

## Chapter 11

### Pretend Play and Emotion Learning in Traumatized Mothers and Children\*

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Pretend play is a context that facilitates learning. It facilitates children's learning about emotions, adults' learning about children, and children's and adult's learning together. Indeed, pretend play, a subcategory of play in which actions, objects, and persons are transformed or treated nonliterally (Haight & Miller, 1993), has long been recognized as pivotal in facilitating early social and emotional development. Through pretend play, young children can express and communicate their emerging concerns and interpretations of the social and cultural world. Children's pretend play also allows adults to learn about children. In the words of a young mother of a 2-1/2 year old:

I have a tendency of watching how she's pretending ... To see if she is having any anxieties or worries or, you know, happiness that she wants to share with me that maybe she, at her age, isn't able to come right out and say, 'I'm scared about

this.'... it's important for me to see what's on her mind... (Haight, Parke & Black, 1997).

When children and adults pretend together they may spontaneously interpret emotionally important issues as they naturally emerge during everyday life. For example, after his colicky baby brother finally went to sleep, a 3-year-old initiated a pretend game of “bad babies” with his mother. Such mundane communications with parents or other caregivers may be helpful to young children in understanding and responding to the stresses inherent in everyday life. They may be particularly important, however, when young children experience highly stressful or traumatic events such as prolonged separation from parents, violence, death, accidents or serious illness. Indeed, pretend play has been used extensively by play therapists to facilitate children's recovery from stressful or traumatic events (e.g., see Singer, 1992). Yet, little is known about the roles of spontaneous, everyday pretend play with parents in children's emerging interpretations of stressful events. In this chapter, we present pilot data suggesting that parent-child pretend play is an underdeveloped resource for professionals helping children to interpret and recover from traumatic experiences.

#### Everyday, caregiver-child pretend play as a context for emotion socialization

Developmental research on the role of pretend play in young children's learning has focused largely on cognitive learning, such as symbolic thought or reading readiness. Yet, theorists as diverse as Freud, Winnicott, Piaget and Vygotsky concur that pretend play is central to emotional development in early childhood. As an interpretive activity, pretend play allows children to explore, practice and critique emotions they have observed or experienced (e.g., Groves, 2002). By as early as 2 years, children begin to

engage in verbal pretense portraying emotionally significant events (Bretherton & Beehly, 1982; Wolf, Rygh, & Altschuler, 1984). Among the affective functions of pretend play is the construction of meaning from emotionally challenging experiences. Pretend play offers children a safe outlet to express negative emotions, including those they might not ordinarily express such as intense anger towards a sibling or parent, in a context in which there are no real-world consequences (See Haight & Miller, 1993, for discussion). For example, in a remarkable study of children experiencing illness (diabetes and asthma), Cindy Dell Clark (2003) described the pervasive and spontaneous use of pretend play by children aged 5-8 as a means of coping with the stress of chronic, serious illness and its treatment. These children engaged in pretend play to reassure themselves about painful treatments, worrisome symptoms, and to compensate for vulnerable feelings related to their illness and treatment. Through pretend play they transformed threatening, painful or frightening events into occasions for mastery or even celebration.

The safe context of pretend play also may facilitate communication about emotionally charged situations with adults: teachers, parents, and other supportive caregivers. When such communication occurs, adults have the opportunity to provide comfort, guide, and contextualize children's emerging understanding of stressful event and the emotions they evoke (Haight & Sachs, 1995). Indeed, naturalistic research indicates that caregivers from a wide variety of cultural communities spontaneously engage in pretend play with young children (e.g., see Goncu, 1999; Haight & Miller, 1993; Haight, Wang, Fung, Williams and Mintz, 1999). Such pretend play, typically, is

highly enjoyable for children, and is associated with secure parent-child attachment relationships (see review by Sutton-Smith, 1994).

Some empirical research suggests that spontaneous, caregiver-child pretend play supports emotion socialization in low-risk, apparently well-functioning middle-class families. In longitudinal research, nine children and their mothers were followed from children's first through fourth birthdays. During 116.5 hours of naturalistic, videotaped observations in and around the home, they produced 320 spontaneous episodes of mother-child pretend play, 79 of which involved the enactment of aggression, illness and accidents (Haight & Sachs, 1995). Eight of the nine dyads enacted aggression for a mean of 14% of all episodes of mother-child pretend play. Six dyads enacted illness or accidents for a mean of 7% of all episodes of mother-child pretend play.

Communication about emotion varied in culturally-appropriate ways in relation to the themes enacted, e.g., enacted anger co-occurred with aggression, and fear with illness and accidents. Furthermore, mothers' participation may have shaped children's portrayals. For example, mothers produced more positive, contingent responses and elaborations to children's initiation of themes involving illness/accident than aggression. Children's initiations of themes involving aggression sometimes were overtly discouraged by mothers. These findings suggest that mother-child pretend play is a context for the socialization and acquisition of culturally-appropriate emotion communication.

Parent-child pretend play also may be a context for co-constructing an emotional understanding of traumatic events in vulnerable children who actually have experienced or witnessed significant aggression, illness, accidents or other highly stressful or traumatic events. Indeed, play therapy has been one of the few effective means of

intervening with young children exposed to trauma. Existing empirical evidence, however, indicates that children's *solitary* pretend play declines considerably during times of stress (Kramer & Schaefer-Hernan, 1994). That is, at the very time when children may benefit most from pretend play, they are less inclined to engage in it. Other children repeatedly reenact traumatic events they have experienced in play with no healing effect (Terr, 2003). To be helpful to children, pretend play during times of extreme stress or trauma would appear to require the support, structure, and guidance provided by a trusted adult. Empirical research, however, has not considered the relation of stress and *social* pretend play with parents. This chapter addresses the extent to which and how parents and young traumatized children actually pretend together.

#### Pretend play as a context for co-constructing interpretations of traumatic stress

According to the DSM-IVTR,<sup>1</sup> traumatic stress involves experiencing or witnessing actual or threatened physical injury to the self or another person, especially a family member, accompanied by feelings of fear, helplessness, and horror and, in children, disorganized or agitated behavior (American Psychiatric Association, 1994). Traumatic stress that results from intentional human design, particularly that which occurs within the family and is caused by parents or other attachment figures, is especially challenging for children (Egeland, Weinfield, Bosquet, & Cheng, 2000). Common responses of children to trauma include the development of specific fears, the repetitive reenactment of traumatic events in play, nightmares, separation difficulties, avoidance of reminders of the trauma, and fear arousal to stimuli associated

<sup>1</sup>Diagnostic and Statistical Manual Version 4, Text-Revision. Describes major mental disorders.

with the trauma, e.g., smells, sounds (Webb, 2002). Traumatic stress may disturb children's emerging understanding of self and other, safety, and protection (e.g., Pynoos, Steinberg & Goenjian, 1996), and interfere with the development of self-soothing capabilities (Parens, 1991).

Evidence from the trauma literature suggests that not all children exposed to traumatic stress will show significant effects on their mental health. Indeed, there is evidence of individual variation in children's resiliency with some children showing relatively normal patterns of development despite profound and ongoing stress (e.g., Garmezy, 1985). In their review of the psychiatric literature, Yehuda, McFarlane, and Shaler (1998) conclude that there is no simple relationship between exposure to trauma and the subsequent development of a psychiatric disorder. Children exposed to traumatic stress may vary in whether they experience PTSD (post traumatic stress disorder) or other psychiatric disorders, and in the intensity of any symptoms.

