child when they were happening, but the clinician's empathic naming of Amelia's sense of loss was sufficient to change the mother's inner stance from an authoritarian expectation of compliance to an understanding of the child's plight. She now felt wanted and missed rather than defied. This internal shift allowed Mrs. Sanchez to move rather quickly from denying that she cared about the power struggle with her daughter to a thoughtful acknowledgement that Amelia was angry at her. This inner shift allowed her to give Amelia the autonomy that the child now needed to feed herself.

From a psychoanalytic perspective, we can hypothesize that the failure of Mrs. Sanchez to recognize that Amelia's distress was a response to separation and to weaning, particularly in light of her extensive experience as a mother, might have been due to her ambivalent feelings toward this unplanned baby. We can also surmise that the mother's aggression found expression both in the forced feedings and in her perception of the baby as a "Yankee"—a term with distinct derogatory overtones in Latin America. The fact that the feeding perturbation was resolved without addressing its possible psychodynamic structure suggests that Mrs. Sanchez's loving commitment to Amelia significantly outweighed whatever anger she harbored toward her.

The cultural component of this intervention was an important element of its success. The clinician defused the tension created by the parents' feeling that the referral was unnecessary by openly affirming the parents' competence and authority. She then tried to make Amelia's striving for autonomy more acceptable to the parents by linking it to their perceptions of the child as "a little Yankee" who partook of the assertiveness and valuing of independence they attributed to this country. The clinician never took issue with the mother' feeding practices but suggested instead an alternative approach that incorporated what she had learned about the parents' values and point of view. This approach proved effective. In three sessions, the child's food refusal was largely resolved, as confirmed in follow-up telephone calls 1 month and 2 months later.

Expectable Anxieties of the Early Years

Along with the epigenetic development of progressively more advanced capacities to act, think, and feel, children also experience a parallel unfolding of developmentally expectable anxieties. As described in Chapter 1, the primordial anxieties consist of fear of abandonment, fear of losing the parents' love, fear of body damage, and fear of being bad (Freud, 1926/1959c). While emerging sequentially in the first 4 years of life, these four anxieties usually overlap. Each of them takes center

lead to the formation of conflicted and conflict-free areas of functioning (Hartmann, 1939).

The fear of being bad is also known as fear of losing self-esteem or fear of superego condemnation, and it signals the young child's progressive internalization of social standards of right and wrong in the form of an emerging moral conscience. Jerome Kagan (1981) has shown that 2-year-olds cry or become upset when they are unable to perform a difficult task if they believe that they are not meeting the expectations of an adult observer. Conversely, the same children show spontaneous joy when they meet a self-imposed standard, such as solving a difficult puzzle or building a six-block tower. Forming and maintaining a moral conscience is a protracted process, with many inconsistencies between self-image, expectations, and actual behavior. It is common to observe toddlers telling themselves "no!" or "bad!" while performing the very same action they are reproaching themselves for. Between 3 and 4 years of age, children begin to feel remorse not only for their actions but also for their feelings of aggression, which they believe make bad things happen. Children of this age blame themselves for events over which they have no control, including marital quarrels and parents' bad moods, illnesses, and even death. The magical quality of their reasoning leads them to attribute to their thoughts, feelings, and fantasies the power to become reality. This might be the origin of the fear of monsters, witches, and wild animals lurking in the dark of the child's room that is so prevalent during this developmental stage.

The anxieties of infancy and early childhood cannot be articulated in words but are enacted in behavior that may seem incomprehensible and irrational from the adults' point of view. The parents may misinterpret expressions of fear as manipulation, disobedience, or bad manners, and they may respond punitively in ways that perpetuate the unwanted behavior. The role of treatment providers is to translate the child's behavioral language into words so that the parent can understand the child's inner life and there can be better emotional communication between the child and the parents. The example that follows illustrates the treatment of a perturbation that originated in the overlap between the child's fear of body damage, fear of being bad, and maternal angry response to the child's behavior.

Example: Maysha and the Tiger

Maysha, age 3 years, 4 months, was brought to treatment by her parents at her day care teacher's suggestion because she had been waking up screaming several times during the night, insisting that there was a tiger

under her bed. Maysha had also become intensely afraid of the dark and was irritable, prone to crying, and aggressive with peers during the day. This behavior had started approximately 2 months earlier and it showed no signs of abating, although some days and nights were calmer than others. Maysha's mother and father were exhausted from lack of sleep, worried about their daughter's condition, and eager for help.

