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Daniel S. Schechter, M.D.

ABSTRACT

This article asserts that a traumatized mother, to maintain her psychobiological homeostasis, must avoid intersubjective connection with a child who is seeking it to regulate his own distress. In this case, what Lou Sander described as a "moment of meeting" cannot take place (Sander, 1995, p. 590). Case examples are used to illustrate how, when all are together in the consulting room, the reflective, mutually regulating therapist can facilitate moments of meeting between therapist, a mother who has been subjected to interpersonal violence, and her child, who has similarly been traumatized. Furthermore, I show how the therapist, in the face of the child's traumatic reenactment in play that can further trigger and dysregulate the traumatized parent, can intervene to coconstruct meaning, for both the traumatized child and mother, obviating mother's need to avoid the child's distress and post-traumatic re-experiencing. This allows *meeting* to occur, reordering the implicit relational knowing of both mother and child.

In his landmark paper, "Paradox and Resolution" (1997), Lou Sander presented what he termed as two "biological givens" (p, 153): (1) self-regulation and (2) the capacity for parent-infant synchrony and attunement. The latter is akin to the concept of "mutual regulation" that was coined by Tronick and Gianino (1986, p. 5) in their efforts to extend Sander's original ideas (Condon and Sander, 1974), a concept that has played a central role in my own research (Schechter et al., 2010). Sander argued that these two biological givens, furthermore, form the foundation for an individual's capacity to self-organize, to experience a sense of agency, to tolerate aloneness, and to love and to be loved. And he further pointed out that psychopathology in the course of early childhood development could originate with difficulties in either or both of these biological givens.

Both the innate drive toward self-regulation and that toward mutual regulation between self and other are continuously operating, parallel, and simultaneous processes that can lend to tension, which can be experienced both as stressful and as pleasurable. The individual is forever seeking to strike a balance between self- and mutual-regulation, and, as Sander himself said, "through mutual modification, [the self-other system can transiently] reach harmonious coordination" (Sander, 1977, p. 138). He spoke of the analogy to the physics of two vibrating bodies such as tuning forks, each with their individual pitch, which when placed in proximity, can interface and resonate with one another or clash (Sander, 2002).

Sander asserted that, as self- and mutual regulation are noncognitive processes, the fluctuation of the degree of resonance, of harmony between self- and mutual regulation and their interaction, leaves traces in the procedural (*implicit*), rather than declarative memory. Past moments, outside of conscious awareness, inform but cannot reliably determine the present interaction. This margin of uncertainty is consistent with non-linear dynamic systems theory to which Sander ascribed.

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Karlen Lyons-Ruth and the Boston Change Process Group (Lyons-Ruth et al., 1998) later defined the term *implicit relational knowing* as a form of such procedural memory traces regarding being able to anticipate interaction patterns with intimate others based on prior experience with that individual—or as Daniel Stern, as called this, "the schema of being with another in a certain way" (Stern, 1995, p. 93). As Lyons-Ruth et al. (1998) wrote, "A moment of meeting is the transactional event that rearranges the patient's implicit relational knowing by rearranging the intersubjective field between patient and therapist" (pp. 285–286). Sander described the specific recognition of the other's subjective reality as a prerequisite for such a moment of meeting to take place.

I assert that if the child's subjective state and striving toward intersubjective states with the traumatized mother must be avoided by her to maintain her psychobiological homeostasis in the wake of trauma, the moment of meeting cannot take place. Indeed, in our empirical research, we have shown that the helpless state of mind of the infant and young child, such as during a laboratory separation of mother from child, is enough to trigger significant psychobiological dysregulation of mothers who have been exposed to interpersonal violence during childhood and later in life and who have developed post-traumatic stress disorder (PTSD) related to their violent experiences. Compared to mothers without PTSD, these traumatized mothers show significantly less medial prefrontal cortical activity and greater limbic activity in response to watching videotapes of their toddlers during separation as compared to during free-play (Schechter et al., 2012). It is as if these mothers are decorticated and turn to a mode of survival that favors auto-regulation over mutual regulation and social affiliation (Porges, 2007). Mothers with PTSD related to violence also show characteristically different patterns of autonomic nervous system response to mother-child separation-reunion stress (Schechter et al., 2014).

These biological data converge with our behavioral findings, as we have shown that it is precisely in the wake of the mother-child separation task in the lab that mothers who develop PTSD following from direct experiences of physical or sexual abuse or assault from childhood onward or who were exposed as witnesses to domestic violence during childhood—and thus who have what we call *interpersonal violence-related posttraumatic stress disorder* (IPV-PTSD), as compared to non-PTSD controls are less available to their toddlers for joint attention when the child makes a social bid to mother (Schechter et al., 2010). Mothers who develop IPV-PTSD have symptoms of re-experiencing, avoidance/numbing, and hyperarousal that develop in the wake of exposure to physical and/or sexual abuse or assault from childhood through adulthood. We have also shown that IPV-PTSD mothers particularly tend to be more withdrawing and avoidant during reunion with their children, as well as more generally in their caregiving behavior (Schechter et al., 2008). And thus, the specific recognition of her child's subjective reality fails to take place. This leads to greater self-dysregulation in the child, as we showed in a follow-up study of the children of mothers with PTSD using the MacArthur Story-Stem Battery (Schechter et al., 2007).

