular tension or depletion, and facilitate emotional expression and liberation in his clients, as well as in building devices to try to collect and direct this orgone for self-healing, or facilitate clients' self-care and release of this tension through self-applied pressure in postures to access and breathe through the armoring (Reich, 1933a, 2004), much like yoga asanas.

Reich's Character Analysis (1933a) is continuing to be revisited and studied using methods more aligned with updated codes of ethics (Anthi, 2020; Bodydynamic International, n.d.; Energetics Institute, n.d.; Lothane, 2017; Sletvold, 2011). In reflecting on his core principles regarding a universal life force that brings human life into being through the orgasm, and how that life force continues to seek expression in directional and receptive movement in order that life be sustained and sent forth, one may appreciate how Reich's rational fear of the rigidly controlling SS soldiers would help shape his beliefs that love and evil could not be embodied simultaneously, but would necessarily split during early character formation, and that these basic setpoints for worldview would have biological expression in myriad ways. Reich was critiquing prevailing Nazi parenting practices that actually encouraged intentional neglect of infant's needs to make babies less able to attach, which may have contributed to the

widespread de-sensitization and lack of empathy that made their genocide possible, and may have ongoing transgenerational effects (Kratzer, 2019).

Among Reich's legacy desires was to change the way parenting and educational practices embraced and fostered the health of all children, to protect their inherent wholeness and freedom, while leading to a more gentle and loving world (Reich, 1983, 1984). As he stated in the most recent biopic "Love, Work, and Knowledge: The Life and Trials of Wilhelm Reich" by Kevin Hinchey,

"... we have to ... derive our whole ... criticism of society from the needs of the living in the child ... hope that (they) will be able to influence ... society from the standpoint of the living, not ... party, state, church, ... culture."

The Wilhelm Reich Infant Trust is a museum and bookstore that offers resources and training for the use of his "pioneering contributions to psychoanalysis, scientific study of human sexuality, and body psychotherapy, as well as his decades of scientific work developing an energetic understanding of medicine, biology, sociology" (Wilhelm Reich Museum, n.d., para. 2).

## Relational–Cultural Considerations

Like Freud, Reich's life and work cannot be separated from the White, Eurocentric, industrialized, patriarchal, cis-heteronormative society with which he identified and within which he enjoyed many more visible and invisible privileges of ableism, citizenship, dominant language facility, educational attainment, financial status, and professional identity, plus all the social collateral those privileges bring. Significantly countering these privileges were his traumatic relational losses, complex trauma of multiple deployments, and the fascist threat and genocide occurring throughout much of his development, although less so for him than those who did not have his protective privileges and freedom of movement to escape.

Though he was able to hold a critical lens to that which caused *him* harm and traumatic stress, Reich did not demonstrate that he was as sensitized to the harm and stress that did not affect those who looked or lived like him directly; his privilege as a White cis and heterosexual able-bodied man informed his biases as he worked toward some semblance of sexual, emotional, and political liberation for those with whom he identified. That Reich's parents were Galician and Bukovina Jews, but opted not to raise him Jewish or speak Yiddish (presumably for fear of persecution), may have further protected him from the Holocaust well enough that he was able to escape and complete the work that he did (Sharaf, 1983, 1994).

Having to deny or be cut off from parts of one's ancestral heritage can mean an irreversible loss that one must find a way to integrate, which is a traumatic pattern in place for millions of people today; this pain of loss can initially sensitize one to that loss in others, unless it becomes pervasively traumatizing, in which case capacity for empathy in others' suffering may be reduced (Hofmeyer et al., 2020). Using his own theory, one could posit that Reich had developed *character armor* in response to the pervasive threat that his parents knew loomed and would require skillful navigation to escape, compounded by his early sexualization by his nanny, and the traumatic death of his mother, loss of his tutor, and then death of his father, and that this embodied tension resulted in shaping his worldview and perception in ways he was trying to work through much of his life.

Reich's character armor work was deeply influenced by movement specialist Elsa Gindler; her role in the development of his vegetotherapy allowed the field of somatics to receive White cisgender able-bodied heterosexual feminist input, and initial attempts at diversification in thought and research (Geuter et al., 2010). His character armor work is also widely credited with inspiring his contemporary Anna Freud's *The Ego and the Mechanisms of Defence* (1936), which then allowed an initial branching out of embodied psychoanalytic theory generation and research through White cisgender women. This preliminary diversification began a practice of applying the White Western scientific method to embodied wisdom and healing traditions from around the world, which is still in the beginning stages of generating peer-reviewed research outcomes (Matlock et al., 2015), a necessary ingredient for legitimacy in the eyes of Western managed care so that interventions may be applied with a Western science evidence base.

### CASE STUDY 5.6

Xquenda's gestation, infancy, and early childhood appear to be devoid of outright abuse, but may have tinges of occasional unintentional neglect resulting in held frustration and reactivity due to the toxic stressors the entire family was having to navigate during his most formative stages, reducing their capacity to focus on regulating his needs and temperament. It is likely he holds more tension than Nayeli in the large muscles of the legs, chest, arms, and along the diaphragm. The brain cannot be relaxed when the muscles are constantly tensed, so finding age-appropriate ways to release this tension through play, movement, and attuned parental touch will be necessary to help fulfill his needs for peace and ease.

### Updated Research

There are a few neo-Reichian researchers who continue to adhere to his original lines of inquiry with updated ethics and methods (DeMeo, 2011; DeMeo et al., 2012; Strick, 2015), however most subsequent body-inclusive psychoanalysts and clinical practitioners have used his premises more as stepping-stones than end-games, and have instead mined Reich's articulation of incarnated childhood trauma to help prevent or resolve character armor (Matlock et al., 2015).

There are now several dozen distinct body-inclusive psychotherapies and somatic approaches, a significant subset of which focus their treatment on the embodied echo of early childhood developmental disruptions that continue to impact people's sense of safety in connection, in resolving held patterns that restrict neurophysiological signs of ease, and in dissolving states of shock that impede effective grieving in order to re-engage fully (Matlock et al., 2015). Though this body of published work is increasingly cross-cultural and beginning to be led by LGBTQ+ and BIPOC practitioners and researchers around the world, the written work has historically been rooted in White-centered and financially privileged educational and training institutions, even though many of the wisdom traditions from which it draws have long oral histories and traditions that made the theories available for Western scientific method application in the first place. Thus, colonization of thought and practice is therefore also evident here, and much more diversification of leadership within and outside of academia will be necessary before meaningful outcomes will be generated for underrepresented and



marginalized groups and individuals who cannot access therapeutic services but must work through the methods approved by managed care.

The evolution of somatics is currently allowing for both increased differentiation and prioritization between the three main foci (awareness, touch, and movement), as well as integrated approaches that honor common factors (Matlock et al., 2015). Work underway is beginning to utilize neurophysiological and other quantitative measures, in addition to a history of qualitative inquiry, to assess mixed-methods outcomes over various treatment modalities (The Traumatic Stress Research Consortium, 2020, September).

Among somatic approaches focused on preventing character armor and resulting dysregulation and disconnection in babies and children, or aiming to resolve character armor defenses from these early developmental phases through body-inclusive interventions for youth and adults are: Biosynthesis (Boadella, 1987, 2015; Boadella & Boadella, 2006); Body–Mind Centering (Cohen, 2017); Body–Mind Integration (Aposhyan, 2004); Bodydynamics (Frazer, 2014; Isaacs & Isaacs, 2001; Suvorov, 2020); Cranio-Sacral Therapy (Exner-Pirot et al., 2018); Dialectical Behavioral Therapy (Bohus et al., 2020; Krüger et al., 2014; Linehan et al., 2006); Gestalt Therapy (Brownell, 2019; Fischer, 2012; Wagner-Moore, 2004); Mindful Parenting (Townshend & Caltabiano, 2019); NeuroAffective Relational Model (Heller & LaPierre, 2010); NeuroAffective Touch (LaPierre, 2021); Nurturing Resilience (Kain & Terrell, 2018); Sensory Awareness (Khalsa et al., 2018; Selver, 1999); Somatic Experiencing (Carleton & Ho, 2009; Levine, 2017, 2019); Sensorimotor Psychotherapy (Ogden & Fisher, 2015); and Trauma Releasing Exercises (Edwards, 2019; Herold, 2015; Lynning et al., 2019; Salmon, 2013), to name a few. While purely Reichian approaches center most of their practice and research on individual or group work to resolve past trauma, Reich’s work has also inspired methods that center attachment relationships as the unit of treatment to enhance felt security in proximity (Carleton & Padolsky, 2012; Isaacs & Isaacs, 2001; LaPierre, 2021; Townshend & Caltabiano, 2019).

