Winnicott's “Capacity to Be Alone” in Normative and Non-Normative Adolescent Development

by

Jennifer H. Roberts

B.A., Gordon College, 1995
M.S., Antioch University New England, 2006

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by

Jennifer H. Roberts

Candidate for the degree of Doctor of Psychology

and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Martha B. Straus, PhD

Dissertation Committee members:
Theodore J. Ellenhorn, PhD
Len Fleischer, EdD

Accepted by the
Department of Clinical Psychology Chairperson
Kathi A. Borden, PhD

on 10-6-11

* Signatures are on file with the Registrar’s Office at Antioch University New England.
Dedicated to Carl and Hildred Schoch
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Abstract

This dissertation introduces and discusses Winnicott’s (1958/1974) capacity to be alone construct and how it is engendered in a child by an attuned environmental framework. Literature from the psychoanalytical, developmental, attachment, and trauma fields are utilized to operationalize the capacity to be alone in terms of attachment status, emotional regulation, executive functioning, and impulse control. The goal was to generate an object relational-developmental framework that will be used as a non-pathologizing lens by which to view the internalizing and externalizing behaviors of adolescents in foster care as well as of youth who have not been placed in substitute care. Clinical implications that result from this model are examined, as well as recommendations for future research.

*Keywords:* Foster Care; Object Relations; Adolescent Development;

  Adolescence (13-17 yrs); Trauma
Chapter 1

Introduction and Methodology

or does some littler bird than eyes can learn
look up to silence and completely sing?

-e. e. cummings

This dissertation explores the implications of an infant’s capacity to be alone for subsequent emotional regulation, executive functioning, creativity, and the developing self in adolescence. The capacity to be alone, a construct put forth by D. W. Winnicott (1958/1974), is an internalization of the presence of the good enough caregiver (Winnicott, 1962/1965) who is reliable and constant. This internalization engenders in the child an ability to tolerate anxiety, thus enabling a child to play and create. As this child ages, she has the necessary frustration tolerance to focus and work. When an infant does not have a dependable caregiver, or when a once-stable caregiver becomes inconsistent, the infant’s capacity to be alone is not engendered, or it is lost. This dissertation applies the construct of the capacity to be alone to understand the pathways of normative and non-normative adolescent development, with non-normative development relating specifically to adolescents in foster care. By using Winnicott’s conceit, this study advances a non-pathologizing perspective on the internalizing and externalizing behaviors of adolescents in foster care. I then discuss ways in which mental health workers can facilitate the capacity to be alone in an adolescent who is currently engaged in internalizing or externalizing behaviors, such as dissociation, intellectualization, lying, stealing, and aggression toward self and others.

Winnicott’s “Capacity to Be Alone”

How does a child learn to play and create? What factors contribute to the imaginative process? What sustains creativity and how does it evolve over time? According to Winnicott (1958/1974), the capacity to be alone, which is a “mature” internal development on the part
of the infant, is a principle component in the development of creativity. The capacity to be alone is manifested in the child as a condition of *unintegration*, and in the adult as relaxation, although both of these states may be more aptly described as authenticity. In this authentic state, according to Winnicott, the child, adolescent, or adult “is able to exist for a time without being either a reactor to an external impingement, or an active person with a direction of interest or movement” (p. 34). The ability to be alone originates, paradoxically, in a relationship—the original relationship between the parent, usually the mother, and the infant. It is this relationship that provides, as Winnicott (1968/2001a) states, the *potential space* between (what was at first) baby and mother-figure, with the baby in a state of near-absolute dependence, and the mother-figure’s adaptive function taken for granted by the baby” (pp. 51-52). It is within this potential space that the infant finds objects—more accurately, the infant believes that she generates objects (e.g., a toy, a blanket, mother’s voice, the infant’s fingers)—that facilitate the growth of the infant’s potential to experience and convey her *True Self* (Winnicott, 1960/1974b).