The child's job

The infant and young child—in the face of an unpredictable, dysregulated, and dysregulating caregiving environment presented by a violence-exposed mother with PTSD—has the job before him to adapt to this environment to maintain a relationship with her so as to ensure survival and to feel her emotional presence. The child thus must enter into the traumatized parent's intersubjective world and attempt to harmonize with her hyperaroused state or in a reversal of roles or attempt to modulate it in order to hold his parent's attention (Schechter, 2017). Even if the child experiences no violent events, he can be exposed vicariously to aspects of his mother's trauma through her behavior in response to traumatic memory traces to which he has no access. Her nonverbal behavior will—as in a game of Charades—communicate one or more aspects of her traumatic experience. In response, the child will interpret his mother's communication, yet without his mother's frame of reference or her adult capacity to make coherent narrative sense of her behavior. In turn, the child's uninformed, developmentally limited interpretation and resultant behavioral response may well have an effect on

his mother and her emotional regulation, leading to a perpetually changing variation on the original maternal memory trace that is only fully knowable to her. The resulting cost to the child's sense of self, to his social-emotional development, can be considerable if, through other relationships, his primary attachment figure permitting, he does not find alternative ways of being-with the other in the interest of the development of intersubjectivity, potential flexibility and complexity in future relationships.

So, what happens when, as we see all too often in our clinical work, a child—on top of having a parent, a mother who has had an exposure to violence and has developed subsequently PTSD—is exposed to interpersonal violence and develops his or her own PTSD? Even if the child's parent has not herself been traumatized, addressing the needs of one's own child who has experienced violent trauma, coping with the disruption to a sense of safety and a need for its restoration, the accompanying emotional pain, possible sense of shame, and terrifying memory traces—not to forget the disturbance to self-regulation and physiologic homeostasis, can all be very challenging. Typically, the parent and child must cope with the child's feeling that there was a failure of protection with accompanying guilt, sadness, and anger on the part of the non-offending parent. Now if the parent also has a history of being a victim and/or witness of violent trauma and suffers from related PTSD too, there might be, on the one hand, an opportunity for greater empathy, reflection, and efforts at making meaning of the trauma, given her possible understanding of what is like to have lived through a similarly threatening event. The latter is particularly true if the parent has had the benefit of a positive, secure attachment and, thus, a model for self- and mutual regulation. Yet, all too often we find that this is not the case, at least not without focused intervention (Schechter et al., 2015). The parent's PTSD and accompanying emotional dysregulation, which are all too often part of an intergenerational process, are rather triggered by helpless states of mind, aggressive gestures as reminders of traumatic events even in the child's play. The post-traumatic re-experiencing, avoidance, hyperarousal, and/or dissociation, the accompanying emotional dysregulation can well foreclose the possibility of parental openness to receive the child's emotional communication, bids for joint attention and striving for intersubjective joining and meaning-making (Schechter et al., 2010).

In turn, the child's post-traumatic re-experiencing often manifested as traumatic re-enactment in play, his anxious avoidance, and hyperarousal and/or dissociation and numbing, as well as his possibly increased aggression toward self via self-endangering behavior or other, are all possible adaptations of the dysregulated (i.e., traumatized) child to being with the dysregulated (i.e., traumatized) and dysregulating (traumatizing) parent. It is most often the traumatized parent who identifies a problem, which is most often perceived as residing in the child and causing distress and/or dysfunction in the parent (Schechter et al., 2011). Alternatively, a health or educational professional might refer the child for evaluation of PTSD and other post-traumatic psychopathology.

The therapeutic consultation involves each member of the dyad, each with their own self-regulatory process, and their mutual regulatory process entering into contact with the therapist, who has his or her own regulatory process and potential for affecting each part of the complex system into which that therapist is allowed to enter. Because the therapist may only be able to enter into that system and to catalyze change in its organization for a very brief time, it is important that the clinician get the most therapeutic effect in the least amount of time. Fortunately, we can, as therapists, observe critical moments during which the child's efforts to self-regulate and communicate his subjective experience with regards to his trauma in not being known or recognized by the caregiver occur.

These critical moments, I assert, must be seized by the therapist in the caregiver's presence to help the dyad out of a mutually helpless and/or hostile, mutually dysregulated state. For the child, the therapist catalyzes a moment of connection with the parent that has been heretofore avoided, and thus validates the child's experience and forges a path to his experience of being known by the therapist and caregiver in an effort of joint attention to the child's emotional communication. For the parent, the therapist's curiosity about and openness to receiving the child's communication, provides a support and model for this impaired function on the part of the parent and a source of

mutual regulation between the therapist and the parent at a moment of heightened stress in the parent-child dyad. This support, modeling, and opportunity for mutual therapist-parent mutual regulation can contribute to a greater sense of parental competence in the face of a crippling parental sensation of helplessness.

Such moments of meeting are often most ripe during traumatic play, during which the child is seemingly compelled to re-experience and re-enact one or more sequences of the experience that overwhelmed him (Gaensbauer, 1995; Coates, 2017). If the caregiver's, child's, and therapist's joint attention can be drawn simultaneously to this communication initiated by the child, going against the caregiver's tendency to avoid it in the service of maintaining her psychobiological homeostasis—and if all members can endure it together, reflect upon it, and readjust their mutual regulation, positive movement forward will ensue. Yet this is the case only if the therapist is prepared to receive the communication by the child and/or dyad, and if the therapist can, at the same time, help contain the traumatized parent's anxiety so as to allow the child's communication to remain clearly the focus of triadic joint attention. The negotiation of joint attention within the biparental family with the child has been well described by Fivaz-Depeursinge and colleagues during the first year of life, with precursors in the prenatal period (Favez et al., 2013). The difficulty of a traumatized parent with her child and the parent-infant therapist can be considered analogous to this triadic situation. As such, Depeursinge and colleagues have described the difficulty in creating triadic interchange when one partner's regulatory needs are so great, that she must create a dyadic connection at the expense of the third, or must cede her place in the triad, so as to protect her own self-regulation, leaving the other two partners alone. In this case, it is necessary for the therapist, as the observing or reflective third, to restore the triadic exchange.