The Parents' Perception of the Problem

The initial session took place with the parents alone in order to learn about the parents' perception of the situation, Maysha's developmental history, the parents' functioning and background, and the family's circumstances. Mr. and Mrs. Lester were a middle-class, college-educated African American couple in their late 20s. Both of them worked in white-collar occupations and were reasonably satisfied with their jobs, their financial situation, and their marriage. They had been married for 5 years and had fallen in love "at first sight" when they met at a church function. Mrs. Lester reported laughingly that their grandmothers had known each other since childhood and had always wanted them to meet, but they had wanted to find their own soulmates without family interference and declined their respective grandmothers' urgings to go on a blind date together. Both parents were clearly pleased by the unexpected success of their grandmothers' plans. The pregnancy had been planned and welcomed. Maysha was the first grandchild on both sides of the family, and the Lesters reported feeling blessed by the amount of support that they had in raising their child. Maysha had been attending the same neighborhood day care center since she was 6 months old and the mother had returned to work. They reported no developmental or behavioral difficulties until the problem that had brought them in for treatment.

When asked about their perceptions of Maysha's behavior, the tone of the exchanges became noticeably awkward, and each parent urged the other to take the lead. Sensing their discomfort, the clinician sought to reassure them by explaining that preschoolers often show the kind of behavior that Maysha was displaying, and added lightly that parents seldom found this reassuring because it is so hard to live with a child who woke up at night, was afraid of wild animals that did not exist, and was aggressive at school. The parents looked relieved, and the clinician went on to ask how they had already tried to change Maysha's behavior. They reported the usual range of behaviors that well-meaning parents usually employ in similar circumstances: saying a prayer before going to bed, asking Jesus to protect her, looking under Maysha's bed and in her closet to show her that there was no tiger lurking in her room, leaving

a night light on in the hallway next to her room, and talking to her reassuringly from their bedroom when she woke up during the night. When none of this helped, one of the parents came into her room for a few minutes, spoke reassuringly while patting her, and told her to go back to sleep. They then let her cry herself to sleep.

This set of strategies seemed like a textbook description of how to intervene, and when the clinician commented on this, the mother reported that she was an avid reader of childrearing books and had "done her homework" in trying to help Maysha during this difficult period. Nothing seemed to work, however, and the parents felt they needed outside help because they were beginning to worry that there was something really wrong with their child.

When the clinician asked what "really wrong" might mean, the earlier awkwardness returned. There was a long silence. The clinician asked if they worried that someone had hurt Maysha. The mother said, reluctantly: "Well, you hear so much about children being sexually abused in day care. There is a male teacher, and although he seems really nice, you never know." The clinician asked if they had seen anything inappropriate in the teacher's behavior, and both parents said they had not. The children at the day care center seemed to like him and the parents could detect no difference in the ways Maysha spoke about him and about the female teacher when she came home from school.

Maysha's Concerns

The next session involved Maysha and both parents and took place in the office playroom. Maysha was a dainty little girl, dressed in a velvety pink sweater with hearts and wearing glittery pink shoes. The clinician had provided a range of age-appropriate toys that included African American mother, father, and daughter dolls; a baby doll with a bottle; a furnished doll house; a kitchen set; and a set of farm animals and wild animals. She told Maysha that her mom and dad had brought her because the clinician was a lady who helped children when they were scared and angry, and Maysha's parents had told her that Maysha was afraid of a tiger under her bed, could not sleep at night, and was angry with her friends at day care.

While seeming to ignore the clinician's explanation, Maysha was busy examining each of the toys and then carefully putting them back in their place before examining the next one. She then sat on the floor, sighed, and looked at her mother as if asking: "What next?" The same question seemed to be in everyone's mind, because the parents looked at the clinician in a silent search for guidance. The clinician sat on the floor facing Maysha and said: "You can do whatever you want here. All these things are here for you."

Without saying a word (she had not spoken since she had first come in), Maysha looked around and then, without hesitation, went to the baby doll, looked at it, and started undressing it. When she got to the underwear, she struggled with it briefly and then gave it to her mother, saying: "Take it off." Mrs. Lester complied. Maysha looked intently at the doll's genital area, which was indistinctive, and after some hesitation fingered it gingerly. She then said to her mother, very seriously: "Put her clothes on." She had clearly thought of the doll as female, but it was unclear whether this was because she attributed her own sex to the doll or because of the absence of male genitals. Maysha watched soberly as her mother dressed the doll, went to the family of dolls, and systematically undressed each of them, looking intently in their genital area. The clinician said: "I think you are trying to see the difference between girls and boys." Maysha nodded in agreement without looking up and continued manipulating the dolls. The clinician continued: "Maybe you saw boys and girls peeing and pooping in your school." Maysha nodded again, this time looking at the clinician, who said: "They are very different, aren't they? Boys and girls don't look the same where they pee."