Achieving the capacity to be alone is a necessary step in Winnicott’s theory of early developmental progression, a construct that posits that an infant has “an inborn maturational thrust toward autonomy” (Stark, 1999, p. 354). It falls to the infant’s environment to facilitate this forward movement, and the environment does so by the *good enough* mother’s utilization of *holding, handling, and object-presenting* (Winnicott, 1962/1965). The good enough mother, or caregiver, is one who initially actively adapts to the needs of the child, but as the child becomes more capable of managing anxiety and frustration related to external failures of accommodation, the good enough mother gradually decreases her provisional output (Winnicott, 1953/1986).

The act of holding occurs in the first phase of the maturation process (i.e., from birth to approximately six months old) in which the infant has *absolute dependence* on the mother
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(Winnicott, 1960/1974a). The mother surrounds the child, protects her, and is attuned to her needs. During this time, there is no separation between the infant and mother. The infant is an integrated entity; that is, the infant has not yet, but is on her way to becoming an “I” as a result of the mother’s holding. Integral to this process is the mother’s primary maternal preoccupation with the infant prior to and just subsequent the infant’s birth (Winnicott, 1956/1975). The baby is able to experience her “I”-ness, her sense of continual being, because the mother is attuned to the infant’s needs in a heightened, sensual manner. This attunement emanates from the mother’s identification with her baby, says Winnicott (1956/1975), an identification based on conscious, and unconscious, remembrances the mother has of herself as a baby. There is direct communication between mother and infant at this time—a nonverbal but physical and psychological communication that occurs as a result of the mother-infant fusion (Winnicott, 1963/1965). The “I” phase, which is the result of the attunement, is the seed of the infant’s ego structure (Winnicott, 1960/1974a); therefore, this is the beginning of ego-relatedness between mother and infant.

In the second phase (i.e., approximately six months old to two years old), the fusion of me/not-me—mother is not an individual/subject but just an extension of the baby—still exists. However, through the mother’s handling, the baby settles into her own skin (i.e., soma) and becomes only relatively dependent on the mother (Winnicott, 1960/1974a). This personalization process fosters a partnership between the psyche and the soma of an infant, and as the psyche becomes ensconced within the body, the baby achieves the state of “I am” (Winnicott, 1960/1974a). According to Davis and Wallbridge (1981), “personalization means…that the psyche is placed in the body…and as cortical control extends, the whole of the body becomes the dwelling place of the self” (p. 38). The infant’s experience of her self in her body provides the baby with her first clue that she is separate from the mother. With this recognition there is advancement towards independence (Winnicott, 1960/1974a). The
baby, who is approximately 18 months to two years old, has reached the final stage in which separation from the mother has occurred. The infant has accomplished “I am alone,” a phase in which she begins to feel omnipotent. During this time, the work of the good enough mother is to furnish the infant with objects to which the infant can relate as creator and manipulator. These objects—blanket, book, toy, stuffed animal, among others—encourage the development of the child’s autonomous self.

Adequate holding, handling, and object-presenting by the mother cultivates an adaptive ego structure within the infant, who then has had the necessary provisional environment in which this structure can be built. These three actions supply the sense of safety and omnipotence needed by the infant in order to spark appearances of the True Self (Winnicott, 1960/1965). This True Self is first seen in gestures generated from personal impulses within the baby. If these spontaneous gestures are given room in the environment (i.e., the impulses are responded to by the caregiver in an attuned and unquestioning manner), the child begins to understand that her presence matters and that she is a creative force. For instance, an infant’s spontaneous cry may elicit food, changing, and/or a pacifier. Or, a baby’s clapping hands cause the caregiver to clap in response; thus, the baby has made music. One result of these experiences is the promotion of a sense of agency within the child.