Reich’s research on character armor is rooted in what would later become known as Types II and III trauma. We will focus on Type II (aka, attachment/relational/developmental) trauma in our next section. From The National Child Traumatic Stress Network (n.d.), current validated measures that assess for Type III trauma include: Child Behavior Checklist (CBCL); Posttraumatic Stress Disorder Semi-Structured Interview and Observation Record; Posttraumatic Symptom Inventory for Children (PT-SIC); Preschool Age Psychiatric Assessment (PAPA); PTSD Symptoms in Preschool Aged Children (PTSD-PAC); Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR); Trauma Symptom Checklist for Young Children (TSCYC); Violence Exposure Scale for Children-Preschool Version (VEX-PV); Violence Exposure Scale for Children-Revised Parent Report (VEX-RPR).

## **Bowlby (c. 1907–1990)**

John Bowlby’s social location and personal development predictably informed his theory development. Like Wilhelm Reich, Bowlby was originally trained in Freud’s psychoanalytic approach (1939, 1940), but he subsequently grounded the prevailing White, educated, industrialized, rich, cis-, and heteronormative intrapsychic exploration of subconscious processes by incorporating biological patterns found in the animal kingdom (Bowlby, 1953), to which humans belong. He was also deeply impacted

## STUDENT REFLECTION 5.4

Many of the historical and ongoing stressors experienced by Xquenda and his family have long-term biological implications if left unaddressed, which then give rise to mood and behavior difficulties. Not all family stress is resolved through psychotherapeutic clinical interventions alone. What referrals, linkage, and holistic interventions may be necessary to help Xquenda and his family begin to find more health, ease, and well-being, so that the byproducts of his mood and behavior can begin to calm and stabilize, and he can more deeply benefit from family play therapy and other clinical support?

by Hungarian psychoanalyst Sandor Firenzi, who broke with Freud over how to work with childhood sexual abuse (Stanton, 1991), and Scottish psychiatrist Ian Suttie's sociological study of parental love and expressed tenderness as central to the ability to love (Suttie, 1935). His personal life and times may be evident in the patterns he was exposed to, which prioritized his clinical research attention; his body of work (Bowlby, 1940, 1951, 1969, 1982, 1973, 1980, 1988; Bowlby & King, 2004) continues to be replicated and diversified.

Bowlby's early childhood was culturally syntonic with a privileged London-based family in service to an imperial reign; his biological parents were focused on their high profile work and societal prominence, believing too much parental attention resulted in spoiling the children, thus he was emotionally raised by nannies and nursemaids in a hierarchy (Van Dijken, 1998). Bowlby asserted upon reflection that when his main attachment figure, nursemaid Winnie, left the family at his tender age of 4, this was as devastating as losing a mother (Bowlby & King, 2004). He was then sent away to boarding school at age 7, and subsequently lost his beloved godfather (Van Dijken, 1998). These losses, grafted onto his parents' minimal bonding behaviors, likely sensitized him to the pain suffered by the many war-orphaned children with whom he worked who ended up living in institutions that were designed to be dismissive of children's emotional needs (Karen, 1998), and probably led to his formulations around the distress of *maternal deprivation* (1953) from the position of first-hand experience in both culturally syntonic and traumatic ways (Van Dijken, 1998).

After his foundational studies in psychology and psychoanalysis, Bowlby worked with maladjusted and delinquent children; this inspired him to become a psychiatrist. During his psychiatry training, he was introduced to the work of Melanie Klein, founder of play therapy, but came to feel her work focused too much on the imaginal world of the kids, and not enough on their family and caregiving relationships and environments. He was asked by the World Health Organization to write a report on homeless children, and in it, he centered the loss of attachment figures (Bowlby, 1951). Happily, he went on to marry Ursula Longstaff, and they had four children (Holmes, 1993); this author hopes he came to enjoy earned secure attachment with her and all his children.

Embedded in the Bowlby family history is a professional *attachment network* which was paid to meet the emotional needs of the children, and Bowlby's life work could be viewed as having tried to make sense of the effects of absent and dismissive parents, while both appreciating the protective effects of substitute long-term, consistent caregivers, and mourning the loss of that continuity of care across critical periods (Bowlby, 1940, 1951, 1969, 1982, 1973, 1980, 1988). While there was fervent peer critique against these original

suppositions (Karen, 1998), ongoing psychological research has borne out how protective *secure attachment* with at least one consistent caregiver is, and how much relational and biobehavioral effort is required to move from *insecurely attached* to *earned secure attachment* in order to confer security when that was not originally given to one as a child (Izard et al., 1991; Roisman et al., 2003; Saunders et al., 2011).

Bowlby established the Tavistock Clinic in 1948 to systematically study parent–child relationships (Polat, 2017). There he identified “three phases of response: protest, despair, and detachment,” when an infant’s primary caregiver leaves (Ainsworth, 1992, p. 1). Noticing that there were also patterns that arose upon reunion, experimental approaches to assess parent–child relationships began to be formulated (Polat, 2017). Generative collaboration between Bowlby and his dissertating student, Mary Ainsworth, began under these circumstances.

### Ainsworth (c. 1913–1999)

Mary Ainsworth’s social location and personal development also informed her theory development. Ainsworth was born in Ohio in 1913 (moving to Canada in 1918) to White, middle-class, college-educated parents in a cis-heterosexual marriage, the eldest of three daughters, and grew up surrounded by expectations for high academic achievement; she reflected that her father was more affectionate and attentive than her mother, and that there seemed to be emotional tensions with her mother due to that (Gale, 2017). Ainsworth’s doctoral studies occurred under security theory founder Blatz (1966); van Rosmalen et al., 2016), and her 1940 dissertation focused on adjustment as a function of family as a *secure base* (Main, 1999). As protégé and lauded attachment researcher Mary Main reported upon reflection of their long mentorship, Ainsworth herself went through a “long, radically enjoyed personal psychoanalysis” prior to her life-altering move to Uganda with her husband, Leonard Ainsworth (1999, p. 2), which appears to have sharpened her focus on the impact of the mother–child relationship in deeply impactful ways (Ainsworth, 1962, 1969; Ainsworth & Boston, 1952; Ainsworth et al., 1956).

Ainsworth’s original naturalistic observations and detailed note taking of infant–mother dyads in the community and at home in Uganda showed that children moved freely between allo-parents in search of attention and interaction, but when distressed, evidenced preferential attention-seeking for the birth mother (Ainsworth, 1967). Within that preference, half the children were immediately soothed upon reunion with the birth mother and in response to her physical affection, verbal reassurance, and attuned attention to their bids for connection (Ainsworth, 1967). About one quarter of them continued to cry whether attended to by mother or not, and another quarter demonstrated flat affect and lack of upset whether with mother or not (Ainsworth, 1967). These *quality of care* observations led to Ainsworth’s “‘tripartite’ classification system of ‘avoidant,’ ‘secure,’ and ‘ambivalent’ (aka resistant) infant–mother attachment relationships” (van Ijzendoorn & Sagi-Schwartz, 2008, para. 1). These observations spawned replication studies in her “Baltimore” research at Johns Hopkins, creating the Strange Situation, which later was applied at the Tavistock Clinic, in order to test whether these categories appeared to hold across cultures and relational configurations (Ainsworth & Bell, 1970). Mary Main and Jude Cassidy subsequently differentiated “disorganized” attachment, which is highly correlated with more serious long-term pathology (Beebe et al., 2012; Main & Solomon, 1986; Reisz et al., 2018; van

Ijzendoorn et al., 1999). Some researchers have begun to re-conceptualize attachment security as on a spectrum, rather than discrete categories (Fraley & Spieker, 2003).