Clinical example 1

During my tenure as director of a hospital-based infant mental health service in New York, I was told by the emergency room adult psychiatrist on call to brace myself for the worst case of domestic violence, in which the victim had survived, that had ever been seen by the staff of the emergency room. I was called because Jahaira, a mother of a three- nearly four-year-old girl, Jessie, had been brutally and repeatedly stabbed and slashed 26 times by knives and broken glass in her face, neck, torso, and arms. Jahaira would likely be disfigured for life. Jessie had witnessed her father attack her mother who, covered with blood and imagining that she would be killed, begged the father to spare Jessie's life. He grabbed Jahaira by the hair and dragged her away from Jessie up the stairs to the roof where he attempted to push Jahaira over the edge, when the police arrived and apprehended him after neighbors had called 911. Jahaira was taken unconscious (having lost a great deal of blood) to the hospital and Jessie, who saw the ambulance workers take Jahaira away, did not know if her mother was dead or alive. She was taken in by her maternal grandmother, Jacinda, who lived in the same building but had not been home at the time of the incident.

I arranged to see Jahaira in her hospital room after she had recovered from many hours of surgery to repair a severed artery and nerves in her right forearm, as well as deep gashes in her neck and chest. She had the left side of her face bandaged, was wearing a minerva, and had bilateral barm-braces covering gauze bandages. Her long wavy hair was strategically placed over visible cuts and scars on the right side of her face. According to Jahaira, she had provoked her husband and it was her fault that he had attacked her. She blamed herself for taking him out of his native country and bringing him to New York, where he knew no one and could not speak English. "I wanted my daughter to know her father. … I left him there to come to New York so I could be a fashion model. I had modeled in the Dominican Republic and a friend told me I could get catalog work so I came with my baby daughter … and I got a job working in a boutique and when I had enough money, almost six months ago, I paid for my husband to come up. It was my mistake." I reinforced that even if it were true that her husband was angry for bringing him to a place where he felt helpless and inadequate, this did not justify his trying to disfigure and murder her. She said, "I don't know."

Although we could not harmonize around the injustice that had been done to her, we were able to resonate to concerns about her daughter Jessie. "She saw a lot of what happened. … Will she be damaged by this? She loved her father." I replied by saying, "You both experienced something very frightening; how about I see you when she is visiting?" Jahaira agreed.

We arranged to meet again when her daughter and mother, Jessie and Jecinda, would be visiting. I came into the hospital room after Jessie had arrived. When she saw me, she walked silently away from me, to stand at her mother's bedside as if to protect her mother from me. Her mother told her that this nice doctor would like to help them, as he is an expert in talking about bad things that happen to people. I reinforced that I knew that Jessie and her mother had been through something very scary together and that it would take time before they both felt better and safe again, but that we would work together to make this happen as soon as possible. The little girl looked at me and then at the floor. She would not speak. Her mother very weak moved her bandaged arm toward the girl. But she remained frozen and whispered to her mother, who told me that she did not want to talk to me now. I suggested that it was enough that we got to meet and that next time we would spend some time together, when mother would be out of the hospital. At that point, the maternal grandmother, Jecinda, came in, a tall bleached blond, attractive woman who drew attention from male staff members. I realized that grandmother, mother, and daughter all shared a similar, elaborate hairstyle and were very conscious of their appearance.

The appointment was scheduled for the following week and coordinated with mother's first check-up with the surgeons to minimize her travelling. The family did not show up. There was no answer when I called. We sent a letter. A week later, I received a call from the maternal grandmother who explained to me that something very bad had happened. What could be worse than her daughter being nearly killed and disfigured, undergoing transfusions and multiple lengthy surgeries? Upon hearing that her husband had been charged with attemped murder and pled guilty with a possible sentence of 20 years in prison, Jahaira took an overdose of pills chased by rum, and was found unconscious by Jessie, who, unable to awaken her mother, got Jecinda to come and help.

I requested to speak with Jahaira on the adult psychiatry unit, where she remained for one month with a diagnosis of PTSD and major depression. She cried when I suggested that she was the most important person in the world for Jessie and that Jahaira's courage to live on and take care of herself, to work toward overcoming her physical and mental wounds, was so important to her daughter's mental health. Jahaira became tearful and reproached herself for trying to take her life and for Jessie having to find her mother unconscious yet again.

Within one week of Jahaira's discharge from adult psychiatry, she and Jessie came into the consulting room at the Infant-Family Service. Jessie sat rigidly on her mother's lap, staring at me mutely and no longer whispering to her mother. Jahaira now was still wearing the minerva, and bandages on her arms, one remaining with a wrist brace. The scars had developed keloids on her face, neck, and hands. I noticed that Jahaira wore a low-cut blouse, which exposed the multiple scars on her upper chest and breasts.

I had brought in to the playroom a family of dolls, a kitchen set that included a plastic knife, a medical kit, paper, and a box of crayons. Jahaira suggested in Spanish that Jessie get off of her lap and look at my toys to choose. Jessie resisted. She would have none of the dolls or the medical kit. So, I placed the blank paper on the child's table and left the open box of crayons next to it. Her mother encouraged Jessie to draw. The little girl sat immobile, stone-faced. I then decided to offer the crayons to Jahaira, who took a piece of paper and began to draw a flower.