If, however, the infant has not received good enough holding, handling, or object-presenting from the environment, this environmental failure leaves little room or encouragement for the infant’s spontaneous gesture. A False Self develops which, according to Winnicott (1960/1965), has several related functions. The principle tasks of this False Self are to shield the True Self from exposure and exploitation, to manage the demands of the mother through precocious compliance, and to seek out environments where the True Self can be expressed (Phillips, 1988; Winnicott, 1960/1965).
As an integral part of this developmental process, the capacity to be alone is founded on reliability and, according to Benjamin (1988), “the safety that a non-intrusive other provides” (p. 42). As the child’s expectation of care is reinforced by the caregiver, Winnicott (1958/1974) writes that the child is able to “build up belief in a benign environment,” as a result of being in the presence of a consistent, attuned other (p. 32). Further, when the child’s capacity to be alone is engendered and reinforced by the internalization of a benign environment, the child is able to relax and, claims Phillips (1993), to be bored. Within this boredom, the infant is now open to internal sparks of creativity, which eventuate as play and self-discovery (Jemstedt, 2000; Storr, 1988; Winnicott, 1958/1974). Additionally, a child with the capacity to be alone can better tolerate ambivalence and frustration due to her implicit and explicit memories of having her needs met within a good enough timeframe (Schacht, 2001; Winnicott, 1958/1974). And, as the capacity to be alone is normatively achieved during the personalization phase of the child’s development, frustration tolerance coupled with the infant’s growing sense of self-agency engenders self-soothing capabilities within the child (Hamalainen, 1999).

The “benign environment” for the child or, as Schacht (2001) and Storr (1988) have theorized, for the adolescent and adult, must be maintained, or the individual’s capacity to be alone may dwindle. Even Winnicott (1963/1974c) acknowledges that a person is never absolutely independent of her environment. According to Winnicott (1963/1974c), “The healthy individual does not become isolated, but becomes related to the environment in such a way that the individual and the environment can be said to be interdependent” (p. 84). Therefore, if the child/adolescent is not confident that her needs, whether they are physical, such as food, shelter, and touch, or emotional, like support, recognition, and understanding, will be met, the child/adolescent might withdraw from others and her surroundings.

Winnicott (1958/1974) and Hamalainen (1999) differentiate between the desire for aloneness
and escape into loneliness. The child with no expectation loses—or has never had—the ability to tolerate frustration and to postpone satisfaction (Hamalainen, 1999). No longer able, in Winnicott’s (1958/1974) phrase, “to rest contented without external stimuli” (p. 32), the child will become panicked, restless, filled with self-reproach, and in constant pursuit of time-fillers (Hamalainen, 1999; Painceira, 2001). Play is no longer enjoyable, and creativity is difficult to obtain because the child feels secure only by being relentlessly alert to the environment (Greenwood, 2002). There is no space for self-discovery—no room for being—and play becomes impingement. That is, creative play, which requires a meaningful engagement with one’s environment, is experienced as overwhelming, tiresome, and, possibly, frightening.

A significant number of children do not have the necessary environmental conditions that lead to a sustained and sustaining capacity to be alone, which is characterized by frustration tolerance, affect regulation, and impulse control. They have not experienced the good enough mother/caregiver who devotedly adapts to their needs (Winnicott, 1953/1986); instead, they are expected to adapt to hostile and chaotic environments. Some of these children have endured abuse and neglect, and are in foster care. Trauma and attachment disruptions compromise their developing ability to play and create, often leaving them anxious and lonely.

**Children and Adolescents in Foster Care**

According to Orme and Buehler (2001), children in foster care have significant behavioral and emotional problems, and, says Kortenkamp and Ehrle (2002), they are more likely to disengage from school activities, get suspended or expelled, have decreased physical, cognitive, and emotional functioning, and suffer from poor health. A study by Vandivere, Chalk, and Moore (2003) showed that close to 60 percent of young children in foster care, ages two months to two years old, are at increased risk for a developmental delay...
or neurological impairment. Children and adolescents in foster care were a growing demographic in the United States (U.S.) during the 1990s. Whiting (2000) cites a 1996 study that indicates a 44 percent rise in this population from 1986 to 1995, and the national placement rate peaked at 567,000 children and adolescents in 1999 (Child Trends Data Bank). Recent data submitted to the Adoption and Foster Care Analysis and Reporting System (AFCARS) estimate that there were approximately 463,000 children and adolescents in foster care between October 1, 2007 and September 30, 2008. Out of this number, 194,833 individual were between the ages of 12 and 20 years old. Preliminary estimates indicate that 424,000 children and youth were in foster care during 2009 (Child Trends Data Bank).