From these observations and experiments, Ainsworth developed the “Sensitivity–Insensitivity to Infant Signals and Communications Observational Scale” (Ainsworth et al., 1974). Ainsworth stated that rather than “warmth” (which was relatively universal among the Ugandan mothers), it was “the amount of caregiving for the baby, and the mother’s excellence as an informant about the baby” that created “a pattern of proximity and availability, interest in the baby, perceptiveness about the baby’s needs, and prompt responsiveness to the baby’s signals” (Mesman & Emmen, 2013; Mesman et al., 2016). Subsequent research highlighted the contingent responsiveness central to *maternal sensitivity*, and its role in fostering secure attachment, which confers lifelong health and social–emotional protective factors for children; Ainsworth’s body of research (Ainsworth, 1962, 1967, 1969; Ainsworth & Boston, 1952; Ainsworth et al., 1956, 1974, 2015) continues to be replicated and expanded upon around the world.

## Relational–Cultural Considerations

*Non-violent communication* would say that though all humans do have the same basic needs represented in Maslow’s hierarchy, and the same basic positive and painful emotions when those needs are and are not getting met; what varies between cultures and individuals (and indeed puts people in conflict) is the *strategies* for getting those needs met (Rosenberg, 2005). While all human beings are born as if covered in glue (Goldberg, personal communication, 2015), primed to stick to whomever they are given, and unable to judge the worthiness of those to whom they are given (Lewis et al., 2000), the ways in which cultures, communities, and families meet those needs varies (Domínguez Duque et al., 2010; Sagi, 1990). Babies and children must learn to survive and cope with whomever people and whichever strategies are available in their caregiving (Lai & Carr, 2018), and their development is deeply influenced by the strategies into which they are born, by the “accident of their birth” (Johnson, personal communication, 2010).

In the communal culture of the West African Nso, birth mothers consider it disadvantageous for their children to attach too much to them, because the risk that the primary parent will not live long enough or be regularly available when needed means that it serves their children better to seek out the bulk of their caregiving from a wide variety of available community members (Keller et al., 2005). Among the many underlying threads this protective parenting strategy reveals is the core survival connection between birth parent and child; if birth parent is not available, how will this child get along (because dependence on birth parent is self-evident) if they do not willingly respond to care from available sources?

The Nso have collectively devised a strategy to reduce the risk that a child would not survive or would be too neglected and devastated if they lost their primary caregiver, and there arose a shared responsibility that all caregivers look out for each others’ children as if they are their own (Keller et al., 2005), in a broad attachment network. Such a strategy also translates into specific parenting practices that require effort to uphold; when children come looking for their primary parent, the primary caregiver will often intentionally redirect the child away to any other caregiver, to break the child’s habit of looking for them. Other communal cultures with higher earlier mortality rates around the world have similar practices, even if the timing or circumstances of pressing the

children away varies (van IJzendoorn & Sagi-Schwartz, 2008). I (Roller) see that as a reflection of how instinctively driven human children are to have an abiding connection with their birth parent, and how much effort is required to overcome that desire for both parent and child if indeed the birth parent is raising them.

Cross-sectional studies of babies raised in Israeli kibbutzim also revealed the monotropy of the birth mother over the (more primarily involved surrogate) caregiver (van IJzendoorn et al., 1992), in particular with regard to the rate of down-regulation of distress when each attachment figure returned (Fox, 1977). van IJzendoorn and Kroonenberg (1988) found in their meta-analysis of 2000 Strange Situation classifications from eight countries that “A (avoidant) classifications emerge as relatively more prevalent in Western European countries and C (resistant) classifications as relatively more frequent in Israel and Japan,” and that “intracultural variation was 1.5 times the cross-cultural variation” (p. 1). In their cross-cultural research, Grossman and Grossman (1990) found that because cultural differences “may exist in terms of frequency and difficulty of potentially conflicting challenges imposed on individuals ... (attachment research must) consider both ... the universal and the culture-specific, when testing the full potential of attachment theory from a life course perspective” (p. 1). Subsequent meta-analysis of data from “various African cultures, the People’s Republic of China, Israel, Japan, and Indonesia ... suggest a balance between universal trends and contextual determinants” factor into how insecure attachment rates and patterns vary between cultures when considering the “universality, normativity, sensitivity, and competence hypotheses (that) constitute the core hypotheses of attachment theory” (van IJzendoorn & Sagi-Schwartz, 2008, p. 1).

Strategies to meet needs appear to arise out of necessity and opportunity while navigating the demands placed upon a family and community system in context, and sociological conditioning powerfully informs the messages sent and received about whether caregivers are using approved strategies, thus *neuroanthropology* studies how culture informs brain development, and vice versa (Campbell & Garcia, 2009; Domínguez Duque et al., 2010; Lende & Downey, 2012, 2020), while biobehavioral studies are beginning to show how the extended nervous system of caregiving aptitude informs the developing nervous system of one’s charges (Perry et al., 2017; Porges, 2006; Townshend & Caltabiano, 2019).

Factoring into the bidirectional processes leading to attachment outcomes is whether there is *goodness of fit* between the caregivers’ and child’s *temperaments* (Sravanti, 2017), and to what degree parental attachment and developmental trauma history (Bretherton, 1990, 1999; Kerns & Brumariu, 2014; Scharpf et al., 2020; Wadsworth et al., 2018), parental stress, problematic coping mechanisms, and/or child developmental delays (Dagan & Sagi-Schwartz, 2018; Finzi et al., 2000; Newland & Crnic, 2017; Scharpf et al., 2020) complicate goodness of fit. In a multiple stress sample it was determined that “for temperamentally difficult children, unresponsive parenting exacerbates risks for behavior problems, but responsive parenting can effectively buffer risks conferred by temperament” (Kochanska & Kim, 2013). Another multifactorial study found that perception of difficult temperament was correlated with insecure maternal attachment and maternal developmental trauma history, suggesting that intervention to reduce risk really must begin before pregnancy and continue through at least the first year of baby’s life to help moderate for suboptimal parental history (Wadsworth et al., 2018).

Of further consideration is that variation in relational priorities across cultures arise in how parents direct their children's attention after they have down-regulated in response to caregiver attention after an upset, which can factor into how researchers perceive relative security through culturally syntonic or dystonic lenses (Fivush, 2006). For instance, while the secure base function of attachment thus far appears to be universal, there are "cultural variations" in how "an infant and mother achieve (that)." In Western cultures, mothers are more likely to separate from their infant and encourage independent exploration. When the infant becomes distressed, infants generally are the ones to seek proximity (Jin et al., 2012). However, Jin and team noted that, "Korean and Japanese mothers encourage their infants to stay physically close. After a separation, the mothers are more likely to approach the infant immediately and stay near even after the infant's distress is no longer present" (p. 42). Such patterns result in different expectations being built for children regarding what happens once one is feeling secure again (i.e., stay connected in proximity and play, or go off on your own to focus on play projects). Jin's team noticed that, "once proximity is achieved, regardless of how it is achieved, the majority of infants across cultures are able to receive comfort and are able to return to their exploration and play" (p. 42). This *amae*, also known as *maternal dew*, or emotional interdependence, is commonly practiced in more collectivistic societies, thus Western assessors might over-attribute anxious "enmeshment" to parent-child dyads engaging in relational patterns more typical of collectivistic cultures (Behrens, 2010; Rothbaum & Kakinuma, 2004; Yamaguchi, 2004).

It has been demonstrated that group-sustaining preferences for individualistic or collectivistic patterns drive group member choices with regard to the reinforcement schedule of bonding behaviors that impact attachment as desired by the primary caregiver (Strand, 2020), and that "behavioral predispositions concerned with security-seeking versus novelty-seeking, established during childhood, hedge interdependent choice behavior in culture-consistent ways and serve as a deep source of cultural stability" (Strand et al., 2019, para. 33). Even when children could not have yet been "exposed to the contingencies that define the adult social world, children behave in ways that are consistent with the contingencies and values of the societies into which they are born" (Strand et al., 2019, para. 32). Thus the internalized cultural messaging a primary caregiver lives out in attending or not to their child's bids for securing attention serve to shape how much that child seeks the reduction of stress from that (and other) caregivers, and how much that child learns to value weak versus strong social ties.