With that, Jessie took the red crayon from her mother, Jahaira; she looked up at her mother who smiled and said in Spanish, "Go ahead!" and then she looked at me. I nodded with approval. She drew a line tentatively. And her mother and I both said, "Nice." Then she drew another line, then another, and then she began to become more fixed in her focus on the paper and more vigorous in her gestures, such that she was stabbing the paper with the crayon and letting lines form that resembled her mother's scars. Her mother said a bit annoyed, "Jessie, easy baby! You gonna break

the crayon; why not try drawing something with a different color too?" I rather said, "But Jessie, you wanted the red. What are you telling us with your picture?" And I looked up at Jahaira.

"Why," she asked, "is she only doing that with the red crayon?" I supported her curiosity and let her know I was thinking the same thing. "What does it make you think of?" I asked Jahaira. With that, tears rolled down her face. "You don't think she drawing what happened?" "I see that this is something that makes you sad…. You'd rather not think about it, I imagine." "Yeah, I don't want to think about that; she's stabbing the paper so angry, like her father was, like, so violent."

I suggested that "Jessie, I think you're showing us what you saw and heard and felt when daddy was hurting mommy." I turned to Jahaira and added, "And many different feelings come up: fear, sadness, excitement, anger that this took place, that mommy got hurt, that she was away in the hospital twice, that dad was sent away and would not be coming back any time soon. Maybe Jessie also feels guilt that she could not have done more to help you?" Jahaira, nodded tearfully and said, "Yes, I think so." I continued to address the fact that Jessie had become selectively mute: "So many different feelings that you both had when so much around you both was out of control and you and Jessie were feeling so helpless. So, I think at least Jessie could control whether and when she would speak or not. And now, she is able to control the drawing of her picture, to express what she wants without speaking; and that feels good."

At that point, Jahaira said to Jessie, "Let's give that picture to the doctor and you come up on my lap and be close for moment." For the first time, with difficulty given her arm braces and neck brace, Jahaira took Jessie in her arms and sat her on her lap and kissed her forehead. And for the first time that I had seen, Jessie and her mom smiled together.

If the story were to end there, we would miss out on a significant amount of the complexity of Jessie and Jahaira's relationship before the attempted murder and suicide. This was not a relationship that provided dependable, predictable mutual regulation and acceptance of the other's subjective state, even before the attempted murder and suicide. After a period of intensive trauma work, during which Jessie's drawings became more elaborate and began to show a male and female figure with the same red lines of blood and scar, Jessie began to draw other things, like a portrait of her mother and her together, a field with flowers and butterflies. And two months later, Jahaira agreed when asked by a research assistant in the clinic waiting area, to participate in our research study with Jessie that looked at how maternal IPV-PTSD affected the mother-child relationship.

During the first research visit, we conducted the working model of the child interview, which probes for maternal mental representations of the child and relationship with the child. What I learned from that interview created a new context for Jessie's drawing and added a new layer of meaning to a possible identification with her violent father. Jahaira repeatedly used the descriptors *conceited* and *self-involved* to describe her daughter's personality. She reported that Jessie looked at herself in the mirror at every opportunity and made faces to herself, as if she were trying on cosmetics. She often seemed "aloof" and like "she doesn't care about anyone but herself." Although I did not say this, I wondered if, tragically, Jahaira was interpreting Jessie's self-regulatory, dissociative, and inhibited behavior in such a negative way so as to create greater distance from her daughter when her daughter needed her to be closer and more empathic. This contributed to what I perceived as greater mutual dysregulation within the dyad.

The attribution of *conceited* struck my ear, as it seemed so developmentally out of sync with the personality of a shy, insecure 3-year-old girl. As Lieberman (1999) stated, parental attributions can be a key that unlocks the door to a larger fixed and traumatically based representation. Indeed, although in part a projection of her own narcissistic personality traits, Jahaira underlined that for her, Jessie was "the clone of my mother," and as such Jahaira is unable to see her child as a child but rather as an adult and a mother. As I followed the connection, Jahaira told the story of how her mother, having been an extremely beautiful and vain woman, took the advice of a friend to come to New York to become a fashion model or screen actress, and in so doing, she left Jahaira with a depressed grandmother, who tended to neglect, yet also punish, Jahaira too severely. That maternal grandmother also labelled Jahaira as "spoiled and selfish." This attribution had crossed four generations.

When Jahaira had turned 19, having gone back and forth from the Dominican Republic to New York and back again, in Santo Domingo, Jahaira married an older man who had repeatedly told her that she was the most beautiful woman in the world. He was an irregularly employed handyman who suffered from bouts of depression and poorly controlled diabetes. They conceived a child and subsequently married. Jahaira viewed the pregnancy ambivalently, as it had been her dream to return to New York and, like her mother, become a fashion model. Her husband accepted that after the birth of her baby Jessie, she would take the baby and live with her mother in New York to realize her dream and that he would follow when she could send him money to travel. While the modeling did not work out as she had hoped, Jahaira found a steady job as a sales person and then manager of a fashion boutique in New York. Jahaira's mother found her an apartment in the same building as hers and told Jahaira that she needed to live on her own now that she was making a good living and that she needed to find someone to take care of Jessie. At that point, Jahaira sent money to her husband who moved up—not having been together with her for 2 years, speaking no English, depressed, and physically unwell. Rather than take care of the apartment and Jessie, Eduardo seemed to Jahaira to expect that she would take care of him. He had no friends or family in New York and began to spend days in front of the television set. More frequent marital disputes occurred between the two. During this time, Jahaira denied that Eduardo had been any more violent than she herself had been in these arguments. Eduardo did develop a caring relationship with his daughter and washed her clothes and prepared her lunches and dinners while Jahaira worked. Increasingly depressed, Eduardo, in the week prior to the attack, only sat in front of the television and slept, neglecting his household chores. Even prior to that, he had begun to have insomnia, sexual dysfunction, and would neglect his personal care and hygiene. Jehaira interpreted her husband's increasing estrangement as indicating that he no longer found her attractive. And it was this insecurity and his impotence the night before the attack that led to her chiding him during an argument the next day, that he was "a useless failure and that he needed to move out." This, plus an insinuation to get a reaction from him, mocking his erectile dysfunction and suggesting that she was perhaps having affairs, threw him into the rage that would lead to him attempting to kill Jahaira in front of their daughter.