The emotional problems of children and adolescents in foster care include negative self-evaluations, low self-esteem, and guilt, perhaps due to a belief of the foster child that she was responsible for the failure of the family (Aldgate, Maluccio, & Reeves, 1989; Whiting & Lee, 2003). Kagan (1996) indicates that foster children “fight against feelings of being thrown away, of being disposable, unwanted, and needing to go into a strange home or institution” (p. 75), and these emotional struggles lead to feelings of shame. McWey (2004), referring to 2001 research by Finzi, Ram, Har-Even, Shnit, and Weizman, writes that children who were neglected perceived themselves as incompetent. Furthermore, Browne (1998), citing the studies of Molin (1990) and Triseliotis (1983), states that adolescents who have experienced multiple moves often have an unstable sense of self-identity as well as a tenuous belief system. These affective and ideational states, either alone or in combination, potentially engender the development of internalizing and/or externalizing behaviors on the part of the adolescent in foster care.

For instance, Whiting and Lee (2003) discuss the tendency in foster children to withdraw into a world of fantasy in order to deal with their feelings of abandonment. Winnicott (1971/2001) differentiates between dreaming and fantasying: with dreaming (and
creative playing), there is an interaction with reality, and a working through occurs which facilitates learning; however, “fantasying interferes with action and with life in the real or external world” (p. 31). In the case of fantasy, the child cannot symbolize her experiences; therefore, says Winnicott, “a dog is a dog is a dog” (p. 33). Thus, although the use of dissociation provides the child with an initially effective way in which to deal with uncertainty and traumatic incidents, the long-term result is a psyche divorced from its soma, personal historical gaps, and an unstable and incomplete sense of self.

In their review of literature on the behavioral and emotional problems of foster children, Orme and Buehler (2001) also found that disrupted parenting was related to higher levels of externalizing problems in children. Kagan (1996) lists several reasons why children and adolescents in foster care “act out.” These can include escape strategies from toxic home environments, the redirection of rage away from the parents in order to preserve the attachment, attempts at control, and the modeling of learned behaviors. Similarly, Winnicott (1956/1997) believes that the antisocial child and adolescent is eliciting from society, through aggressive actions, the structure and security denied to her by depriving and unstable caregiver relationships. The antisocial tendency is an expression of hope on the part of the adolescent and child, claims Winnicott. It is a hope that the current environment will locate and legitimize the grievances experienced by the child in her early environment so that appropriate reparations can be made, and then the developmental process of the child and adolescent can be reignited (Phillips, 1988).

Whiting’s (2000) belief that insecure and poor attachment experiences engender behavioral and emotional problems in foster children echoes Winnicott’s (1956/1997) theory regarding the development of the antisocial tendency. Without the reliable presence of the caregiver to facilitate in the child the capacity to be alone, the child is unable to learn self-soothing techniques; there was no one who initially soothed her. A state of unintegration,
which accompanies the capacity to be alone, is intolerable for the child because she did not experience the holding needed to produce an initial sense of integration. Unintegration feels like disintegration for the child who was not held. Thus, rather than welcoming the peaceful state of unintegration, the child lives in fear of terrifying disintegration. A very low tolerance for frustration or ambivalence, combined with heightened anxiety, severely compromises the child’s ability to concentrate, focus, and maintain interest. Instead, as Greenwood (2002) states, “more denial or ‘acting out’ is needed to smother the feeling which threatens to overwhelm” (p. 296).

Storr (1988) points out that the capacity to be alone is negatively impacted not only by a child’s fear of abandonment, but also by the placement of too many expectations on the child. In the best case scenario, these expectations may come from foster parents who are attempting to set limits with and/or teach the child; however, the fostered youth may experience rules and exhortations as impingements. However, many foster children seem to be the recipients of negative expectations, which may further undermine the psychosocial functioning of foster youth. For example, Aldgate, Maluccio, and Reeves (1989) cite a 1983 study by Festinger, which indicated that social workers and foster parents who pushed foster children to accept the limitations of their educational opportunities inhibited the foster children’s learning capabilities. Foster children are additionally burdened by low expectations from their peers. Within this same study, foster children reported that they did not like to be known as foster children because other children treated them poorly. Folman (1998) also posits that foster parents tend to interpret the behavior of their foster children in a more deleterious light than they interpret the behavior of their “own” children.