## Secure Attachment Benefits

One key element that does appear to hold across cultures is how primary or continuous secure attachment leads to increased ability to form a subsequent attachment network once children begin moving out into the world (Riggs & Riggs, 2011; Rosenthal & Kobak, 2010), which creates a tiered system for seeking support across the lifespan, and more positive academic and social outcomes across various domains (Balzano, 2010; Carli et al., 2019; Gillath et al., 2019). It also appears that optimal *plasticity* in how that network is achieved and maintained is correlated with the more initial security one is afforded (Gillath et al., 2019; Joseph, 1999; Kobak et al., 2005; Mundo, 2006; Schore, 1994, 2001, 2003a, 2003b, 2013). This appears to be true for neurotypical children, as well as those on the autism spectrum (Teague et al., 2017).

To help achieve these optimal outcomes, natural generation of *oxytocin*, the “bonding hormone,” appears to deeply influence empathy, sensitive attunement to baby, and parental enjoyment of soothing, nursing, and other caregiving behaviors in biological females, and in activating play behaviors in biological males (Feldman et al., 2013; Mah et al., 2015; Scatliffe et al., 2019; Strathearn et al., 2012). Tragically, it appears so far that there is a critical window in infancy and early childhood to develop the endogenous ability to produce and respond to oxytocin, with all its stress and trauma-mediating effects, and that taking oxytocin intranasally to try to gain the same benefits can paradoxically decrease stress coping and caregiving-related memories and behaviors (Kim & Strathearn, 2017). Thus, interventions to interrupt the transgenerational transmission of trauma really must occur prenatally whenever possible (van IJzendoorn et al., 1995), to increase the baby’s possibility of generating the neurological capacity to produce oxytocin for lifelong protective benefits. To do so reduces the risk of parents transmitting their insecure attachment, which in its most severe form can become reactive attachment disorders and problematic coping that result from inadequate caregiving environments, and morph into two basic clinical presentations: an emotionally withdrawn/inhibited phenotype, and an indiscriminately social/disinhibited phenotype (Kim et al., 2017; Zeanah & Gleason, 2015).

There will be many circumstances in which clinicians will not be able to intervene prenatally, and must find ways to support children and families to experience the benefits of parental bonding behaviors even after critical windows for building neurological protective factors may be closing on the child. Currently, 40% of infants assessed in the United States do not meet criteria for secure attachment, with 25% avoiding parents and the other 15% resistant to their intervention, because the parents are more agitating than regulating (Huber, 2014).

Children in foster care will have among the highest rates of insecurity, but they too can demonstrate gradual movement toward earned secure attachment once they are placed in a stable home and can begin to count on identified caregivers, though this is more likely for avoidant/withdrawn children than indiscriminately attached children (Lehmann et al., 2020; Smyke et al., 2012; Zimmermann & Soares, 2019). Because it gets harder to find a forever home the longer a child is institutionalized or in the foster care system, it is even more critical to try to find goodness of fit in permanent placement for children as soon as possible, for the long-term deleterious effects of reactive attachment disorder come to have generally global negative effects on a person’s quality of life (Chase Stovall & Dozier, 1998; Humphreys et al., 2017; Pritchett et al., 2013). What does not appear problematic about attachment is the sex or gender of the caregivers (Ahnert & Schoppe-Sullivan, 2020; Gutierrez et al., 2018; Manning et al., 2014; Salinas-Quiroz et al., 2018; Trub et al., 2016) so long as they are engaging in secure base provision (Woodhouse et al., 2009, 2020).

## Secure Base Provision

Secure base provision (SBP) appears to be the key takeaway for lifelong relational satisfaction and epigenetic protections from all attachment research to date (Woodhouse et al., 2009). SBP includes soothing a crying baby to a “fully calm and regulated state while in chest-to-chest contact ... (so the) infant learns ... whether the caregiver can be counted on to be available as the infant achieves a calm state or whether (they) typically must stop crying alone” (Woodson et al., 2019, para. 14). Such patient and regulated

soothing and attending tends to morph into securing co-regulation that facilitates culturally syntonic toddler development and play (Alcock, 2013), which then allows for securing support for early childhood explorations into adolescence (Jones & Cassidy, 2014). These patterns tend to hold over adulthood, with regression toward insecurity less likely the more primary security one had (like old money). Thus, clinical efforts that cannot be directed at prenatal resolution of trauma and toxic stress may need to focus on the development of secure base provision in spite of past risk factors, as a history of insecure attachment increases the risk of not knowing how to provide a secure base for one's children (Feeney et al., 2013; Grossmann et al., 2006). Therefore, for clinicians to proactively help their clients move toward greater earned security, no matter the clinician's theoretical orientation, the greater likelihood humanity will move toward peace, ease, safety, respect, connection, love, and healthier longevity.

## Treatment Modalities

In addition to the Reichian approaches that center attachment relationships, there is a growing evidence base of practices that have developed specifically for the evolution of attachment theory, with a focus on preventing insecurity, or fostering earned security. FirstPlay Infant Storytelling (aka Kinesthetic) Massage teaches caregivers how to gently approach the baby's space, read their cues, make sensitive and soothing contact, and coherently narrate their emotional state, while validating and normalizing their feelings in response to the various experiences they have throughout the day (Baldwin, 2020; Courtney & Nolan, 2017). Theraplay, a dyadic child and family therapy, has been "recognized by the Association of Play Therapy as one of seven *seminal psychotherapies for children*. Developed over 50 years ago ... practiced around the world," Theraplay aims to foster secure attachment for "lifelong good mental health as well as the mainstay of resilience in the face of adversity" (The Theraplay Institute, n.d.). Theraplay teaches clinicians and caregivers how to assess what their toddler to young child is needing, when and why, and fosters four essential qualities found in healthy parent-child relationships: structure, nurture, engagement, and (appropriate) challenge. Emotion-Focused Therapy has expanded from focusing on attachment in couples to working with family attachment patterns in many relational constellations (Johnson, 2019). And any family or systems-inclusive approach that brings secure base provision and emotional attunement as central to the work is likely to help nudge clients along toward greater earned security.

## FUTURE DIRECTIONS

The Adverse Childhood Experiences Scale (ACES) is among the most widely recognized measures to capture events of Type II (attachment/relational/developmental) trauma that have been shown to have lifelong effects on medical and mental health; extensive collaborations and program planning are now funded by ACES-related federal funds due to the billions of dollars of loss longitudinal ACES effects have on the U.S. economy. The ACES does not yet assess for Type III (hate-based targeting and other public threat) traumas, or for subjective response to traumatic developmental events; those nuances are better captured in the Childhood Trauma Scale (S. Porges, personal communication, April 21, 2021), though there is not currently significant funding available for program development around this measure. The Adverse Early Experiences and Resiliency Survey aims to capture trauma and protective response during the pre- and perinatal period, to enhance



opportunities for prevention and reduce the need for later, much more expensive and labor-intensive attachment-based intervention.

Polyvagal-informed therapies are leading the way with biobehavioral feedback measures tracking response to attunement and connection, while noting the various deleterious effects of disconnection (Cherland, 2012; Flores & Porges, 2017; Porges, 2009; Porges & Buczinsky, n.d.), to assess what fosters co-regulation for mutual satisfaction in counseling and therapy in a variety of client constellations (Porges & Dana, 2018). Polyvagal theory emphasizes that the range of social behavior is “limited by physiological state ... mobilization and immobilization behaviors may be adaptive strategies to a challenged (e.g., frightened) individual. Thus ... creating states of calmness and (regulating) brainstem structures may potentiate positive social behavior by stimulating ... the social engagement system” (Porges, 2006, p. 52). This research can help operationalize what clinicians may do in session to co-regulate clients while avoiding compassion fatigue, and provide effective psychoeducation to loved ones to help extend the benefits of therapy that aims to resolve attachment trauma and move clients toward earned security.

### CASE STUDY 5.7

Xquenda and his sister Nayeli have been blessed with attentive and responsive parents who do all they can to foster secure base provision in spite of the multiple stresses they have faced with forced migration, loss, and acculturation adjustments over the last several years. Xquenda’s temperament requires more biobehavioral effort to regulate, so due to these factors complicating goodness of fit, attachment-based family play therapy would be indicated to help the whole family find more ease and enjoyment together, giving him the best future possible.