Variation in children's responses to traumatic stress has been attributed, in part, to their quality of relationships and communications with parents (e.g., Bowlby, 1988; Coates & Schechter, 2004; Garmezy, 1985; Levy, 1945; Pynoos, et al., 1996; Lynskey & Fergusson, 1997). Children may rely on parents for interpreting the traumatic events and the feelings they evoke because they trust their parents (Bowlby, 1988) and because children have fewer and less developed psychological resources to respond to trauma (e.g., ability to reason about causes and motivations, and imagine a more hopeful future) (Marand & Adelman, 1997; Pynoos & Eth, 1985). Following exposure to trauma, parents may begin both to comfort children and to scaffold their emerging interpretation

of the event (e.g., Bat-Zion & Levy-Shiff, 1993), for example, through comfort, emotional security and explanations. Indeed, even infants use emotional cues from parents to assess the meaning of new or stressful situations (Campos & Stenberg, 1981). The crucial role of parents as mediators may be one reason why children often are especially stressed when parents are physically or emotionally unavailable to them in times of trauma, for example, during war or maternal rape (Punamaki, 1987).

Surprisingly little research has addressed caregivers' socialization practices with respect to how and when children are socialized for responses to traumatic stress. Existing evidence suggests that children's resilient responses to traumatic stress are enhanced by calm, comprehensible communication with parents. Parent-child pretend play is one of the contexts in which such communication may occur. For example, parents' spontaneous involvement in children's post-traumatic pretend play after Hurricane Hugo was identified as possibly instrumental in children's constructive resolution of their fears (Cohler, 1991), and in helping young children in New York to come to terms with the aftermath of 911 (Lehmann, 2001; Zero to Three, 2002). Alternatively, parents' own feelings of trauma may compromise their abilities to support their children (Coates & Schechter, 2004; Marand & Adelman, 1997), including through parent-child pretend play, and thus affect children's subsequent coping. Indeed, the psychological well-being of some children in the years following the Chernobyl catastrophe was attributed, in part, to parents' open communications of their own emotions including anxiety and grief (Bromet et al, 2000). Evidence from disasters (e.g., Vogel & Vernberg, 1993; Bromet et al, 2000; Perry, Silber & Black, 1956; Norwood, Ursano & Fullerton, 2000), violence (Marand & Adelman, 1997), childhood sexual abuse

(e.g., Lynskey & Fergusson, 1997; Feiring, Taska & Lewis, 1998; Cohen & Mannarino, 1996), war (Freud & Burlingham, 1943; Punamaki, 1987), life threatening illness and painful medical procedures (Stuber, Nader, Yasuda, Pynoos, & Cohen, 1991; Ackerman, Newton, McPherson, Jopnes, & Dykman, 1998) indicates a relationship between children's and parents' responses to traumatic stressors. For example, the intensity of Israeli school children's stress responses to SCUD missile attacks was related to parental behaviors and attitudes. Parents' negative emotional manifestations (e.g., confusion, exhaustion, anger) were associated with negative attitudes in children, while positive parental emotional manifestations (e.g., holding and soothing) were associated with children's increased coping efforts (Bat-Zion & Levy-Shiff, 1993). After a devastating tornado, some parents argued that the best strategy for helping their children to recover was to avoid discussion of the disaster, a response that the researchers associated with children's acute stress reactions (Perry et al., 1956). Some parents even respond to traumatic events in a disturbed or out-of-control manner as distressing to the children as the precipitating event (Burt, 1943).

One source of individual variation in parents' responses to traumatic stress experienced by their children is their own mental health. Many mothers involved with the public child welfare system themselves have unmet mental health needs. They have experienced high levels of stress and many experience complex trauma; that is, traumatic experiences repeated over time often from childhood into adulthood which remain troubling and affect concepts of self, interpersonal relationships and coping skills (e.g., Haight et al., in press). High levels of ongoing stress and trauma history may compromise mothers' abilities to buffer children from traumatic stress. In addition, witnessing

traumatic stress in her child may reactivate a mother's own past trauma experiences (Banyard, Williams & Siegel, 2002), and lead to dissociative and other trauma reactions in the mother.

Considerable research does suggest that parents' own complex, unresolved trauma history negatively impacts their interactions and relationships with their own children (Banyard, Williams & Siegel, 2003). For example, a number of studies have revealed that adults who have experienced trauma in childhood are more likely to be classified as "unresolved" when assessed using the Adult Attachment Interview (AAI) than are adults who do not have such histories of trauma (Hess, 1999). The AAI is a semi-structured interview developed by George, Kaplan and Main (1985) to evaluate a parent's current state of mind about attachment. In the AAI, adults who are unresolved with respect to attachment speak in unusual ways regarding loss experiences or trauma either in childhood or adulthood. Unresolved feelings about loss or trauma often are suggested by lapses in meta-cognitive monitoring. For instance, a parent may evidence odd slips of the tongue (speaking about a long dead parent in the present tense), change topics abruptly or may have other pronounced difficulties in even speaking about the event. Interestingly, adult unresolved classifications are in turn significantly related to higher rates of insecure attachment, specifically disorganized attachment in their own children (Hess, 1999; van Ijzendoorn, 1995). Infants with disorganized attachment do not develop a coherent strategy for coping with stress and obtaining comfort from their caregiver. Many show overt fear or dissociative-like symptoms under stress. Disorganized attachment is associated with vulnerability to stress as assessed through salivary cortisol (e.g., Hertsgaard, Gunnar, Erickson & Nechmias, 1995), and is a risk factor for the

development of a variety of psychosocial and mental health disorders in childhood and adolescence (e.g., Crittenden & Ainsworth, 1989; Greenberg, Speltz & DeKlyen, 1993; Lyons-Ruth, Alpern & Repacholi, 1993; Lyons-Ruth, Easterbrooks & Cibelli, 1997; see Main, 1996 and Zeanah, Mammen & Lieberman, 1993).

Existing research also suggests considerable variation in traumatized parents' socialization beliefs and strategies for supporting their children's interpretations of traumatic events. For example, during in-depth, semi-structured interviews, most battered women involved in the public child welfare system gave specific descriptions of how exposure to domestic violence had harmed their children's psychological well-being, and many also described specific strategies to enhance young children's recovery (Haight et al., in press). Considerable variation, however, was present in mothers' reports of their directness in addressing the trauma of domestic violence, attempts to instill in their children hope for a more positive future, and efforts to educate their children to prevent their own future involvement with violence. In a survey of battered women, Holden, Stein, Ritchie, Harris & Jouriles (1998) posed an open-ended question: "What do you say to your child after he/she becomes aware of a violent conflict?" The two most common responses, each provided by approximately 20% of mothers, was to tell their children that their father was angry with the mother and not the child, or to explain to their children that their father was sick and needed help, responses which could prevent children from internalizing blame or misconstruing violence (Bowlby, 1988). Another 17% of the mothers indicated that after a violent incident they would reassure their children that they were okay. In contrast to these explanations, some mothers wrote that they would offer other types of comments including threats ("You better behave before he hits you too")

and excuses for the fathers' violent behavior ("It's not his fault.") These reports suggest that there are some potentially important differences in how mothers interpret traumatic stress with their children, and hence in how mothers support or compromise their children's resilient responses. Some responses may be more conducive to children's mental health, whereas others, especially those where a parent is not forthcoming about what happened or places blame elsewhere may contribute to confusion, disturbance and psychopathology, especially if a parent's explanations vary considerably from what a child has observed or seen herself, or if a parent denies what has happened or provides no explanation whatsoever (Bowlby, 1988).