The capacity to be alone, with its concomitant self-soothing, behavioral control, mental focus and flexibility, and creativity, may be undeveloped or completely thwarted for children and adolescents whose early home environments were so unstable, neglectful, and
dangerous that they had to be removed from these settings. Foster children are then likely to contend with the additional loss of home(s), the disruption of attachments, and the unrealistic or negative expectations of others. While the early environmental failure impeded the development of the capacity to be alone, the continual changing of environments further ensures that this capacity is not established. Unfortunately for the child and adolescent who have not been able to achieve the capacity to be alone, the resulting effects—poor impulse control, mood lability, impaired frustration tolerance—can lead to multiple placements, and persistent experiences of chaos, due to a foster family’s inability to manage the child and adolescent’s behaviors.

Proposal

In the following chapters, Winnicott’s capacity to be alone is employed as a non-pathologizing means of understanding the internalizing and externalizing behaviors of adolescents in foster care. In the process, connections are highlighted between an environmentally-dependent achievement and its subsequent effect on the affect regulation capabilities and executive functioning of children and, later, adolescents. From this framework, with its emphasis on exterior provisional conditions, psychological interventions are suggested that may be employed to engender the capacity to be alone in adolescents in foster care.

Methodology

A critical exploration of the object relational and attachment literature that explores the capacity to be alone construct is required in order to determine the etiology and preservation of this achievement (Chapter 2). Since the capacity to be alone has its origins in the relationship between the infant and her parent(s), and because of its contributions to self-soothing and cognitive-behavioral mechanisms (e.g., concentration and cognitive flexibility to play and/or work), the normative and non-normative (i.e., adolescents who
reside in foster care) adolescent developmental literature will be examined (Chapter 3).
Specifically, literature related to attachment, aloneness and solitude, emotion regulation, and executive functioning must be compared and evaluated as a means of accentuating the role of the capacity to be alone in adolescent behavior. This study further draws on trauma literature on self-harm, dissociation, and aggression to demonstrate how the lack of a self-soothing facility reinforces “acting in” and “acting out” behaviors in adolescents that have experienced complex developmental trauma; the compounding effects of abuse, neglect, and environmental disruptions.

After critically assessing the literatures related to the capacity to be alone, normative and non-normative adolescent development, and trauma, these discourses will be integrated in order to outline an object relational-developmental framework (see Appendix A) for understanding the experiences of adolescents in foster care (Chapter 4). Guided by this model, interventions mental health providers can use to facilitate the capacity to be alone in adolescents in foster care will be suggested. Particular attention is dedicated to these adolescents’ awareness and feelings of longing and belonging (Chapter 5). Since the capacity to be alone is typically achieved when the infant is in a preverbal state, and because of the effects of trauma on the body’s affect regulation system, some of these treatments necessarily include nonverbal components.

This dissertation’s final chapter more broadly examines aspects of current adolescent culture in the U.S. (i.e., technologically-induced connections and/or impingements, and the over-scheduled adolescent). The purpose of this inquiry is to explore whether or not it is only adolescents in foster care, or actually the majority of American teens, who are lacking the capacity to be alone (Chapter 6). Here, recommendations for future research are also provided, including the appropriateness of conducting qualitative research to “flesh out” and expand Winnicott’s concept through the narratives of adolescents who live in foster care.
Chapter 2

Understanding the “Capacity to Be Alone”

I said: “The wonder that I feel is easy,
Yet ease is cause of wonder.”