### PERSPECTIVES FROM THE FIELD: PODCAST

Access this podcast at <http://connect.springerpub.com/content/book/978-0-8261-8279-1/part/part02/chapter/ch05>

The goals of this chapter are to: provide you with an initial understanding of how developmental theories of infancy and early childhood conceptualize these most formative stages; expose you to their seminal concepts; encourage your critical thinking about their own context; and introduce you to clinical research and applications of these developmental theories. I invite you now to listen once again to Dr. Judyth Weaver, this time speaking about how she might start applying Freudian, Reichian, and attachment principles to her work with Xquenda and his family.

### SUMMARY

Freud, Reich, Bowlby, Ainsworth, Main, and hundreds of subsequent child developmental researchers around the world have traveled from the infant’s erogenous zones

and projections of their minds, to their soft animal bodies, to their extended nervous system of caregiver co-regulation, to the varied context in which children are born and grow and learn about themselves in relationship to their immediate families, their families' support systems, their eventual peer relationships, and their ultimate families of choice, situated within their cultures of origin and migration. What all have pointed out is how sensitive and vulnerable children are to the impact of developmental trauma, such as abuse and neglect, and how the quality of their caregiving may mediate for that risk in myriad ways. They all forwarded methods to recognize, prevent, and work with this traumatic stress through clinical intervention, education, or policy work. Their collected body of work gives clinicians and clients of varying constitutions and cultural preferences various roads inward to help resolve the anxiety and depression that come from not having a reliably secure base. Their collected body of work also shows that, though our species may have walked and re-planted all over this planet, we all fundamentally do better and find life more manageable when we have at least one receptive and responsive heart to call a stable home.

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PREVIEW

Instructor's Manual  
to Accompany  
Lifespan  
Development  
Contextual and  
Cultural Dimensions

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# CHAPTER 4

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## **Cultural and Contextual Factors of Infancy Through Early Childhood**

### **Learning Objectives**

Upon completion of this chapter, students will be able to:

1. Describe the perinatal and early childhood periods of human development.
2. Identify risk and resiliency factors for infancy and early childhood.
3. Recognize contextual factors that may merit therapeutic attention for early individual and relational healing.
4. Describe how cultural humility and trauma-informed care may be applied for early developmental needs in families, as well as longitudinal effects from this foundational period.

### **Key Words**

Prenatal Adversity, Contextual Factors in Infancy, Cultural Factors in Infancy, Contextual Factors in Early Childhood, Cultural Factors in Early Childhood

### **Suggested Topics for Discussion**

1. In response to the overall chapter, how has Xquenda's family shown their resilience and strengths? What capacities and skills does the mental health professional want to be sure to leverage in support of this family staying cohered, connected, and able to reclaim aspects of their wellbeing they may have had to surrender in their series of losses? How can the mental health professional support them to grieve what cannot be replaced?
2. In response to Student Reflection 4.4, brainstorm a variety of ways mental health professionals may facilitate embodied integration of stress in the settings where we work with children. What are some age-appropriate ways to help children discharge stress to help them build confidence and calm to face the demands placed upon them?

### **Classroom Activities or Homework Assignments**

1. In response to Student Reflection 4.2, brainstorm a referral chart to help students think through what kind of consultation and supervision questions they would have to assure they were securing the necessary support and collaborations to ethically and effectively serve young clients with any

special needs. Consider using a [Jamboard](#) and make a page for each clinical or medical presentation, so that students can carry the resources with them beyond graduation for reference.

2. In response to the podcast, have students journal write about ways they discharged stress and came back into self-regulation as children. What people, places, and practices helped them feel whole, calm, safe, connected, loved, and joyful? How were they similar and different from siblings, cousins, friends, and classmates?

### **Additional Resources for In-Depth Discussions and Written Assignments**

All of the topics relating to this chapter's material can be explored in more depth, with each student or small group choosing one or more of these information sources:

#### ***TV series:***

- **Becoming You:** <https://tv.apple.com/us/show/becoming-you/umc.cmc.2eln6544k8wo99s3vrdl5amwf>

#### ***Online Resources:***

- **Jamboard:** [https://jamboard.google.com/d/1fmGwSvQvajbxq3CSnq3bnI7qf\\_D9q1PpNwtfSneHOcQ/viewer](https://jamboard.google.com/d/1fmGwSvQvajbxq3CSnq3bnI7qf_D9q1PpNwtfSneHOcQ/viewer)
- **Immigrants and Refugees:** [https://www.aamft.org/Consumer\\_Updates/Immigrants\\_and\\_Refugees.aspx](https://www.aamft.org/Consumer_Updates/Immigrants_and_Refugees.aspx)
- **Help for Refugees Who Need Mental Health Care:** <https://www.apa.org/monitor/2018/06/help-refugees>
- **Trauma Psychology: American Psychological Association:** <https://www.apatraumadivision.org/837/refugee-mental-health-resource-network.html>
- **Resources for Immigrants:** <http://immigrationpsychologyservices.com/resources/>
- **Mental Health Interventions for Refugee Children in Resettlement:** [https://www.nctsn.org/sites/default/files/resources/mental\\_health\\_interventions\\_refugee\\_children\\_resettlement.pdf](https://www.nctsn.org/sites/default/files/resources/mental_health_interventions_refugee_children_resettlement.pdf)
- **What Immigrants and Refugees Need to Know About the Affordable Care Act:** <https://www.samhsa.gov/sites/default/files/immigrants-refugees-affordable-care-act-with-notes.pdf>
- **Informed Immigrant:** <https://www.informedimmigrant.com/#>



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# CHAPTER 5

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## **Developmental Theories of Infancy Through Early Childhood**

### **Learning Objectives**

Upon completion of this chapter, students will be able to:

1. Identify the stage of lifespan development known as “early childhood”.
2. Describe key theories impacting this stage of development.
3. Discuss key research impacting this stage of development.
4. Recognize future directions for research and understanding of children and families in early childhood.

### **Key Words**

Attachment in Early Childhood, Ego Development in Early Childhood, Therapy and Counseling Related to Early Childhood

### **Suggested Topics for Discussion**

1. Invite the class to reflect on sources of security in their lives. Whom did they turn to when scared/stressed? What did those people do to help reassure, support, normalize, validate, and encourage them? What did those sources of support DO nonverbally and SAY verbally to communicate acceptance, understanding, and protection? How can the students, as developing mental health practitioners, carry those behaviors and statements into their clinical work to enhance earned security among their clients?
2. In response to Student Reflection 5.5, invite the group to hypothesize about the differences between Xquenda and Nayeli. What would a caring and qualified mental health professional do to help normalize the differences in temperament, reduce problematic comparisons, and optimize bonding between family members? What struggles are likely to surface between the siblings? What are some ways a mental health professional could help the family navigate those struggles and honor each child’s strengths?

### **Classroom Activities or Homework Assignments**

1. In response to the podcast and Student Reflection 5.7, have the students practice facilitating a regulating reflection in dyads. Invite the students to choose a mildly stressful interaction they have had recently, and have them practice attuning to their classmate’s sharing through intentional use of

non-verbal empathy, matched oculesics and proxemics, and soothing prosody as they normalize needs for safety, respect, and connection. Have them share-pair about how it feels to express their needs without having to justify or beg and provide strength-based feedback re: what they appreciated in their partner's reflective listening skills.

2. Have students use the Adverse Childhood Experiences Scale to self-identify risk factors and journal about personal work to do in their own self-care and treatment prior to and during clinical work with families. Since all caregivers are fallible human beings, there is no such thing as "perfect" secure attachment; what residue could benefit from experiencing to completion and release?