Some evidence on mothers' narrative practices with young children in relation to potentially traumatic events also suggests variation across cultural communities.

*Evidence from North American working-class and middle-class families suggests that such variation is linked, in part, to culturally-specific belief systems. Such belief systems are taken-for-granted ideas about the nature of reality that provide a frame of reference within which individuals interpret experience and formulate goals and strategies for living and problem solving within the constraints of culture (Bruner, 1990; Goodnow, 1988; Harkness & Super, 1996). Many working-class mothers tell stories involving traumatic stress in the presence of, and with, their young children while middle-class mothers typically censor such talk (Burger & Miller, 1999). In addition, working class mothers generally view such exposure as protective because children need to know about predictable dangers so that they may avoid or effectively handle them in the future. In contrast, middle class mothers generally believe that shielding children is protective*

*because children are psychologically vulnerable and exposure to topics involving trauma can be harmful (Cho & Miller, in press).*

Existing research has not addressed mothers' pretend play with young children related to traumatic themes. Most children in developmental studies of caregiver-child pretend play have been from low risk, middle-class families with no known trauma history. Hence, any challenging events that children interpreted with their caregivers during pretend play were limited and comparably mild. By contrast, young children in foster care have experienced traumatic separations from parents. Most also have experienced family violence, maltreatment, exposure to adults' substance abuse or other traumatic events. Not surprisingly, young children in foster care have three to seven times more chronic emotional disorders than children of similar socio-economic backgrounds (Blatt & Simms, 1997), and also experience disproportionate rates of developmental delays (Cicchetti & Toth, 1995) and educational underachievement. It is imperative to develop effective prevention and intervention strategies for these high-risk children in the aftermath of traumatic events. Describing and understanding spontaneous beliefs and practices is a first step in developing such interventions. In addition, developmental research on the functions and limitations of parent-child pretend play will be advanced by describing the breadth, diversity, and intensity of events and emotions interpreted; as well as the ways in which stressful or traumatic events are communicated, constructed and developed during pretend play. This requires observation of children with diverse life experiences. Our preliminary study describing high-risk families, reported below, suggests that spontaneous parent-child pretend play does occur around

traumatic themes, and that such play can serve as a context for children's positive emotion socialization.

#### Caregiver-Child Pretend Play in High-Risk Families

Our study focused on mothers and children involved with the public child welfare system in central Illinois. They were part of a larger study of parent-child relationships in high-risk families (Haight, Black, Workman & Tata, 2001). Children were between the ages of 2 and 4 years (mean = 32 months), and were living in foster homes. Five children were African-American, three were white, and one was biracial. Seven were girls. All children had experienced multiple traumas. All had been forcibly separated from their primary caregivers (mothers) within the last year because of maltreatment; five were known to have witnessed repeated and severe domestic violence, three were known to have witnessed parent substance abuse; and three were known to have been physically and/or sexually abused. All mothers and children had regular, weekly contact with one another (described, below). Those who did not were excluded, as lack of play in such circumstances could be expected due to grief responses or strong emotional detachment resulting from prolonged separation (Heinicke & Westheimer, 1966).

Mothers were between 16-30 years (Mean age 23 years). None of the mothers resided with the target child's father. Four were employed at service or factory jobs, and five were unemployed. One was known to be actively abusing drugs, and one was known to be suffering from clinical depression. With two exceptions, mothers also has experienced significant trauma in addition to the ongoing loss of their children. Five mothers had experienced domestic violence, five reported significant childhood trauma

(physical and sexual abuse), four reported unresolved mental health problems, and three struggled with substance abuse.

Children and their mothers were videotaped during one-hour long “visits.” Visits are the scheduled, face-to-face meetings that occur between parents and their children who are in foster care. For the families in our study, visits were relatively unstructured. Mothers were to be sober and refrain from abusive behavior. Otherwise, they were free to interact with their children as they chose. Parents and children typically visited for one hour, once a week. Visits occurred in a well-stocked play room. The room was comfortable and homelike with furniture, toys appropriate for young children, and refreshments. Available toys particularly suitable for pretend play included a dollhouse with miniature toys; puppets; dolls; toy phones; shopping carts; medical instruments; weapons including a hunting knife and guns; handcuffs; and a sand table with miniature toys. Mothers were asked to interact with their children as they ordinarily would during a visit. They were given no other specific instructions, for example, regarding play. Mothers and children then were videotaped for one hour.

Videotapes were transcribed verbatim with notes describing relevant contextual features such as affect, gestures and objects. Adequate reliability was established for all codes described below. (Details are available upon request from the authors).

#### Cross-case overview of mother-child pretending

A cross-case overview suggests that mother-child pretend play may be an important context in which young children who have experienced trauma communicate with their parents about traumatic events to understand and clarify events, derive comfort, recover a sense of self independent from the trauma, and/or develop hope for a

more positive future. Pretend play in many of the high-risk dyads observed in this study looked very similar to that which we have observed in dyads with no known history of trauma (e.g., Haight & Miller, 1993; Haight, Parke & Black, 1997; Haight et al., 1999). Our cross-case overview, however, also suggests considerable variation across high-risk dyads in the propensity to engage in mother-child pretend play, the ways in which pretend play is socially conducted and the enacted themes. Such variation may impact children's responses to traumatic events, and hence their subsequent well-being and mental health (Bowlby, 1988).

In contrast to reports of children's solitary pretend play following trauma, all mothers and children, even those who had experienced recent trauma, spontaneously pretended together. As with the low-risk, middle-class mothers and children observed in our previous studies of everyday caregiver-child interaction (e.g., Haight & Miller, 1994; Haight et al., 1999), all dyads engaged in some pretend play, but there was variation across dyads in the frequency of pretending. We adopted a conservative approach to determining the amount of pretend play within the visit. Following Garvey (1990), we defined pretend play as a subcategory of play in which actions, objects, persons, places, or other aspects of the here-and-now are transformed or treated nonliterally. For example, a doll is animated, a child is transformed into a superhero, behaviors conventionally associated with one context are enacted in a different context (e.g., a child says "good night", lays down on the playroom floor, and covers up with a napkin. We defined an episode of pretend play as a continuous stretch of pretending on a given topic or theme. Episodes began with the first action of pretend play produced by, or directed at, the child, and continued as long as the chain of transformational actions and supporting responses

continued. An episode ended with the final action of play produced by or directed to the child. Actions that were suggested by an object's unique and salient physical properties (e.g., placing a toy biscuit in a toy bowl), unless accompanied by other clearly transformational actions or talk (e.g., discussion of feeding the baby), were excluded on the grounds that they were ambiguous as to whether the child was treating the object nonliterally. (See Haight & Miller, 1993, for further details). Even using this conservative definition of pretend play, the mean percentage of the visit time spent in pretend play was 21% ranging across mother-child dyads from 1% - 49% of the visit.