Jessie had already been groomed to gain her mother's affective presence by adoring her, taking care of her in a parentified role, by not demanding care herself. And hence, her increasing preoccupation with looking in the mirror and retreating into herself in dissociated states took hold, further reinforcing the negative and distorted attribution that Jahaira had named *conceited*. Even before the horrendous double trauma, Jessie had no one with whom she could engage reliably in mutual regulation of emotion and arousal.

Discussion

Sander pointed out that opportunities for mutuality and shared intersubjectivity are largely dependent upon the way that the primary attachment figure's attention is organized and available. Indeed, Jahaira's mental representations of Jessie as conceited in the context of her negative, maternal transference to her own daughter did not allow her to understand that Jessie, even before the horrendous trauma that they both survived, had profound difficulty with self-regulation. Part maternal identification, part irony perhaps, Jessie developed the habit of using mirrors not out of vanity, but out of a need to be seen and to identify and own her own emotional expressions—in short, to self-regulate. The resulting misinterpretation of her as being vain and self-absorbed fueled a self-fulfilling prophecy, nourishing her mother's negative and distorted mental representation of Jessie, and only created further distance between mother and daughter, rather than desired proximity and mirroring within the attachment that Jessie craved.

Given her mother's negative and age-inappropriate (*distorted*) mental representations and resultant projections, we can imagine that Jessie's rage built up over time without daring to be expressed. In my previous papers, I have emphasized how infants and young children can remind a parent of

a perpetrator of violence by virtue of this developmentally determined incapacity to regulate her emotions and arousal and by their resemblance physically or in imitated gesture and expression to the perpetrator. But in this case, I wonder if, conversely, Jessie saw her own dysregulated aggression toward her mother as mirrored in her father, with whom she had a close relationship. Already faced with such an ambivalent mental representation in her mother's mind and the insecure attachment that that signals—and given Jessie's behaviorally inhibited temperament—to have seen her father act out the rage that she herself might also have felt toward her mother would be even more horrifying. This could also have contributed to Jessie having become selectively mute. This hypothetical reaction is all the more possible given that Jessie, at the time of the attack on her mother, was at an age when she might still magically believe that by being angry with her mother for the way Jahaira treated her, she, Jessie, could be responsible for what her father did to harm her mother. Jessie's opportunity during the session to draw and stab her mother symbolically with the red crayon on paper was tolerated—and even supported and co-regulated—by the curious and mentalizing therapist, who jointly focused with Jahaira on Jessie's emotional communication and symbolic act. This support of Jessie's agency and initiative, this opening of eyes to Jessie's subjectivity, allowed the treatment to move forward without the mother feeling worse about her capacities and without the therapist ever having to (*make*) any extensive verbal interpretation. The therapist's seeing Jessie's subjective state opened mother's eyes so that Jessie could be seen and heard.

The second clinical example again shows how members of a mother-child dyad who survived life-threatening violence both want to know and do not want to know what happened to lay the memory of an ambivalently held, deceased father to rest. The mother, who repeatedly had to leave the sessions, could not and would not see her own son's suffering for fear, as I came to understand, of activating her own sense of helplessness, fear, and guilt. One decisive moment of traumatic play clued the therapist into what drove the mother's avoidance and this moment was enough to catalyze change in the mother-son relationship thereafter.

Clinical example 2

Ms. Garcia brought her 6-year-old son Jason in after her 7-year-old daughter's former therapist called to say that their mother had begun to worry about how their father's suicide had affected them, as Jason was recommended for an evaluation for inattention and disruptive behavior at school. During the first session with Ms. Garcia, the therapist was struck by the detached, rather matter-of-fact way she recounted how her husband, a carpenter, had become increasingly depressed and withdrawn prior to his suicide just before Jason had turned 5. She spoke of how, despite seeing a psychiatrist, being voluntarily hospitalized for 3 days, medicated and improving, he dropped his kids off at school, called his wife to ask if she would pick up the children as he would be unavailable, went home, picked up his army revolver, went into the local forest, and shot himself in the head. When his wife tried to return his message, thereafter, there was no answer.

Jason and his sister had repeatedly asked when their father was coming home, even after they had attended the funeral. Mrs. Garcia said that he had gone to heaven, which was too far away to come back. The children asked if it was a place reachable by airplane. Mrs. Garcia replied, "no" without further elaboration. She confided that she found the children's questions painful. She stated that she was very careful never to describe or to have the children be anywhere near discussion of how their father had died. After several weeks of sleepless nights having been awakened by the children's cries, pleas to sleep in her bed—that gradually subsided, along with their questions—Mrs. Garcia thought that "they had gotten over the loss and moved on as [she] had."