- T.S. Eliot, Little Gidding, Four Quartets

The Paradox of the Capacity to Be Alone

Winnicott (1958/1974) states that the capacity to be alone is born out of a paradox: “this experience is that of being alone, as an infant and small child, in the presence of the mother” (p. 417, author’s emphasis). For Winnicott, this statement is not a contradiction. Instead, it is a nondual proposition; that is, aloneness and presence, while distinct, are in relationship with each other. One cannot exist without the other, like a mother (or parent) cannot exist without a child. “Such separateness and relatedness,” says Laing (1960/1990), “are mutually necessary postulates” (p. 26). This nondualism occurs throughout Winnicott’s writing and, according to Clancier and Kalmanovitch (1987), an individual’s managing of this paradox is part of the maturation process in Winnicott’s theory of development.

Benjamin (1995) further highlights this paradox in terms of the engenderment of an intersubjective matrix. This matrix, says Benjamin, begins in the affective attunement between caregiver and child and then develops, in the second year of the child’s life, to a tension between “assertion of the self and recognition of the other” (p. 35). The capacity to be alone is both the result and a facilitator of the connection-separation paradox. The child can separate from the other because she has been effectively connected with; indeed, the stronger the experience of this connection, the greater the knowledge of a self and of an other. Therefore, the person is capable of and enjoys intimacy because she knows herself and others as individuals.
Prior to the infant achieving the ability to be in relation to an other, or to being alone, the infant must first, according to Winnicott (1960/1974a), experience creating and manipulating the other as if the other were part of the infant’s actual body. Winnicott states

The paradox is that what is good and bad in the infant’s environment is not in fact a projection, but in spite of this it is necessary, if the individual infant is to develop healthily, that everything shall seem to him to be a projection.

(p. 38)

A robust and resilient ego develops when the infant is able to feel as if her needs are consistently, not perfectly, met by the contingency of “mom” and/or “dad.” “Mom” and “dad” are not yet whole individuals to the infant; they are the givens, akin to oxygen and gravity, on which the infant relies. It is the internalization of the sufficient consistency of “mom” and “dad” that induces a sense of security within the infant. Once the infant feels secure, it becomes less threatening for her to acknowledge and interact with less controllable individuals (i.e., the actual mom and dad).

**Primary Maternal Preoccupation**

Winnicott (1963/1974b) refers to the contingent caregiver as the object-mother and to the actual caregiver as the environment-mother. The infant’s journey from interacting with only the object-mother to having the capacity to relate to and with the environment-mother is fueled by primary maternal preoccupation. Winnicott (1956/1975) refers to this state as a “normal illness” in the mother that enables her “to adapt delicately and sensitively to the infant’s needs at the very beginning” (p. 302). This illness can only develop in mothers who are psychologically healthy and have the capacity to recover from this state of heightened awareness of her baby. Primary maternal preoccupation is a projective identification. Winnicott (1960/1974a) writes that “mothers do in one way or another identify themselves with the baby that is growing within them, and in this way they achieve a very powerful
sense of what the baby needs” (p. 53). (Interestingly, Winnicott indicates that the infant “releases” the mother from this state, thus giving actual, not just perceived, power to the infant. This statement seems to underline Benjamin’s (1988, 1995) contention that the baby is an active participant in the developing mutuality between the mother and her. There is mutual holding between mother and infant.)

The primary maternal preoccupation seems like a deep sleep for the mother who is able to attune to her baby by dreaming of herself as an infant being cared for by her own mother. This psychosomatic tunnel vision is due to a shift, says Stern (2004), in the mother’s mental landscape. Stern calls this psychological landscape the *motherhood constellation*, which is predicated by the mother’s intrapsychic representations of the interpersonal relationship she had with her own, good enough mother. These representations become highly salient with the pending birth of the mother’s infant, so much so that the mother-to-be finds herself yearning for the actual presence of an older, caring woman. Stern states that this older woman would provide means (e.g., time, practical support, etc.) by which the mother, who has fallen in love with her baby, would be able to show this baby love. As Winnicott (1960/1974a) affirms, “mothers who have it in them to provide good enough care can be enabled to do better by being cared for themselves in a way that acknowledges the essential nature of their task” (p. 49).