### **Additional Resources for In-Depth Discussions and Written Assignments**

All of the topics relating to this chapter's material can be explored in more depth, with each student or small group choosing one or more of these information sources:

#### ***Online Resources:***

- **ACES Aware:** <https://www.acesaware.org/>
- **ACES Aware Training:**  
[https://training.acesaware.org/?utm\\_source=Google&utm\\_medium=SEARCH&utm\\_campaign=ConversionDriving](https://training.acesaware.org/?utm_source=Google&utm_medium=SEARCH&utm_campaign=ConversionDriving)
- **Theraplay Activities:**
  - <http://www.socialworkerstoolbox.com/theraplay-activities/>
  - <https://www.aberdeengettingitright.org.uk/wp-content/uploads/2020/05/Therapy-activities-by-Dimension.pdf>
  - <https://theraplay.org/product/theraplay-activities-flip-book/>
  - <https://www.merakilane.com/play-therapy-techniques-30-therapeutic-activities-for-children/>
- **Child-Parent Relationship Therapy:**
  - [https://cdn.ymaws.com/www.a4pt.org/resource/resmgr/telehealth/8\\_-\\_CPRT\\_Pages\\_from\\_Treatmen.pdf](https://cdn.ymaws.com/www.a4pt.org/resource/resmgr/telehealth/8_-_CPRT_Pages_from_Treatmen.pdf)
  - <https://www.playtherapysupply.com/books/child-parent-relationship-therapy--cprt--therapist-notebook>
  - <https://www.mightier.com/articles/child-parent-relationship-therapy-cprt/>
- **Adventure-Based Counseling Experiential Activities:**  
[https://www.alfredadler.org/assets/docs/2014\\_Conference\\_Handouts/2%20watkins%20-%20experiential%20activities.pdf](https://www.alfredadler.org/assets/docs/2014_Conference_Handouts/2%20watkins%20-%20experiential%20activities.pdf)
- **Experiential Therapies for Children with Trauma:** <https://www.iriss.org.uk/resources/esss-outlines/experiential-therapies>
- **Creative Family Therapy Techniques:**
  - <https://lianalowenstein.com/articleFamilyTherapy.pdf>
  - <https://wonderscounseling.com/5-creative-play-based-therapy-activities-for-families/>

Test Bank to Accompany

# Lifespan Development

Contextual and  
Cultural Dimensions

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PREVIEW

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# CHAPTER 4

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## Cultural and Contextual Factors of Infancy Through Early Childhood

1. In-utero adverse experiences have no real effect on the developing baby because fetuses cannot feel anything yet, and are just relaxing while they grow inside.

- A. True  
\*B. False

Rationale: Pre- and perinatal research refutes the claim that fetuses' sensory processes are not yet operable or encoding experience through sensory reactions and brain/nervous system development; as fetuses grow, they even show emotion on their faces while still in-utero.

2. Babies' temperaments develop as:

- A. a by-product of maternal genes only  
B. a by-product of maternal and paternal genes only  
\*C. a mix of genetic and epigenetic influences  
D. a mix of environmental influences only

Rationale: Pre- and perinatal research emphasizes that genetic inheritance from both parental sides creates certain biological tendencies (risk and protective factors), and that epigenetic experiences then impact those genetic/biological tendencies by silencing or activating both risk and protective factors that have been inherited on both lines.

3. Early adverse childhood experiences:

- A. have no real impact on infant, toddler, or child development  
B. have been linked to medical and mental health disorders across the lifespan  
C. have been found to have impacts even transgenerationally  
\*D. b. and c.

Rationale: Pre- and perinatal research, as well as adverse childhood experiences research, highlight how lifelong damage may be acquired and transmitted even across generations, as genetic material is impacted by prolonged stress; this damage may pass through to subsequent generations and increase risk factors for medical and mental health diagnoses.

4. Buffering support relationships provide:

- A. logistical and practical aid, such as food, childcare, and respite  
B. emotional support, such as empathy, validation, and normalization of needs  
C. challenge that forces people to go through a quantum leap of growth  
\*D. a. and b.

Rationale: "Buffering" from stress means insulating against or absorbing shock from it, not imposing stress or challenge beyond what scaffolds development in an organic way. "Forcing" a quantum leap

in development tends to fracture trust and safety; forcing is a rupture that requires repair for relationship to endure, and can often leave a traumatic interruption on development.

5. Babies who learn to rely only on themselves during infancy become very confident and emotionally secure children and adults.

A. True

\*B. False

Rationale: Pre- and perinatal literature demonstrates that babies who must learn to rely on themselves rather than trustworthy and consistent caregivers do not learn to self-regulate as they grow, but rather to “auto-regulate”, a state often characterized by dissociation and withdrawal from consensus reality. Depending on the patterns of withdrawal from contact, this will result in avoidant, ambivalent/resistant, or disorganized attachment, all of which are contrary to emotional security across the lifespan. When babies are regulated, they do like to explore, but this can only be done if they can consistently rely on attuned caregivers (Tatkin, 2009).

6. Toddlers really have no interest in what adults are doing; they aren’t paying attention or copying anyone’s behavior, but instead are fixated on their internal world.

A. True

\*B. False

Rationale: Toddlers tend to fixate on and repeat what adults are doing; the chapter presents research to show that toddlers and young children “over-imitate” adults even when the behavior is not productive or makes no sense, which is theorized to be a by-product of our evolutionary history incorporating complex tools resulting in “high-fidelity copying” in order to succeed (Bhushan, 2007). Therapeutically, this has significant implications when we consider all forms of abuse against self and others, as well as general stress coping for anxiety etc; rational explanations and insight do not by themselves change the deeply wired drive to copy what adults in our vicinity have modeled, the experience of which moves into long-term implicit memory, which runs subconscious behaviors.

7. Toddlers’ language development:

A. typically is slow and steady, without any clear leaps in gains

B. does not always allow them to express their needs or feelings, the frustration of which can erupt into tantrums

C. requires both practice on their own terms, and emotional supplies from their secure base to scaffold toward more advanced articulation

\*D. b. and c.

Rationale: Toddlers tend to have more receptive language acquisition than expressive language earlier on in their development, but as they grow from age 1 to 3 and 4, adults around them begin to realize how closely they have been paying attention as they repeat phrases, string together their own phrases, increasingly ask thoughtful questions and provide running commentary, and exponentially increase the complexity of verbal communication in general. That said, emotional stress for neurotypical children, and any form of auditory, sensory, or cognitive processing difficulties, can delay this exponential development, and is often cause for early referral and intervention.

8. Young children commonly:
- A.** start building tolerance for less-preferred activities so long as their caregiver/helper is patient with them
  - B.** are only able to do what they want to do and cannot understand why they have to keep their bodies safe and clean
  - C.** begin to work more cooperatively and interactively with peers, showing more interest in imaginal and shared play
  - \*D.** a. and c.

Rationale: Young children's neurological development, so long as it has been fostered toward emotional security, allows them to build emotional stamina and trust in their caregivers' guidance and reasoning related to health, safety, and social requirements. While they are still powerfully driven by momentary sensory processes and affect, neurotypical young children increasingly let go and move on to the next task without needing to tantrum out of frustration if things aren't going their way, so long as their needs are generally getting met. This allows them to focus more on cooperative and interactive play with peers, with more time spent in creative play, while still appreciating the need to be safe themselves and with others.

9. Young children:
- A.** should play only with kids their own age
  - \*B.** start to recognize socially expected norms for gendered behavior
  - C.** are commonly interested only in their family of origin
  - D.** outgrow imaginal play

Rationale: Cross-cultural research cited in the chapter shows how mixed-age groups are beneficial for young children, and that as children grow, they are interested in both their families AND others of all ages in the community, replicating what is modeled. Young children incorporate imaginal play anywhere they are safe to do so, and it is a sign of neurological maturation as children grow away from imaginal play towards other forms of social engagement in later childhood and adolescence, however imaginal play is a component of all play, even athletics, throughout adulthood, so it is never fully outgrown. Because of over-imitation, societies with rigid gender rules tend to hold steady highly gendered play in children, which children begin to recognize and conform to by preschool age. In societies with more androgynous behavior modeled, children tend to be more fluid and flexible in their gender play.

10. Young children:
- A.** tend to like to play with others more than alone
  - B.** can be supported to use some adult tools quite effectively
  - C.** should be treated clinically as an independent entity to protect their privacy
  - \*D.** a. and b.

Rationale: As social mammals who are literally fused to their gestating parent for the first chapter of life, humans are hardwired to seek reconnection and community from the first moments of life outside the womb, and to copy what those around them are modeling as they grow. While some small children can happily entertain themselves for short periods of time, this is generally in proximity to others, enjoying safety in numbers and the din of community available as needed. Children cannot meaningfully shape the environments that shape them 168 hours per week, and though they have some rights to privacy of feelings where reactions to trauma need to be protected, clinically, they benefit from the systems they inhabit engaging in their care so that those systems can be improved for their benefit.

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# CHAPTER 5

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## Developmental Theories of Infancy Through Early Childhood

1. Freud's original suppositions have been translated accurately and consistently interpreted according to the original text.