And then she saw, one day, that Jason made sure he got her attention before he made a gesture with his hand forming a gun, pointed his index finger to his head and pulled the trigger, and fell down. Mrs. Garcia, in tears, burst out in anger and it was then that her daughter and son began to blame her for their father's "not being here anymore." Mrs. Garcia suspected that another child in school told Jason how his father had died. She wanted to "move on," but was repeatedly shocked

when, for example, she would introduce Jason to an acquaintance on the street and he would say, "I'm Jason and this is my mom. My dad is dead."

The more she spoke about Jason, the more it was clear that she identified him with his father, both in terms of his appearance and his personality. She said, "He is clownish, but then moody … has his tantrums. He's a lady-killer, seductive, but he can turn provocative and aggressive." These attributions were negative and not fitting for his age, such as we have often noted among mothers suffering from IPV-PTSD—but Mrs. Garcia had denied violence-exposure (Schechter et al., 2006; Schechter et al., 2015). When I tried to get more information about her own life, she changed the subject to tell me that Jason was "exhausting." She said, "He's always trying to get away with more … testing limits. He sticks to me and won't leave me alone! He insists on sleeping in my bed."

Mrs. Garcia brought Jason into the next session. He was a very somber, indeed very separation anxious, shy child at first. When I told Jason that he seemed very serious for his age and asked if he felt sad, he answered, "My dad is dead and never coming back." "That is very sad," I said. When I asked what he used to do with his father, Jason recalled with an intense gaze, smiling, "all kinds of sports, bicycle riding … soccer … skiing." At that point, his attention turned to the toys in my office and he asked to play a game with me involving hammering cubes of plastic ice on a skating rink until a skating polar bear falls through the ice. As soon as he asked to play, loudly hammering the plastic cubes, his mother, somewhat frazzled, drying her eyes, stated that she absolutely had to run out to move her car so she would not get a parking ticket. At first, he protested, and then his mother redirected him to the game and stated she would be right back. He stared seriously at the game until she closed the door and then shortly after he hammered all the ice cubes in one fell swoop and began to hurl the cubes all over my office. When I asked him to stop and help me put them back so we could play the game he got up and ran to the other end of my office and began to throw the cubes at me and laughed. He then discovered on my shelf a toy pistol.

First, he pointed it at his head and then at me and fired. I pretended to fall down and then got up. He shot me over and over and laughing when I would pop up again. Clearly, we were in traumatic play. I said, "I have a feeling we're thinking about your father and what he did with you and without you." Jason looked at me intently and continued playing. I noticed that his mother had not returned on time and that the session was about to run over. I insisted in a playful way that we clean up. To my surprise, Jason returned to his serious demeanor and obediently began to clean up. His mother arrived 10 minutes late with pastry for him and they left.

One week later, during his second session, Mrs. Garcia came in alone first; Jason sat in the waiting area with an iPad, and spoke about how since the last session he had been even more clingy and scared about her leaving him alone in his room to sleep. He had asked his mother, "If daddy is in the sky, can he see me?" Mrs. Garcia had said that she did not know but that he could always see his father in photographs. At this point, she stated again that she would have to go and run an errand but would not be late this time to pick him up. I let him into the office. He entered and quickly ran for the toy pistol on the shelf and this time, pointed it at his mother. She told him to put it down, sternly, and then looked at me anxiously and said, "I don't let him play with guns." I suggested that this was a toy and that he was both playing and trying to communicate with us but acknowledged in language that Jason could understand that, "Some people like mommy do not like toy guns even because they remind them too much of real guns that can hurt people. And a gun hurt daddy." He threw the gun in a toy box and went to get a ball. After saying, "that's a good choice," she told Jason she would be back in a few minutes and to go on playing with me like last time. He followed her to the elevator bouncing the ball hard on the floor despite my asking him to wait until we were back in my office. I followed him. Then he came back with me to my office. He threw the ball hard toward the wall where I had a picture covered with glass in a frame. I encouraged him, rather, to throw it more gently toward me so we could play catch. Instead, he threw it up at the ceiling toward the light fixture and then at my face. I caught it and said, "I won't let you do that here. When you throw the ball so hard and at things that can break and then at my face, it makes me think you're angry! Angry is ok. Throwing the ball so hard at things that can break is not." Then he said, "I don't want to play

anymore. I want to go home!" I said, "Now it's clearer. You are angry at me for taking the ball. And I think you are also angry at your mom for bringing you here and leaving. But feeling angry at your mom does not feel safe. You want to protect her and make sure she's safe. She's very important to you!" With that, he opened the door to see if she had come back. He looked very disappointed to see that she had not yet returned. I showed how the jack-in-the-box worked. He became interested and repeated over and over having the clown pop up and stuffing him back as I said, "There he is! Now he's gone. Ah, there he is again!" He was very happy and reassured just to do this repetitive play until his mother returned. And I commented, "If only it were so easy to make your dad go and come back. We can't really make people disappear and come back."

He then went to my box of toy animals that I had opened on the floor and chose a small plastic shark. He pretended to bite me with it. I asked if the shark wanted to eat me. Jason replied while smiling, "The shark is very hungry!" I replied, "We all can have a hungry shark in us when we become angry and want something that we cannot have and when we lose something or someone we loved."

Having spent time with Jason, I realized that it was time to come back to Mrs. Garcia's own past. I made an appointment to see her alone. During that visit, she described a very close relationship with her mother. And when I asked about her father, she stated that she does not think much about him because he died when she was 15. I asked what he had been, what she recalled. "He was very strict," she replied solemnly. She reported that when he was angry, he was intimidating and could give very severe punishments as were "common in all families in Ecuador," according to Mrs. Garcia. I asked if she feared her father and she replied, "I prefer to think of the nice things he did for me, like take me to the park."