Given that mothers and children spontaneously pretended together, it is important to consider whether or not such interactions are likely to have affected children's interpretations of, or responses to, emotionally stressful or traumatic events. Clearly, any effects of mothers' participation on children's pretend play will depend on how the play is socially conducted; in particular, the degree to which pretending is constructed as a mutual activity. Maternal involvement that is too passive or dominating is unlikely to support children's emerging emotion interpretations. Mutual involvement is indicated if both mother and child abide by the conventions of mutuality, initiating joint pretending and pretending in response to the other's initiations. We considered the "initiator" to be the first person to direct pretend play to the other person. We considered a "responsive" reaction to be one which continued the play initiated by the other, for example, through producing a contingent pretend response, or encouraging nonverbal responses such as smiling and nodding. (See Haight & Miller, 1993, for discussion).

Similar to our low-risk dyads, most mothers and children in this study were mutually engaged and responsive to one another's pretending. Both mothers and children

actively participated in initiating pretend play with the other (mothers initiated a mean of 44% of all episodes). In addition, children and mothers were generally responsive to one another's initiations. Mothers were responsive to a mean of 95% of children's initiations of pretend play, and children were responsive to a mean of 83% of mothers' initiations.

There was, however, considerable variability in how episodes of pretend play were socially conducted in these high-risk dyads with some extreme scores not seen in the low-risk dyads of our previous studies. Although children generally were very responsive to their mothers' initiations of pretend play, their responsive reactions ranged from 0%-100%. The child who did not respond to her mother's initiations of pretend play responded to few of her mother's other social overtures. This mother and child were separated because of the mother's active substance abuse and profound neglect of her daughter. Similarly, although mothers were generally responsive to their children's initiations of pretend play, the range was from 50% to 100%. In accordance with past research (e.g., Tarullo, DeMulder, Ronsaville, et al, 1995), the mother with the lowest rate of responsive reactions was experiencing clinical depression.

The extent to which mutually engaging mother-child pretend play facilitates children's responses to emotionally stressful or traumatic events also will depend on the extent to which such themes actually are incorporated into the play. Children and mothers did enact some themes that were related to stressful or traumatic real life events that they had experienced. Similar to our earlier studies with low-risk families, mothers and children enacted a variety of stressful events including interpersonal aggression, illness and accidents. They also enacted a theme of traumatic separation (described below) which we did not observe in our low-risk families. (Note that more than one of

these themes could and did occur within single episodes of pretend play, for example, the mother and baby are traumatically separated, and the baby then becomes ill.)

We considered interpersonal aggression to be the enactment of intentional physical or psychological harm or threat of harm to persons. It included the enactment of stabbing or obscene name calling. As with our low-risk, U.S. samples, aggression was the most frequently enacted stressful event. Seven of the nine dyads enacted aggression accounting for a mean of 40% of episodes, ranging from 0% - 100% of all episodes. Again, we saw extreme scores on aggression which we had not previously seen in our low-risk dyads. For one dyad, all episodes of pretend play involved the enactment of aggression, and for another dyad, 89% of episodes involved aggression. In addition, the aggression enacted by many children was realistic and resembled anti-social, adult behavior. For example, during doll house play, Molly made the daddy doll shake the mommy doll while screaming in a “doll” voice, “Stop it! Stop it, bitch!” Clinical studies suggest that such realistic enactments are often linked to behaviors that a young child has observed (Bowlby, 1988; Terr, 2003), for example, at home between his or her parents. In our low-risk dyads, enacted aggression typically involved portrayals of media characters such as Batman and villains.

We considered “illness/accident” to be the enactment of accidental harm such as getting burned or having a heart attack. (Haight & Sachs, 1995). Illness/accident occurred much less frequently than aggression (two dyads enacted accidents or illness accounting for a mean percentage of 16, ranging across dyads from 0%-100%).

In addition to these themes, some mothers and children displayed a theme of traumatic separation. This theme involved the forced separation of child and primary

caregiver (in these cases, the mothers with whom they were playing). Although we have observed the theme of mother-child separation enacted in low-risk families, this theme typically involves the child's protestations, for example, of the mother's departure for work. In the high-risk samples, the mother's distress also is enacted and the child's behavior may become disorganized. For example, during play with a doll house, May asked her young daughter, "Are you at your new (foster) house?" To which Molly responded, "No!" Later in the episode, she picked up the mother doll, and screamed in a "doll" voice, "Stop it! Stop it! Give me back my baby! Don't do that no more!!" Molly then began visibly distressed and began throwing the doll house props. Three dyads enacted traumatic separations from a parent accounting for a mean percentage of 8%, and ranging across dyads from 0% - 25%.

#### Four illustrative cases

The cross-case analysis suggests that traumatized mothers and children regularly engage in spontaneous pretend play together during visits. Since pretend play can provide a "safe" environment for exploring feelings about family experiences, it could potentially be an important resource for intervention with some traumatized children. If a parent can engage the child emotionally in play, allowing for some expression and exploration of the child's feelings and thoughts, a therapist could help the parent provide the parent and child with clear feedback about events and feelings. Such communications could contribute to the healing process both for parent and child. None of the children in the current study, however, were receiving mental health intervention to help them to deal with their prolonged separation, or previous traumas leading up to placement in foster care. An analysis of several illustrative cases suggests qualitative differences in styles of

mother-child pretend play that may impact children's responses to the literal traumatic stresses they have experienced. These four patterns are not intended to reflect a comprehensive typology. They do suggest that of the context of mother-child pretend play may be an important resource on which a therapist might begin to work with some, but not all, traumatized children. They also suggest different strategies that a therapist might need to employ to support different mothers and children. (Identifying details have been changed to disguise the cases).

#### Maternal proactive support of child's trauma resolution during mother-child pretend play.

Despite their own difficult histories, a number of mothers in our study displayed remarkable sensitivity and wisdom in responding to their children's reactions to trauma including the use of pretend play. For example, both 19-year-old Susan and her youngest daughter, 2-1/2- year-old Anna, had experienced significant trauma in their young lives. As a child, Susan was sexually abused by her alcoholic father, and later by her stepfather. At the age of 15, her first daughter, Melinda, was born, and at the age of 16, Susan married Melinda's father. Sadly, her husband was an addict and physically abusive. He was primarily abusive to Susan, but had begun to abuse the children as well. Susan had been a good student ("when I could concentrate"), but did not finish high school. She had recently obtained her GED. Her children were removed 3 months prior to our observation of her visit with Anna. At that time, Susan was engaging in some petty criminal activity and, although she herself did not drink or abuse drugs, she associated with substance abusers. Her children were removed because of endangerment related to the domestic violence and because of abuse. Anna cried inconsolably for her mother at the end of each weekly visit, suffered from nightmares, and displayed withdrawn and

regressed behavior in her foster home. At the time of the visit, Susan had filed for divorce and obtained an order of protection. She was in therapy, in her words, “to learn to make better choices.”

Despite her own difficult history and youth, Susan was warm, attentive and remarkably wise in her face-to-face interactions with Anna. In the following excerpt, Susan spontaneously used pretend play to comfort a distraught Anna at the end of their weekly, hour long visit by reminding her of the dinner and bedtime routines they had shared when they lived together. (Susan and Anna are pretending with a doll house. They have chosen dolls to represent Susan, Anna, and Anna’s older sister, Melinda.)

*Susan:* You want to sit at the table with Melinda? (Susan places the Anna doll in a chair at the table.) You know how we used to do it at home? Do we have another chair so Mommy can sit at the table? (They place the Susan doll at the table.) What do we do at home? We put you in a highchair, right? (They change the Anna doll to the highchair, and the dinner play continues)

*Anna:* That’s you! (Referring to Susan doll).