A. True

\*B. False

Rationale: Bruno Bettelheim is a Viennese German-speaking psychologist who translated Freud's work, and he asserts Freud's work has consistently been mistranslated and therefore, misinterpreted, resulting in faulty meaning-making about Freud's suppositions. Bettelheim asserts Freud's stages have been over-simplified into a reductionistic stage theory that was not his intention, but rather that Freud's trauma-informed lens was written in a time and place where Freud would have been murdered had he not written in code.

2. Freud's id, ego and superego coincide with modern neuroscience's architecture of the triune brain.

\*A. True

B. False

Rationale: Citations in the text address how the human triune brain maps over the layers originally postulated by Freud, and that ongoing research explains how implicit recall results in subconscious beliefs and behavior, as well as conscious, explicit recall and behavior, yet with difficulty transitioning between the various levels and tasks.

3. Disruptions during Freud's *oral* phase can result in:

A. eating disorders

B. substance abuse

C. emotional security

\*D. a. and b.

Rationale: Citations in the text address updated research into how early disruptions during the first year of life (the oral phase) are correlated with mouth-related addictions and interruptions to the emotional tasks of that phase, resulting in difficulties with healthy self-regulation as well as impact on the vagus nerve.

4. Disruptions during Freud's *anal* phase can result in:

A. an easy-going temperament

\*B. power and control struggles

C. increased imaginal play

D. fluid cooperation

Rationale: Citations in the text address research into the anal triad, with a fixation on controlling others and circumstances in order to avoid anxiety, shame, etc. This can result in an anally-retentive (withholding, uptight) or anally-expulsive (messy, wasteful) character imbalance, depending on how

much negative affect or neglect was employed on the developing child as they navigated culturally syntonetic expectations for toileting.

5. Reich's theory of character armor:

- \*A. is a way to describe the subconscious tension or flaccidity held in the muscles to defend against or avoid threats
- B. states stress can be resolved fully with just cognitive processing
- C. has very little to do with how people respond to stress
- D. describes only defensive people, and not how people generally respond to stress

Rationale: Citations in the text address how Reich and subsequent related researchers have explored and treated the ways stress shows up in the body, which impacts the mind and identity development. Reich addressed stress in family and personal relationships, as well as cultural and political systems, and highlighted how damaging this can be for children, which then increases danger in society. Reich's system attempted to balance out tension in the body so one can be in loving contact with self, partner, and others, and asserted this is beyond cognitive processing alone.

6. Reich was an activist for:

- A. state's rights
- B. the global sexual revolution
- \*C. children's rights in caregiving and socialization
- D. b. and c.

Rationale: Reich's life and work were deeply impacted by the abuse of power of the Third Reich; the last thing he would have worked for was more state power. He has been called the godfather of the sexual revolution, however he had cis-het, culture-bound privileges that limited his sensitivity to the rights of LGBTQ+ folx, and therefore did not take positive action for sexual rights for all. Citations in this chapter addressed how Reich's work centered children as sovereign beings, with rights over their bodyminds and the need for protection from abuse in the family, and from society. He asserted that children can only be healthy and grow into adults who will create a healthy society if those rights are honored and protected, and took positive action to educate the general populace through brochures and books equivalent to public service announcements; these works and others are held and sold through a library dedicated to Reich, cited in the text.

7. Reich's work is now being developed as:

- A. art therapy
- B. music therapy
- \*C. somatics
- D. second wave psychoanalysis

Rationale: Citations in the text address how Reich's work has diversified into the growing field of trauma-informed body-inclusive psychotherapy known as somatics. There is no reference to his work including art or music; Reich was firmly focused on resolving held tension from stress and trauma and bringing strength to areas of the body that have collapsed and are withholding due to stress and trauma, in order to help balance out the life force flowing through the body for healthy assertion of boundaries without overriding others' rights. Though Reich was originally trained as a psychoanalyst under Freud, they eventually broke ties over Reich's even more controversial attitudes about sexual



rights and freedoms (as cited in text), and thus Reich moved away from identifying as a psychoanalyst, and instead developed “character analysis”.

8. Attachment Theory is rooted in:
- A. Piaget’s cognitive theory
  - B. Blatz’s security theory
  - C. Suttie’s sociological study of parental love
  - \*D. b. and c.

Rationale: Neither Piaget nor an emphasis on cognitive processing is mentioned in the roots of Attachment Theory. As cited in the text, both Bowlby and Ainsworth had been deeply impacted by Blatz’s security theory and Suttie’s study of parental love as central to children learning what to expect from the world through their caregivers. Personal experiences with needing care and parental love led Bowlby and his student Ainsworth to appreciate the qualitative differences in caregivers’ capacity to attune effectively to emotional needs and install a sense of security in response; this informed their research developments which center the importance of secure base provision.

9. Insecure attachment can manifest as \_\_\_\_\_ behavior when the fear system is activated.
- A. avoidant or ambivalent/resistant
  - \*B. avoidant, ambivalent/resistant, or disorganized
  - C. ambivalent/resistant, confused, or disorganized
  - D. avoidant or disorganized

Rationale: As cited in the text, attachment occurs on a spectrum from secure about seeking soothing contact and secure base provision on one end, to insecure about seeking soothing contact and secure base provision on the other. Within the insecure end of the spectrum, fear and anxiety-driven behavior will show up as either avoiding contact (when the attachment source is consistently overwhelming or unavailable), being ambivalent/resistant to contact (when the attachment source is unpredictable, i.e., minimally soothing and often overwhelming), or disorganized about seeking contact (when the attachment source is chaotic, as is often the case with substance and physical abuse). The insecure behavior is a measurable demonstration of how the child’s nervous system has been wired to cope with stress and duress when those they’ve been handed to do not know how to provide a secure base.

10. Secure attachment:
- A. is the result of having consistent secure base provision
  - B. reduces risks of medical and mental health diagnoses across the lifespan
  - C. cannot be developed across the lifespan with effort if not provided in childhood
  - \*D. a. and b.

Rationale: As cited in the text, consistent secure base provision results in children being able to count on their attachment figures as reliable sources of soothing, which counters the deleterious effects of stress in early childhood, and increases the likelihood of children choosing friends and partners who go on to honor and foster their security. When children and adults can spend the bulk of their time not inflamed by stress neurochemistry, the epigenetic risk factors for medical and mental health diagnoses are reduced. Adverse childhood experiences research highlights how lifelong deleterious effects of insecure attachment can reduce life expectancy, increase chronic illness, and increase risk of mental health diagnoses. Moving towards earned secure attachment across the lifespan is possible with sufficient access to reliable sources of secure base provision, and is the focus of psychotherapy that centers embodied relational healing.

POWERPOINTS TO ACCOMPANY

## Chapter 4

# Cultural and Contextual Factors of Infancy Through Early Childhood

## Learning Objectives

- Upon completion of this chapter, students will be able to:
  - Describe the perinatal and early childhood periods of human development.
  - Identify risk and resiliency factors for infancy and early childhood.
  - Recognize contextual factors that may merit therapeutic attention for early individual and relational healing.
  - Describe how cultural humility and trauma-informed care may be applied for early developmental needs in families, as well as longitudinal effects from this foundational period.

## Key Words

- Prenatal Adversity
- Contextual Factors in Infancy
- Cultural Factors in Infancy
- Contextual Factors in Early Childhood
- Cultural Factors in Early Childhood

## The Case of Xquenda and Family

- Xquenda is a five-year-old, presumably cis-gendered male child.
- He is referred by his kindergarten teacher for aggressive behavior in class.
- Xquenda has had multiple disruptions and adverse experiences throughout his in-utero development.
- Xquenda's family has force-migrated and suffered much loss.
- Xquenda's family continues to struggle with multiple stressors and does not have access to their buffering relationships.
- Xquenda is becoming a polyglot, but his parents are too busy working to provide and do not have free time to study.
- The family is assimilating to dominant culture and has had no previous involvement with authorities or helping professionals.