During Jason's next session, he entered and went straight for the jack-in-the-box. I took the risk of asking Mrs. Garcia to come into the session and not leave this time, as I had a sense that Jason needed her to be present. She seemed a bit flustered, but took a seat. She and I watched as Jason repeated over and over winding up the jack-in-the-box and saying "There he is! Now he's gone…" Mrs. Garcia remembered that she had meant to tell me that Jason had awakened that morning crying and asking for his father. And then she said, "Oh, I forgot also to tell you that Jason had a nightmare!" She then described what Jason had told her: "He was at the beach. He saw a shark in the water. He was so frightened." I said out loud so that Jason could hear, "And what could be a link between the shark and daddy and Jason?" Mrs. Garcia said that she did not think that there was one. I told her about our prior session in which we spoke about the "angry shark in all of us." At that point, Jason looked at his mother and smiled and went over to a clay figure of a girl with long hair that a previous patient had made and left on my desk. Jason smashed and flattened it with his hand. Mrs. Garcia became uncomfortable and apologized; she chided him in Spanish. I told her that worse things had happened and I asked Jason if he wanted his own clay to smash. She then said that she had to go to the toilet and got up. Jason got down on the floor and curled around her ankles to stop her. "Do you want me to fall and get hurt?!" she yelled. Then he got up and said, "If you try to go I will step on your foot!" She got quite angry, "Stop it!" I said, "I think he's telling you that he wants you to stay." She responded, frazzled, "Well, then I just have to go to the bathroom and then I can come back." She walked out. Jason started to cry quietly, "I want to go home!" and he threw the modeling clay at the wall. I said, "I think now there's an angry shark in the room!"

I took out the toy house and left the bend-a-family doll set in it, including a mother, father, brother, and sister doll. I asked Jason, "Look here, where's the angry shark in this family?"

In response, Jason took the father doll and began to scream at the mother doll, "You caca. … I won't let you leave!" He made the mother doll approach the door to leave and the father doll come back and pull her by the hair and hit her. At this point, I asked if the brother and sister watching were afraid of their dad, and the answer was in the form of an affirmative nod. I told Jason that he was telling us something very important in this doll-play and that I thought it would a good idea if his mother saw, was that ok? I got up to open the door and motioned for her to come in.

Jason watched wide-eyed and began to throw the father doll up in the air and catch it. I summarized what had happened in the play thus far. Ms. Garcia turned pale and appeared uncomfortable as she nervously shifted her position on the couch. Tears welled up in the corner of her eyes. Jason at this point was making screaming sounds and tossing the dolls in the air, at times rubbing his scalp. Jason looked at Ms. Garcia and then looked at the father doll he threw up in the air. They jointly attended to the doll. Ms. Garcia became visibly tense and looked away. I then asked Ms. Garcia what she thought was going on. She said, "Jason's father and I had a very bad argument a week or two before the 'accident' and Jason was there." Mrs Garcia said, "I couldn't take his (Jason's father's) constant questions as to where I had been, his threats, so I told him I would leave him."

Ms. Garcia turned to Jason as she nervously shredded a Kleenex in her hands. For the first time, she addressed Jason, "You must have been so scared!" She got up and crouched down next to him on the floor where he was playing and hugged him. He nuzzled his head under her arm. I said, "You were both scared together then. Too scared to think about how scared each of you were."

This was a turning point in the treatment, "a moment of meeting." Tronick (2007) has written: "Moments of meeting catalyze change in parent-infant interaction as well as in psychotherapy. In the process of infant development, the baby's implicit relational knowing encompasses the recurrent patterning of mutual regulatory moves between infant and caregiver" (p. 414). I believe that my presence as an active, observing third, allowed Ms. Garcia to look back when Jason solicited her attention to the father doll and its "violent" tossing up in the air. It was then that she was able to validate Jason's experience with him of the dispute, face and label Jason's helplessness and fear, as I was able to address Mrs. Garcia's.

From there on in the treatment, Jason's distractibility and oppositional behavior in school diminished. And his mother and he slowly but surely began to have more frequent moments during which she could open herself intersubjectively without feeling so ashamed and threatened. When his mother did so, Jason was better regulated. As Lyons-Ruth et al. (1998) have written, "In the course of … ongoing mutually constructed regulation, the interactive field between infant and caregiver becomes more complex and well-articulated, giving rise to emergent possibilities of new forms of interaction" (p. 286).

Discussion

As Gaensbauer (1995) has pointed out, the therapist, following from his experience of being with the patient and holding in mind the trauma history as told by the parent(s), can offer a cue to the child to let him know that it is safe and encouraged that the child play out and tell about his traumatic experience. Lost in feelings of helplessness and guilt, given her husband's depression and suicide, and traumatized by her husband's violence, Ms Garcia could not do this for Jason. She could not let herself see her children's fear and helplessness. Intersubjectivity between Mrs. Garcia and Jason was thus blocked. As in the previous example of Jahaira and Jessie, in which Jahaira viewed Jessie as a clone of her mother and as resembling her father, Ms Garcia viewed Jason as a clone of his father and was unable to see in him aspects of herself. She went out of her way to avoid confronting and setting limits with her son's aggression, or helping to calm his distress, this being another effect of her need for self-protection and self, at the expense of mutual, regulation of emotion and arousal. Lyons-Ruth et al. (2013), in their longitudinal family pathways study, have described the adverse consequences of early maternal withdrawal and role-reversal that we observed in both clinical vignettes. Early maternal withdrawal was found to be more noxious than early maternal intrusiveness, and associated with dissociative symptoms, antisocial behavior, and over time, self-damaging acts and other symptoms and behaviors that are intrinsic to borderline personality disorder. In the case of Jason and Ms. Garcia, we were able to note that Jason, in response to his mother's withdrawing behavior, became increasingly dysregulated in his days at school and during sleepless nights. Being called into the school by the teachers and into Jason's room during the night further dysregulated Mrs. Garcia. And she and Jason became hopelessly embroiled in a frequent cacaphony of mutual dysregulation.