*Susan:* Are you talking to Mama Susan? Hmm?

*Anna:* That you.

*Susan:* Yeah.

*Anna:* Yeah.

*Susan:* Does Mama Susan read books to you when you go to bed at night?

*Anna:* Yeah. ... (Haight, et al., 2001).

Pretend play was a favored activity of Anna and Susan in which they spontaneously engaged for 23% of their visit time. In the play episodes, Susan was able

to connect with her daughter emotionally and to remind her of their shared lives together and of her commitment to their remaining together. By reminding Anna of daily routines they had shared, Susan was reminding Anna that she was her mother and was there to help her. For a young child who is experiencing the trauma of a prolonged and forced separation from a caregiver, this is crucial information that may help to sustain the parent-child attachment relationship. At the time of our study, Anna was not receiving any services to address the traumas that she had experienced, either at the hands of her father, or the traumatic separation from her mother.

Yet, given Susan's "spontaneous maternal proactive support of the child's trauma resolution during mother-child pretend play," a skilled therapist would have a sturdy base on which to build an intervention to support Anna. If Anna and her mother were seen by a skilled therapist, their joint play episodes could potentially provide a safe and powerful environment for exploring and processing past trauma. In this context, Anna's mother could provide her with critical information that could facilitate healing (e.g. confirming what she saw, explaining misconceptions, as well as reassuring her of her current safety and her commitment to her).

Minimal communication about stressful or traumatic events during mother-child pretend play.

Not all dyads, however, used mother-child pretend play to communicate about separation experiences or other traumatic events. Some mothers and children simply preferred other forms of expression such as asking and answering direct questions. Other mothers lacked strategies for communicating with their very young children about the trauma they had experienced. As one mother expressed during a discussion of domestic

violence, “How do you talk to a 2-year-old about the fact that Daddy almost killed Mommy? I don’t understand it myself.” In this latter case, pretend play between the dyad and a skilled therapist could reveal how much difficulties the dyad is having in communicating about powerful and painful events in their lives. Using the play as an impetus for discussion about feelings and events (Fraiberg et al, 1975; Lieberman, 1999), the therapist could then help the dyad to begin to communicate about the trauma and pain, thereby promoting a healthier developmental trajectory for the mother and child.

In many ways, Dorothy and Clarissa were similar to Anna and Susan. Dorothy was 20-years-old, had two small children and a violent boyfriend. Both Dorothy and 2-year-old Clarissa had experienced significant trauma. Dorothy described a difficult and traumatic childhood. As a young child she witnessed her mother’s boyfriend murder her slightly older sister. She entered foster care and was eventually adopted. Her adoptive father sexually abused her for a number of years until her adoptive mother “threw” her out of the house at age 16. By the age of 17, Dorothy was an emancipated minor, working full time. When she became pregnant with Clarissa, she obtained her GED and advanced to the level of supervisor at a fast food chain. Unfortunately, the father of her children was physically abusive. Several months prior to our observation, the children were placed in foster care because of risk of endangerment related to the domestic violence. As reported by Dorothy, 2-year-old Clarissa actively fought her father off of Dorothy when he “almost killed me.” Clarissa was described by her foster mother as “high tempered,” difficult and fearful of men. A beautiful little girl, Clarissa’s arms and legs were covered with scabs from nervous picking and scratching at her skin. At the

conclusion of each weekly visit she screamed and tantrummed when separated from her mother.

Like Susan, Dorothy was remarkably warm, attentive and insightful in her interactions with Clarissa. Although Dorothy and Clarissa engaged in spontaneous pretend play (17% of the visit time), they did not enact trauma themes. Their play focused on domestic routines such as shopping and cooking enacted by a mommy and her little girl, and social routines such as phoning. As with Anna and Susan, the themes of home routines appeared to connect the two together emotionally, providing a vital link for maintaining their relationship. At the time of our study, Clarissa was not receiving services to help her to interpret the violence she had witnessed at home, or the traumatic separation from her mother. Given this, “minimal communication about stressful or traumatic events in mother-child pretend play” in a dyad that clearly enjoys sharing pretend play, a skilled therapist might help to open up the possibility of greater communication through play. For example, when Dorothy introduced a male figure into their dollhouse play, Clarissa objected, “No bad man.” Although Clarissa resisted the inclusion of the male figure into their peaceful play, her spontaneous identification of the male figure as “bad” suggests the potential for her to explore past traumatic experiences with her mother in play, especially if these enactments were guided by a skilled clinician. Having a clinician work with the dyad appeared to be important since her mother made no response to Clarissa’s comment about the “bad man.” Therapeutic interventions that build constructively on the themes that were emerging spontaneously in play could help Clarissa and her mother to come to terms with past violence and with the ongoing separation.

### Maternal disapproval of child's aggressive pretend play

Similar to the low-risk samples we observed in our earlier studies, some mothers in the current study actively discouraged their children's enactment of aggression and other anti-social behaviors during pretend play. The explicit message sent by these mothers during mother-child pretend play was that interpersonal aggression is wrong. Given that many of the children in our high risk sample had repeatedly witnessed interpersonal aggression, especially domestic violence between parents, pretend play could be a context for re-socialization. In some instances, however, disapproval of the child's enactment might foreclose on opportunities to explore and communicate about these traumatic experiences.

May was a 27-year-old high school graduate. Four-year-old Molly entered foster care because of neglect. May was homeless after leaving Molly's father who was violent. She was struggling to find a job and appropriate housing. She described her childhood history as "boring," with no significant trauma. She did cry, extensively, when telling us about her separation from Molly. During the visit, May and Molly co-constructed a narrative of when Molly was placed by child welfare professionals in protective custody. May also made positive comments about Molly's foster placement encouraging Molly to get along in her temporary home, and reassuring Molly that she was actively seeking a home for them. Molly was doing relatively well at her foster home, but had begun to act out aggressively in her preschool. She cried inconsolably at the end of each visit when she had to separate from May. May was the only mother in our study who had regained custody of her child at the 6-month follow-up.

May and Molly pretended extensively during their visit (49% of the visit time). Their play was animated, lively and encompassed many themes. Similar to our low risk families, pretend play for May and Molly was not only fun, but a context of socialization. In the following excerpt, May responds to Molly's enactment of rough and tumble play, but explicitly discourages anti-social aggression.

(May and Molly are playing with puppets. Molly initiates pretend rough and tumble play and begins tickling May's puppet. May makes her puppet squeal and retaliate. May makes her puppet playfully hit Molly's on the head. )

May: No! No! Stop! Stop! (playfully, while smiling. May laughs and reaches for a plastic, hunting knife).

Molly: I'm gonna get that knife... I'm gonna cut her.

May: (no longer playing) No, you ain't gonna get no knife. Knives are bad. Put the knife back.

At the time of our observation, Molly was receiving no services to help her cope with the separation from her mother or other traumas. Given the "maternal disapproval of the child's anti social enactments," and this dyad's elaborate and imaginative pretend play around other themes, a skilled therapist might help May to both communicate the inappropriateness of interpersonal violence, and also open up pretend play as a context for communicating about Molly's feelings evoked by such past traumas and her separation from May. In the above play episode, May gave Molly clear verbal feedback regarding the interpersonal aggression she was beginning to enact in her play. Given that anger is a common response to a major separation and exposure to domestic violence, having a therapist present could both support May's legitimate attempts to

communicate about interpersonal aggression, and her understanding that her daughter's anger is a natural sequelae of their separation and exposure to domestic violence.