The parents were listening attentively and exchanging glances with each other. The clinician said: "Your mom and dad did not know that you want to find out about boys and girls." Taking this cue, the mother said a little awkwardly but with much clarity: "These dolls are just pretend. They are not made like boys and girls. Boys have penises and girls have vaginas." Perking up, Maysha asked: "Do I have a penis?" The mother answered that she did not have a penis because she was not a boy, but she had a vagina because she was a girl. Maysha hit the mother's arm and said grumpily: "But I want a penis!"

This response took everyone by surprise. Mrs. Lester later told the clinician that, on the basis of her reading, she had expected questions about sex differences to emerge at some point. She had been preparing herself to answer questions about who had a penis and who had a vagina, but she was totally taken aback by Maysha's circumventing of this plan with her plaintive disagreement with how things were. In the silence that followed, Maysha looked around the room, took the giraffe from among the wild animal set, and put it between her legs. "I have a penis!," she announced.

The parents looked pained and worried. The clinician said: "You can play that you have a penis. Penises don't come off like that giraffe. Girls never have real penises and boys never have real vaginas, but they can pretend that they do." Maysha jumped all around the room holding the giraffe in place and saying: "I have a penis, I have a penis!" She then stopped in front of her father and said: "Do you have a penis?" Mr. Lester answered "Uh-uh." Maysha said: "Can I see it?" Mrs. Lester

came to her husband's rescue, saying: "No, sweetie, that is private." Maysha put the giraffe down, sat on the floor, and started trying to dress the dolls, asking her mother for help. At the end of the session, on saying goodbye, the clinician said to Maysha: "You learned something really important today. You can ask your mom and dad for help to remember it." She then suggested that the parents call her to discuss over the phone what had transpired.

During the telephone conversation, the mother expressed amazement at Maysha's clear distress over not having a penis. She said that the parents had tried to pursue the topic of sex differences on the way home, but Maysha was not interested. The clinician suggested that Maysha might have had enough of the topic for the time being, and that she might bring it up again spontaneously when she was ready. In the meantime, the parents could observe her behavior to see what they could learn from it.

Before the following session, Mrs. Lester called to inform the clinician that in the intervening week Maysha had insisted on watching when her father went to the bathroom, something that was against the parents' values and he refused to allow. The clinician supported this stance, explaining that there were different ways of teaching children about sex differences and that it was important to do it in a way that felt right to the parents. The mother also reported that Maysha had continued to place small objects between her legs and declaring that she had a penis. At school, she had asked her friend Joshua if she could look at his penis when he peed, causing much embarrassment to Joshua and some hilarity in the children who heard her request. The teacher took this opportunity to tell the class matter-of-factly about the differences between boys and girls, an explanation that was followed by the expectable series of questions about who had a penis and who had a vagina. Maysha did not participate but listened silently to this exchange.

For the next session, the clinician provided two anatomically correct dolls, a boy and a girl. When Maysha arrived, she went immediately to them and proceeded to undress them. She put the two naked dolls side by side, and looked systematically from one to the other. She said to her mother: "Why doesn't she have a penis?," pointing to the female doll. "Because she is a girl," said the mother. "Girls have vaginas so that babies can grow inside them when they are ready to be mommies." Maysha answered decisively: "Boys can have babies too growing inside them." The mother answered: "No, they can't. If they have a penis, they can't have babies inside them because they don't have room." Maysha asked: "Will I have room?" The mother answered: "Yes, you will. You are made inside so that there will be room for a baby when you grow up." The mother then spontaneously took a pen from her purse, asked

the clinician for some paper, and drew a boy and girl with the appropriate genitals. She then sang Fred Rogers's song about "girls are fancy on the inside, boys are fancy on the outside," which she had learned while growing up.

The Outcome

After this session, Maysha's behavior took a dramatic turn for the better. Her fear of the tiger diminished to the point that a cursory look under the bed was now enough to satisfy her that it wasn't there. She continued waking up once or twice during the night but went back to sleep by herself with minimal parental intervention. Her aggression in school declined markedly. She continued showing interest in pregnancy and in sex differences, but she no longer tried to go into the bathroom with her father and did not ask Joshua to watch him when he went to the bathroom. In follow-up telephone calls the next week and in the following 2 months, the mother reported that Maysha often had her hands on her genitals and looked dreamy while riding in the car, watching TV, or being told a story, and she liked to soap herself thoroughly between her legs when taking a bath. Occasionally she put a small object next to her vulva and tried to urinate standing up, but disliked having urine running down her leg and quickly sat down again. A few times she hid a doll under her shirt and said to her mother: "I am having a baby." These behaviors were taken in stride by the parents as a manifestation of Maysha's ongoing effort to learn about the sensations and possibilities associated with being a girl.