Bringing his mother into the room and focusing jointly with her on Jason's communication of his experience of violence, allowed her to fill in a gaping hole in the family narrative. This completion of the family trauma narrative, itself, was healing and allowed Ms. Garcia to become increasingly available to Jason and to move past their complicated bereavement over the subsequent sessions. Both Jason and Ms. Garcia had been players in a scene that felt out of their control. The ability to coconstruct a narrative under their control that reintegrates fragmented traumatic memory traces, thoughts, and affects together with the observing, reflective therapist creates a reconsolidated, updated version of the traumatic scene that they have authored and shared. They were then together with each other able to share good, bad, and ambivalent memories of each one's relationship to Jason's father. To enhance a regulated and regulating observing third in the form of a reflective therapist helped to restore self-regulation both for mother and for child, and mutual regulation between them. That this was consolidated in a brief play-scene that was seized by the therapist and that led to systemic change within the family, points to a window of opportunity that was opened to permit light to enter in which had prior only been a dark and frightening state of mind.

Sander had described infants during the first ten days of life who were subjected to a noncontingent environment, as having enduring regulatory difficulties over several months and as having a lower tolerance for sensory stimulation. Indeed, Ms. Garcia, as an adult having endured a dysregulating, violence-prone relationship with her depressed husband, noncontingent to her emotional needs, similarly had little tolerance for Jason's expression of aggression and demonstration of traumatic memory traces. The presence of the observing and reflective third, the clinician, enabled Ms. Garcia to develop greater tolerance of Jason's states of mind and emotional expression. I assert that it is the mutual regulation that is stimulated in the parent-clinician relationship that permits greater attunement between Ms Garcia and Jason.

Conclusion

This article has taken as its departure point the interference posed by violent trauma and associated parent-child psychopathology to self- and mutual regulation of emotion and arousal. Lou Sander drew a parallel between the capacity to engage in mutual regulation and the formation of intersubjective states during which moments of meeting arise. Our clinical experience and research have shown how violent traumatization can make the parent unable to receive the child's efforts towards intersubjectivity. PTSD can render the traumatized parent blind, deaf, senseless to her child's emotional communication particularly when it triggers helpless states of mind that stir up traumatic memories. The child cannot depend on such a parent to help make sense of the present moment, as the parent remains hostage to her traumatic past.

The clinical examples in this article illustrate how the child, in such a context, who additionally himself has been exposed to violence, will, in the absence of a mutually regulating, intersubjectively receptive caregiver, attempt to self-regulate through repetitive traumatic play. This traumatic play can further alarm and distance the post-traumatically stressed caregiver such that the child and parent each become more dysregulated and then enter into a vicious circle of mutual dysregulation. In addition to traumatic play, we have shown how the transmission of traumatic memory traces occur in daily, routine, parent-child interactions (i.e., separations and reunions) via "traumatically skewed intersubjectivity" (Schechter, 2017). As Sander stated long before, "The simple repetitive situations that are a part of the daily life of mother and child in this early time of life should lend themselves admirably to a solid set of reliable anticipations about many dimensions of the mother's behavior" (Sander, 1977, p. 144). Traumatic play is one form of such simple, repetitive behavioral manifestation of trauma-related memory traces within an intersubjective space shared by both caregiver and therapist. The addition of the therapist as an observing, reflecting third renders the traumatic memory traces open to updating and reconsolidation within that space (Stein, Rohde, and Henke, 2015). 1 Updating and reconsolidation of the traumatic memory traces that incorporate the therapist's mentalizing stance, reassociation to previously avoided emotions (i.e., fear and

helplessness), and the mutual regulatory process between therapist and traumatized parent and, in turn, parent and traumatized child, in a triadic constellation helps to extinguish fear and helplessness and offer shared meaning to what had been disconnected and nonsensical.

Summary

This article illustrates how the therapist can, as Fraiberg suggested (1980), (1) ally with the parent in her effort to spare her child from the suffering that she herself experienced and (2) pick up on the child's communication and seize the opportunity to engage the child and the mother-child dyad straight away, to confront their avoidance of making sense, of linking the present moment to the past. To do so, requires that the therapist engage in a mutually regulatory process that leads to triadic coconstruction of meaning and a new intersubjective field. As such, both the child's and parents' suffering can be contained and reduced. The important end-result is a moment of meeting between parent and child that parallels that between the therapist and the parent-child dyad. As Sander (2002) wrote in his paper "Thinking Differently," the "recognition" of the child's intersubjectivity by the parent induces "a profound advance in the organization of consciousness—the development of awareness of own state and awareness of own role as an initiator of action" within the dyadic system (p. 37). Sander went on to point out, moreover, that such moments of meeting as I have described within the triad of child, parent, and therapist "provide(s) the essential positive motivating pole in the nonlinear dynamic system that they (i.e., mother and child) are constructing, that is moving each partner to seek the positive affective accompaniment of being 'together-with' the other" (pp. 37–38).

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