#### Maternal pressure for anti-social pretend play

Mother-child pretend play typically is a context supportive of children's positive socialization and well-being. It may be tempting to encourage all traumatized parents and children to pretend together under the guidance of a skilled therapist. To do so, however, would be naïve. Parent-child pretend play does have limitations. If parents are anti social or enact their own unresolved trauma histories in play, the emotion socialization their children experience during parent-child pretend play may not be conducive to their positive development. In the following case, the mother initiates anti-social themes into the pretend play which are initially resisted by the child. The child's mother, perhaps because of her own unmet needs, failed to create a safe environment within which experiences about past trauma, and the feelings they engendered, could be explored. Indeed, antisocial themes initiated by the mother within the play itself apparently were highly stressful to the child.

17-year-old Shareese had been in foster care because her step father was known to have sexually molested her sister. Prior to that time, she had lived with her 2-1/2 -year-old son, Robert, with her family in a public housing facility notorious for its violence. Before and after participation in this study, Robert had visited Shareese in jail where she was beginning a sentence for selling drugs. At the time of the study, Robert had been in foster care for 10 months.

Shareese's interactions with Robert were complex. There was a sense of warmth and playfulness in their interactions. On the other hand, Shareese rushed from toy to toy

with little attention to Robert's interests or emotional cues. On several occasions she made him cry by scaring him with a stuffed snake, or threatening to end the visit if he did not comply with her frequent demands. Although this dyad did engage in frequent, spontaneous pretend play (25% of the visit), the episodes were very short, and all were initiated by Shereese. Furthermore, in many of these episodes, Shereese seemed to pressure Robert to enact anti social themes which he apparently found distressing.

*Shareese:* Look. I'm gonna handcuff you. (Picking up play handcuffs. Smiling, she takes Robert by the arm and tries to lead him back to the chair. Robert whimpers and resists.)

*Shareese:* C'mere. (Robert whines. Shareese frowns.) Gun—C'mere! C'mere! (She pulls Robert back to the chair, sits in the chair, and stands Robert in front of her.)

*Shareese:* C'mere. Turn around. Put your hands behind your back. (Shareese puts a toy gun in her lap and handcuffs Robert.) OK, we're goin' to take you to jail. Gonna take you to jail. . . . You're gonna go to jail. We're gonna shoot you. (Shareese takes a toy gun, and puts it to Robert's chest and pulls the trigger.) Pow! (Robert starts to shake and whine.)

*Shareese:* Break out! (Robert shakes his hands to free his wrists from the handcuffs. Shareese holds the gun near Robert's head and pulls the trigger. He whines.)

*Shareese:* OK. Here. (She holds the gun out for Robert to take. Robert takes and stands watching as Shareese takes another gun. She puts a holster on her waist and returns to the chair.)

*Shareese:* You want it (the gun)?

*Robert:* No (whining).

*Shareese*: C'mere. (She points her gun at Robert and shoots twice. Then, smiling, she hands it to Robert, pointing it at herself.) Shoot it. Shoot it.

*Shareese*: OK, give me your knife. I'm gonna stab you. (*Shareese pretends to stab Robert to death. The play continues, and eventually, Robert joins in as a willing partner pretending to shoot and stab his mother.*) (Haight et al., 2001).

Like the other children in our study, Robert was receiving no intervention to help him to deal with past traumas and the current separation from his mother. Given "Maternal pressure for anti-social pretend play," any joint therapy could proceed only if *Shareese* has access to, and successfully responds to, counseling. In the above episode, *Shareese* was unable to create a sense of safety for Robert in their shared play. Instead, her behaviors only frightened her son. Her comments also served the function of inculcating him into anti-social behavior by teaching him to respond to aggression with aggression. Under the guidance of a skilled clinician, pretend play might provide an important venue for this vulnerable and at-risk dyad to connect in a more positive way with each other and to communicate about the trauma and violence. To do so, however, it would first be important for the therapist to help *Shareese* consider the origins of her angry feelings and to connect her anger to the events and experiences that conditioned it (Bowlby, 1988). It would also be important for the therapist to help *Shareese* empathize with her own sense of vulnerability and with Robert's need for empathy and love (Fraiberg, et al., 1975; Lieberman, 1999).

### Conclusion

In this chapter, we have explored the pretend play of mothers and children from high risk families who have experienced recent trauma. Despite the facilitating role

accorded to pretend play in emotional development and socialization in early childhood, previous empirical research has focused on the cognitive and linguistic functions of pretend play. In addition, much of the existing empirical research focuses on children in low-risk groups which may restrict our understanding of the range of emotion themes enacted during mother-child pretend play.

In many respects, the mothers and children from the high-risk families described in this chapter resembled those from low-risk families we have observed in our previous studies. In a supportive context, all mothers and children spontaneously pretended together. Much of this play displayed mutuality: episodes were initiated by both mothers and children, and mothers and children were generally very responsive to one another's initiations of pretend play. There was, however, variation across our high-risk, mother-child dyads. In one of the dyads, the mother dominated the pretend play with little regard for the child, and in another, she was minimally responsive to the child's initiations of pretend play. Such variation may affect the extent to which mother-child pretend play supports children's positive development.

Similar to the pretend play we have observed in low-risk families, mothers and children from high-risk families enacted a range of themes including those related to trauma such as interpersonal aggression. In some of the high-risk dyads, however, aggression dominated the play or contained the realistic enactment of adult aggression such as the aggression experience or observed by the children in their actual lives, e.g., the daddy punching and swearing at the mommy. In contrast, much of the aggression we observed in many low-risk dyads involved fantasy aggression, e.g., superheros fighting bad guys. The pretend play of some high-risk dyads also contained themes infrequently

observed in low-risk families such as the traumatic separation of babies from their mothers in which mothers as well as babies display distressed and disorganized behavior.

This exploratory research has two primary implications. First, understanding the role of pretend play in emotion learning requires the study of diverse families experiencing a range of emotional events. Past research suggested that children experiencing stress do not engage in solitary pretend play, or pretend much less frequently. This exploratory study suggests that some traumatized children do pretend frequently in the supportive context of mother-child interaction. Future research on pretend play as a context for emotion socialization should recruit diverse families to consider the range of emotion enacted during parent-child pretend play, and consider the role of parent-child pretend play in children's recovery from trauma. Unanswered questions for future research include: Do traumatized children who spontaneously engage in parent-child pretend play display better developmental and mental health outcomes than those traumatized children who do not have this resource? What are the characteristics of mother-child pretend play that do or do not support more positive developmental outcomes in traumatized mothers and children?

The second implication is for intervention with traumatized children. Although play therapy is commonly used to support the recovery of traumatized children, rarely are parents utilized directly. For some of the dyads in the current exploratory study, mother-child pretend play was an un-utilized resource for children's recovery from trauma. Such play was mutual and included culturally appropriate messages about stressful or traumatic events. Furthermore, unlike play that is elicited in the context of therapy, spontaneous pretend play emerges in the context of the child's everyday life, as issues

and reactions related to trauma actually emerge, and the child is motivated to communicate about them. For example, in the hands of a skilled play therapist, the pretend play routines that Susan, Dorothy and Anna had spontaneously developed could be used to support systematically their children's recovery from trauma.