## Infancy Through Early Childhood

- This phase focuses on pre-conception through school entry.
- The foundation of biological, neurological, and emotional development occurs here.
- Toxic stressors can result in lifelong difficulties if not resolved.
- Multiple theories focus on this earliest phase of development:
  - Pre- and Perinatal Psychology
  - Freud's Psychoanalysis
  - Reich's Orgonomy
  - Attachment Theory

## Biological Development—Infancy Through Early Childhood

- Brain, nervous system, organs, bones, genes for sex, and gender identity all begin to organize in-utero.
- Biological systems continue to grow and integrate, evolve and express themselves throughout early childhood.
- Epigenetic resilience and risk factors inform biological and neurological development throughout this phase.
- Genetic risk factors more likely to be expressed with more Adverse Childhood Experiences (Jiang et al., 2019).

## Contextual Factors in Infancy Through Early Childhood

- Baby or young child can impact the development of their body, brain, stress regulation when Maslow's hierarchy of needs is not consistently met, stress on the developing fetus, systems, cognitive capacity, emotional reactivity, speech and language development, etc.
- Energy that needs to be directed toward survival must come from somewhere; especially when people are not yet fully-formed (but truly throughout life), this energy must come from their developmental processes.
- The sensory experiences and belief systems that inform biobehavioral interactions between people early in a baby or child's life tend to go into long-term implicit memory, rather than explicit recall; those people, places, and practices that cohere and bring regulation to caregivers tend to also do that for their charges.

## Cultural Factors in Infancy and Early Childhood

- Communal cultures tend to prioritize the needs of the larger group and family cohesion over individual needs; babies born into these circumstances tend to have more access to multiple committed caregivers and participate in these cohering activities.
- Individualistic cultures tend to prioritize personal needs and attainment over that of the larger group or family cohesion; babies born into these circumstances tend to spend more time apart from birth parents and less time in cohering rituals.

## Intersectional Contextual Factors for Xquenda

### Oppression

- Child
- Indigenous
- Low SES
- Undocumented
- Force migrated
- Learning difficulties
- Job insecurity

### Privilege

- Currently able-bodied
- Family intact
- Have housing
- Presumably cisgender

## Cultural Considerations for Treatment

- Family's preferred names, beliefs, and cohering practices need to be brought into assessment, ongoing sessions, and advocacy efforts.
- Family has lost ancestral lands and access to family-of-origin buffering relationships that provide logistical and emotional support; grief work to be done as family relates to grieving process.
- Connecting with local community members who speak mother tongues necessary for networking, support.

## Contextual Factors for Treatment

- Children are minimally differentiated from family; trauma-informed care for entire family necessary for Xquenda to benefit long-term.
- Trauma and loss prior to and due to migration needs to be titrated in processing for all members.
- Acculturation stress can be buffered slightly by skillful advocacy and activism at school and as family engages in linkage support.
- School has its own expectations of appropriate behavior that will have to remain in focus for Xquenda's stability.

## Further Relational-Cultural Considerations of Infancy Through Early Childhood

- Discrimination
- Bullying and Peer Abuse
- Civilian Gun Violence
- Neurodevelopmental Differences and Difficulties
- COVID-19
- Runaways
- Abduction and Trafficking
- Foster Care and Adoption
- Unaccompanied Minors and DACA

## Perspectives from the Field

- Listen to the podcast with Dr. Judyth Weaver.
- What components of Xquenda's conception, gestation, birth and bonding are likely to have caused developmental disruptions?
- What cultural considerations of Xquenda's family are buffering for these risk factors?
- What interventions are developmentally appropriate to consider for Xquenda and his family?



POWERPOINTS TO ACCOMPANY

## Chapter 5

# Developmental Theories of Infancy Through Early Childhood

## Learning Objectives

- Upon completion of this chapter, students will be able to:
  - Identify the stage of lifespan development known as “early childhood”.
  - Describe key theories impacting this stage of development.
  - Discuss key research impacting this stage of development.
  - Recognize future directions for research and understanding of children and families in early childhood.

## Key Words

- Attachment in Early Childhood
- Ego Development in Early Childhood
- Therapy and Counseling Related to Early Childhood

## Sigmund Freud's Psychosexual Stages

- **Oral**: Newborn to one-year-old infant's life force is sustained through ingestion; suckling, nursing help regulate baby and give sense of connection, safety, belonging, being wanted. Disruptions can result in frustration, fixation on oral satisfaction through food, substances, emotional reassurance.
- **Anal**: Primary project is toilet training from approx age 1-3. If done collaboratively, child is proud of initiative and self-control. If done with shame/aggression, child becomes fixated on issues of control.
- **Phallic**: Preliminary sex and gender identity processes manifest behaviorally age 3-6, affection and sexual boundaries continue to develop. Self-acceptance as sexual and gendered being vs. fixation on safety as developing sexual being.
- **Latent**: Life force is focused on transition from family-of-origin to larger society as a whole, fitting in at school and developing mastery compared to peers, age 6-12. Sexual identity less salient; social, physical, cognitive factors become more salient.
- **Genital**: If previous stages have gone smoothly, age 12+ focus on self becomes other-focus, capable of providing mutuality in peer and love relationships, available to give satisfying empathy and love.

## Cultural Considerations of Freud

- Bruno Bettelheim translated Freud's work from Viennese German to English
- Bettelheim highlights how Freud's work was mistranslated by English-speaking psychologists who did not know Viennese German
- Bettelheim highlights context of Freud's discoveries; Freud was bringing incest and molestation to light, sometimes learning of his contemporaries' sexual abuse of their family members
- Gestapo threatened Freud, killed some of his family members, burned his books; he feared for his life and hinted/intimated at why neuroses developed to protect his patients from excommunication from their families
- Freud was discovering how relational and sexual trauma lives in the bodymind and surfaces as traumatic reactions; his theories were over-simplified and over-generalized

## Updated Research on Freud

- Triune brain maps onto Freud's *id, ego, and superego*
- Traumatology studies have demonstrated that overwhelming sensations from trauma often result in dissociation and numbing, to later resurface when activated by internal or external stimuli
- Traumatology studies have demonstrated that Type II relational/developmental trauma in particular has lasting, often global effects on personality development

## Wilhelm Reich's Orgonomy

- Further developing Freud's theories, Reich (student of Freud's) expanded focus from sexual identity and personality development to muscular tension held in segments of body based on stressors and impingements imposed on babies and young children.
- Since babies and small children cannot escape threats, they must withdraw from contact with consensus reality, relationships, authority figures to survive. This withdrawal results in flaccid disengagement, and/or rigid holding patterns of muscular tension in patterns he called *character armor*.
- Character armor, if not resolved, changes the way the person perceives the world and their place in it. Chronic defenses, overcompensation, reactivity, people-pleasing, inability to relax into mutual empathy, inability to really love fully are considered byproducts of unresolved character armor.

## Cultural Considerations of Reich

- Also had to escape the Gestapo to survive. Multiple relational/developmental traumas that disrupted his sense of safety and belonging during his early upbringing and launch to adulthood and career, likely informed his priorities as a student of Freud before they, broke over philosophical differences.
- Brought up in individualistic culture with a shared cultural trauma
- Ex-communicated and died of heart failure in prison after books burned
- Dozens of somatic approaches now studied to resolve embodied tension and overwhelming memories of trauma, resulting defenses

## John Bowlby and Mary Ainsworth's Attachment Theory

- As social mammals, we've evolved with a big brain that requires extensive construction after birth to survive. As such, we are equipped with appearances and behaviors at birth to hijack caregiver attention and elicit caregiving behaviors.
- Our long memories mean that our brains record associations giving rise to fear. When our fear systems are activated, we seek proximity with those who soothe and protect us.
- Secure attachment is the result of reliable caregivers effectively soothing us 40% of the time, and showing they are trying the rest of the time.

## Cultural Considerations for Treatment of Insecure Attachment

- Collectivistic cultures have an over-representation of ambivalent/resistant attachment.
- Individualistic cultures have an over-representation of avoidant attachment.
- Facilitating regulated connection through attunement of needs and feelings allows for autonomy when sought, and support when sought, so that neither child nor partner must sacrifice one for the other but can seek them as needed.

## Perspectives from the Field

- Listen to the podcast with Dr. Judyth Weaver.
- What components of Xquenda's conception, gestation, birth and bonding are likely to have caused developmental disruptions?
- What developmental theories seem relevant to consider for Xquenda and his family?
- What interventions from these or other theories are developmentally appropriate to consider for Xquenda and his family?