The parents' support during this process was pivotal in the resolution of the child's perturbation. The anticipatory reading that the mother had done about children's discovery of sex differences had helped her to answer Maysha's questions appropriately during the initial session. It was particularly noteworthy that she was able to use the adult words for the male and female genitals rather than resorting to colloquialisms, something that she attributed to the books that she read. In spite of this excellent preparation, the mother needed some help in retaining her flexibility and emotional balance to cope with the child's unexpected initial rejection of her gender status. Maysha's disappointment about not having a penis could well have become more persistent with a less supportive response from her parents and her teacher. The father's firm stance in preserving his privacy according to his values conveyed to Maysha a clear message about what was appropriate and was not appropriate in her family. The mother's drawing of a boy and a girl gave the child an appropriate channel to symbolize her curiosity without overstimula-

tion, so that Maysha no longer showed interest in watching her father or other boys in her day care center. The quick resolution of what had been a protracted behavior problem indicates how important it is to identify accurately the source of a child's difficulties and to respond with a combination of developmental guidance and emotional support.

The cultural differences in background between these African American parents and the Asian-born clinician did not interfere with their smooth communication. The parents asked casually about the origin of the clinician's accent in the second session. The clinician answered factually and asked whether their different backgrounds might make it more difficult for them to talk with her about their concerns. The mother replied that their pediatrician was Asian and that they were used to people of different backgrounds. The clinician invited the parents to let her know if they found that she did not understand their point of view for whatever reason, including having a different cultural perspective, and they agreed to do so. The topic did not come up again. This exchange illustrates the usefulness of addressing cultural differences as an integral component of all interventions, without waiting until the issue raises a communication problem but without making it a central topic unless this is clinically indicated.

The Role of External Events in Perturbations

Children respond to environmental events with a range of responses that are influenced by the nature and magnitude of the event, the child's individual characteristics and developmental stage, and the supports available from the parents and other significant people. Responses to environmental changes run the gamut of children's behavioral, social, and emotional problems. Temporary regressions in developmental milestones are frequent responses to environmental changes, and they include reverting to baby talk in children who were speaking at age-appropriate levels, wanting to nurse in children who had been successfully weaned, and regressions in toilet training. Mood changes and changes in biological rhythms are also a common response, with the child becoming subdued and withdrawn, losing appetite, or developing sleep problems. Other manifestations are temper tantrums, increased aggression, and oppositional behavior.

DC:0–3R includes a diagnostic category labeled adjustment disorder for mild, transient situational disturbances that last no longer than 4 months and are clearly tied to environmental changes or events, such as a family move, a change of caregiver, the mother's return to work, an illness in the family, or the birth of a sibling (Zero to Three: National

Center for Infants, Toddlers, and Families, 2005). Events that from the adult's point of view seem quite ordinary may represent a major source of worry or distress for a child. For this reason, it is imperative to ask very specific questions about any changes in the child's or the family's life when a child is referred. Seemingly minor changes might affect the meaning that the child attributes to people and routines and lead to major disruptions in the child's sense of safety and predictability.

The intensity and duration of the perturbation usually increase when the environmental change coincides with a developmental touchpoint that makes the child particularly vulnerable to additional stress. When the child is undergoing such a transition, it is preferable if at all possible to postpone changes that will disrupt the child's daily routine. For example, if the child is at the height of separation anxiety it is better to wait until it subsides to institute a change in caregiving routines. Toilet training is best postponed if the child is in the midst of an intensely negativistic period. The time spent waiting for a more propitious timing will be recouped by a faster and smoother child adjustment to the new situation.

Interventions that target perturbations caused by environmental changes need to be tailored to the specific characteristics of the event, but their intent is similar to interventions for perturbations resulting from maturational changes. Both situations involve efforts to improve the child's self-regulation and developmental progress. Children can be helped to negotiate transitions by (1) familiarizing them gradually with the new environment and new caregivers before a major change takes place, (2) giving them transitional objects that will create a bridge between the familiar setting and the new situation, and (3) incorporating familiar routines into the new situation. For children who are beginning to use language and symbolic play, speaking to them about the changes, giving them a chance to express their reactions through play, and helping them to put their feelings into words are time-tested methods of helping children navigate challenging transitions.