Clearly, any use of parent-child pretend play by therapists would need to be utilized with discretion. Some dyads might simply prefer other expressive activities. Clarissa and her mother, for example, seemed to prefer drawing and other forms of creative play which might be a more natural context for this mother and child to begin communicating about traumatic events. In addition, not all mother-child pretend play has the potential to be therapeutic. Anti social tendencies, unresolved trauma, active substance abuse, or unmet mental health needs, for example, may prevent some parents from pretending in an emotionally supportive manner with their young children.

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## References

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders: Fourth edition*. Washington, DC: The American Psychiatric Association.
- Ackerman, P.T., Newton, J.E.O., McPherson, W.B., Jones, J.G., & Dykman, R.A. (1998) Prevalence of posttraumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse and Neglect*, 22(8), 759-74.
- Banyard, V. L., Williams, L. M., & Siegel, J. A. (2003). The impact of complex trauma and depression on parenting: An exploration of mediating risk and protective factors. *Child Maltreatment*, 8, 334-349.
- Banyard, V. L., Williams, L. M., & Siegel, J. A. (2002). Retraumatization among adult women sexually abused in childhood: Exploratory analyses in a prospective study. *Journal of Child Sexual Abuse*, 11, 19-48.
- Bat-Zion, N. & Levy-Shiff, R. (1993). Children in war: Stress and coping reactions under the threat of scud missile attacks and the effect of proximity. In L. Lewis & N. Fox (Eds.) *The psychological effects of war and violence on children* (pp. 143-161). Hillsdale, NJ: Erlbaum.
- Blatt, S. & Simms, M. (1997, April). Foster care: Special children, special needs. *Contemporary Pediatrics*, 113.
- Bowlby, J. (1988). (Ed.) *A secure base: Parent-child attachment and healthy human*

- development*. London: Routledge.
- Bowlby, J. (1988). On knowing what you are not supposed to know and feeling what you are not supposed to feel. In J Bowlby: *A secure base: Clinical applications of attachment theory*, pp. 99-118, Routledge London.
- Bretherton, I. & Beeghly, M. (1982). Talking about internal states: The acquisition of an explicit theory of mind. *Developmental Psychology*, 18, 906-921.
- Bromet, E.J., Goldgaber, D., Carlson, G., Panina, N., Golovakha, E., Gluzman, S.F., Gilbert, T., Gluzman, D., Lyubsky, S., & Schwartz, J.E. (2000). Children's well-being 11 years after the Chernobyl catastrophe. *Archives of General Psychiatry*, 57(6), 563-71.
- Bruner, J. (1990). *Acts of Meaning*. Cambridge, MA: Harvard University Press.
- Burger, L.K. & Miller, P.J. (1999). Early Talk about the past revisited: affect in working-class and middle-class children's co-narrations. *Journal of Child Language*, 26, 133-162.
- Burt, C. (1943). War neuroses in British children. *Nervous Child*, 2, 324-337.
- Campos, J. & Stenberg, C. (1981). Perception, appraisal, and emotion: The onset of social referencing. In M.E. Lamb & L.R. Sherrod (Eds.) *Infants' social cognition: Empirical and social considerations*. Hillsdale, NJ: Erlbaum.
- Cho, G. & Miller, P.J. (in press). Personal storytelling: Working-class and middle-class mothers in comparative perspective. In M. Farr (Ed.) *Ethnolinguistic Chicago: Language and Literacy in Chicago Neighborhoods*. Mahwah, NJ: Erlbaum.
- Cicchetti, D. & toth, S. (1995). Developmental psychopathology perspective on child

- abuse and neglect. *Journal of American Academy of Child and Adolescent Psychiatry*, 34, 541-565.
- Clark, C. (2003). *In Sickness and in Play: Children coping with chronic illness*. New Brunswick: Rutgers University Press.
- Coates, S. & Schechter, D. (2004). Preschoolers' traumatic stress post-9/11: Relational and developmental perspectives. *Psychiatr Clin N Am*, 27, 473-489.
- Cohen, J. & Mannarino, A. (1996). Factors that mediate treatment outcome of sexually abused preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(10), 1402-1410.
- Cohler, B. (1991). Overcoming adversity: Family response to natural disaster. In J. Vofel (Chair), *Children's responses to natural disasters: The aftermath of Hurricane Hugo and the 1989 Bay Area earthquake*. Symposium conducted at the meeting of the Society for Research in Child Development, Seattle.
- Crittenden, P., & Ainsworth, M. (1989). Child maltreatment and attachment theory. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect*. New York: Cambridge University Press.
- Egeland, B., Weinfield, N.S., Bosquet, M., & Cheng, V.K. (2000) Remembering, repeating, and working through lessons from attachment-based interventions. In Osofsky, J.D., & Fitzgerald, H.E. (eds.), *Infant mental health in groups at high risk* (Vol. 4). *WAIMH Handbook of Infant Mental Health*, pp.35-89. John Wiley & Sons: New York.

- Feiring, C., Taska, L., & Lewis, M. (1998). Social support and children's and adolescents' adaptation to sexual abuse. *Journal of Interpersonal Violence, 13*(2), 240-260.
- Fraiberg S, Adelson E, Shapiro V. J. (1975). Ghosts in the nursery. A psychoanalytic approach to the problems of impaired infant-mother relationships. *American Academy of Child Psychiatry, 14* (3), 387-421.
- Freud, A. & Burlingham, D. (1943). *War and Children*. London: Medical War Books.
- Garnezy, N. (1985). Stress-resistant children: The search for protective factors. In J. Stevenson (Ed.), *Recent research in developmental psychopathology* (pp. 213-233). Oxford: Pergamon.
- George, C., Kaplan, N., & Main, M. (1985). The Adult Attachment Interview. Unpublished manuscript, University of California at Berkeley.
- Goodnow, J. (1988). Parents' ideas, actions, and feelings: Models and method from developmental and social psychology. *Child Development, 59*, 286-320.
- Goncu, A. (Ed.) (1999). *Children's engagement in the World: Sociocultural perspectives*. New York: Cambridge University Press.
- Greenberg, M., Speltz, M., & DeKlyen, M. (1993). The role of attachment in the early development of disruptive behavior problems. *Development and Psychopathology, 5*, 191-213.
- Groves, B.M. (2002). *Children who See too Much: Lessons from the child witness to violence project*. Boston: Beacon Press.

- Haight, W., Black, J., Workman, C., & Tata, L. (2001). Parent-child interaction during foster care visits: Implications for practice. *Social Work, 46*, 325-338.
- Haight, W., Mangelsdorf, S., Black, J., Szwczyk, Shoppe, S., Giorgio, G., Madrigal, K., & Tata, L. (in press). Enhancing parent-child interaction during foster care visits: Experimental assessment of an intervention. *Child Welfare*.
- Haight, W. & Miller, P. (1993). *Pretending at Home: Early development in a sociocultural context*. Albany: State University of New York Press.
- Haight, W., Parke, R. & Black, J. (1997). Mothers' and fathers' beliefs about and spontaneous participation in their toddlers' pretend play. *Merrill-Palmer Quarterly, 42*, 271-290.
- Haight, W. & Sachs, K. (1995). The portrayal of emotion during mother-child pretend play. In L. Sperry & P. Smiley (Eds.) *Exploring young children's concepts of self and other through conversation*. W. Damon (Series Editor). New Directions in Child Development.
- Haight, W., Shim, W., Linn, L. & Swinford, L. (in press). Promoting children's psychological resilience in violent families: The perspectives of battered women involved in the public child welfare system. *Child Development*.
- Haight, W., Wang, X., Fung, H., Williams, K. & Mintz, J. (1999). Universal, developmental, and variable aspects of young children's play: A cross-cultural comparison of pretending at home. *Developmental Psychology, 70*, 1477-1488.
- Harkness, S. & Super, C. (1996). Introduction. In S. Harkness and C. Super (Eds.)

- Parents' cultural belief systems: their origins, expressions, and consequences.*  
New York: Guilford.
- Heinicke, C. & Westheimer, I. (1966): *Brief separations*, New York: International Universities Press.
- Hertsgaard, L., Gunnar, M., Erickson, M.F. & Nechmias M. (1995). Adrenocortical responses to the strange situation in infants with disorganized attachment relationships. *Child Development*, 66(4), 1100-1106.
- Hess, E. (1999) The Adult Attachment Interview. In J. Cassidy & P. Shaver (Eds.) *The handbook of attachment* (pp. 395-433). New York: Guilford.
- Holden, G., Stein, J., Ritchie, K., Harris, S., & Jouriles, E. (1998). Parenting behaviors and beliefs of battered women. In G. Holden, R. Geffner, & E. Jouriles (Eds.) *Children exposed to marital violence: Theory, research and applied issues.* Washington, DC: American Psychological Association.
- Hughes, F. (1998). Play in special populations. In O. Saracho & B. Spodek (Eds.). *Multiple perspectives on play in early childhood education.* Albany: State University of New York Press.
- Kramer, L. & Schaefer-Hernan, P. (1994). Patterns of fantasy play engagement across the transition to becoming a sibling. *Journal of Child Psychology and Psychiatry.*
- Lieberman AF & Zeanah C (1999). The influence of attachment theory on infant-parent psychotherapy and other interventions with young children. In: P Shaver & J Cassidy (Eds.), *Handbook of Attachment Theory and Research.* New York: Basic Books.
- Lehmann, C, (2001) Psychiatrists Advise Parents in Responding to Children's Concerns

*Psychiatric News*, 3, : 8-28.

- Lynskey, M. & Fergusson, D. (1997). Factors protecting against the development of adjustment difficulties in young adults exposed to childhood sexual abuse. *Child Abuse and Neglect*, 21(2), 1177-1190.
- Lyons-Ruth, K., Alpern, L., & Repacholi, B. (1993). Disorganized infant attachment classification and maternal psychosocial problems as predictors of hostile-aggressive behavior in the preschool classroom. *Child Development*, 64, 572-585.
- Lyons-Ruth, K., Easterbrooks, M., & Cibelli, C. (1997). Infant attachment strategies, infant mental lag, and maternal depressive symptoms: Predictors of internalizing and externalizing problems at age 7. *Developmental Psychology*, 33, 681-692.
- Main, M. (1996). Introduction to the special section on attachment and psychopathology: 2. Overview of the field of attachment. *Journal of Consulting and Clinical Psychology*, 64, 237-243.
- Marand, S. & Adelman, A. (1997). Experiencing violence in a developmental context. In J. Osofsky, (Ed.). Foreword by Peter Scharf. *Children in a violent society*. New York: Guilford Press, 202-22.
- Norwood, A., Ursano, R., & Fullerton, C. (2000). Disaster psychiatry: Principles and practice. *Psychiatric Quarterly*, 71(3), 207-226.
- Parens, H. (1991). A view of the development of hostility in early life. *Journal of the American Psychoanalytic Association*, 39(Suppl), 75-108.
- Perry, B., Silber, E., & Block, D. (1956). *The child and his family in disaster: A study of the 1953 Vicksburg tornado (Publication 394)*. Washington, DC: National Academy of Sciences, National Research Council.

- Punamaki, R. (1987). Psychological stress response of Palestinian mothers and their children in conditions of military occupation and political violence. *The Quarterly Newsletter of the Laboratory of Comparative Human Cognition*, 9, 76-79.
- Pynoos, R. & Eth, S. (1985). Children traumatized by witnessing acts of personal violence: Homicide, rape, or suicide behavior. In S. Eth & R. Pynoos (Eds.), *Post traumatic stress disorders in children* (pp. 17-44). Washington, DC: American Psychiatric Press.
- Pynoos, R., Steinberg, A. & Goenjian, A. (1996). Traumatic stress in childhood and adolescence: Recent developments and current controversies. In B. Van der Kolk, A. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society*. New York: Guilford Press, 331-58.
- Silverman R & Lieberman AF (1999). Negative maternal attributions, projective identification, and the intergenerational transmission of violent relational patterns. *Psychoanalytic Dialogues*, 9, (2), 161-187.
- Singer, D. (1993). *Playing for their Lives: Helping Troubled Children through Play Therapy*. New York: The Free Press.
- Stephens, D. L. (1999). Battered women's views of their children. *Journal of Interpersonal Violence*, 14(7), 731-746.
- Stuber, M., Nader, K., Yasuda, P., Pynoos, R. & Cohen, S. (1991). Stress responses after pediatric bone marrow transplantation: Preliminary results of a prospective

- longitudinal study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(6), 952-957.
- Sutton-Smith, B. (1994). Paradigms of intervention. In J. Hellendoorn, R. van der Kooij, & B. Sutton-Smith (eds.) *Play and intervention*. 3-22.
- Tarullo LB, DeMulder EK, Ronsaville DS, Brown E, Radke-Yarrow M (1995): Maternal depression and maternal treatment of siblings as predictors of child psychopathology. *Developmental Psychology* 31: 395-405.
- Terr, L: "Wild Child": How Three Principles of Healing Organized 12 Years of Psychotherapy. *Journal of the American Academy of Child & Adolescent Psychiatry*. 42(12):1401-1409, December 2003.
- van Ijzendoorn, M.H. (1995). Adult Attachment representations, parental responsiveness, and infant attachment: A meta analysis on the predictive validity of the Adult Attachment Interview. *Psychological Bulletin*, 117, 387-403.
- Vogel, J.M., & Vernberg, E.M. (1993). Psychological responses of children to natural and human-made disasters: I. Children's psychological responses to disasters. *Journal of Clinical Child Psychology*, 22(4), 464-84.
- Webb, N. ((Ed.) (2002). *Helping the Bereaved Child: A Handbook for Practitioners. (Second Edition)*. New York: Guilford Press.
- Wolf, D., Rygh, J. & Altchuler, J. (1984). Agency and experience: Representations of people in early play narratives. In I. Bretherton (ed.) *Symbolic Play: The development of social understanding*. New York: Academic Press.

Yehuda, R., McFarlane, A., & Shalev, A. (1998). Predicting the development of posttraumatic stress disorder from acute response to a traumatic event. *Biological Psychiatry, 44*(12), 1305-13.

Zeanah, C., Mammen, O., & Lieberman, A. (1993). Disorders of attachment. In C. Zeanah (Ed.), *Handbook of infant mental health*. New York: Guilford Press.

Zero to Three: How to discuss terrorism with young children (special issue following 911). (2002).