Stern (2004) indicates that the mother’s new mental landscape is also suffused with a “fearful preoccupation” to make sure the baby is “alive and thriving” (p. 33). The mother protects the infant from things that would physically harm her. Bowlby (1990) similarly underscores the evolutionary and biological imperative that the *ordinary sensitive mother* has to keep her child safe from harm. Bowlby writes that “adequate time and a relaxed atmosphere are necessary” elements that create the ordinary sensitive mother (p. 13). He characterized separation anxiety in a child as a threat to connection between the child and
mother. If the mother is not sufficiently available, the child experiences anxiety, which signals to the child that she is increasingly at risk. The child feels terror because the mother is not there, whether psychologically and/or practically, to protect her.

While Winnicott’s (1956/1975) focus is on how primary maternal preoccupation ensures the security of the infant, the mother’s experience of the child in utero and after birth may also have a profound effect on the mother’s own development. For example, Kinsley et al. (1999) investigated the changes to the neural networks of female rats that were pregnant. The researchers found that pregnancy “may produce long-lived improvements that…contribute to the survival and rearing of pups” (p. 137). Hormones related to pregnancy modify the mother’s hippocampus, which improves her learning and memory, thus making her a better and more attuned provider and homemaker for her pups. Additionally, report Diamond, Johnson, and Ingham (1971), the mother’s hypothalamic connections seem to be enriched as a result of the sensory stimulation produced by interactions with her babies (as cited in Kinsley et al., 1999).

Winnicott (1958/1974) emphasizes that primary maternal preoccupation is achieved by the ordinary devoted mother who is a reliable presence in the child’s life. This reliable presence, says Winnicott (1960/1974b), protects the developing ego of the baby from experiencing “threats of annihilation” emanating both from outside and inside the baby. Winnicott’s focus seems to be on two egos. The first is the body ego, which is the somatic encasement in which the psychological ego both survives and animates the soma. The neglectful or misattuned mother may create an environment in which the infant is in physical danger. Yet, even if this caregiver is able to attune to the child in a degree that will keep the child physically safe, the mother may not be attuned to the point she is able to provide the infant with the appropriate holding and handling that will facilitate the connection of the child’s psyche and soma. Without the protection and motility of the body boundary, the
psyche is particularly vulnerable to threats of annihilation because it has no place to rest, or no frame with which to assert its spontaneous gesture—that is, make meaningful impact—in and on the environment.

Primary maternal preoccupation, which is an essential facilitator of holding, manifests in direct communication between the mother and infant. Winnicott characterizes direct communication as silent communication that is the result of the infant and mother’s experience of feeling merged (Davis & Wallbridge, 1987). According to Winnicott (1963/1974a), “In so far as the object is subjective, so far is it unnecessary for communication to be explicit” (p. 182). This would be Winnicott’s “I” phase in which the mother responds with appropriate holding, that is, direct communication. The mother, says Winnicott (1960/1974a), acknowledges “the infant’s skin sensitivity—touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling,” among other infant characteristics (p. 49). This is a feeling and felt language. Trevarthen (1993) describes the mother acting “particularly quiet and soft if the baby is sleeping, calming if the baby acts distressed, friendly and inviting if the baby is attentive” (p. 130). Stern (1985) discusses affect attunement, which is the capacity of the caregiver to reflect and match the internal emotional state of the infant through the use of various modalities (e.g., touch, vocal pitch, and facial expressions, among others).

Representations of primary maternal preoccupation have been a longstanding artistic and cultural motif. In one of the fifteenth-century Italian painter Andrea Mantegna’s many paintings of the Madonna and Child (Berlin, Gemäldegalerie, 1470) Mary is depicted cradling the sleeping infant Jesus, demonstrating affective and kinesthetic attunement (Benjamin, 1995). The mother holds the child against her chest, her heart beating into the infant’s back. One of her hands holds his tilted head still while the other rests gently on the infant’s chest. While there is no eye-to-eye mirroring, the observer may sense a mirroring of
the dyad’s heartbeats. The mother’s shawl, wrapped closely around her, parallels her holding of the infant as well as the swaddling of the infant. The mother is not asleep—her head sits lightly on the top of the child’s head, and she appears to be staring into space. Her eyes and mouth are not engaged in communication, but her whole body seems engaged with her sleeping infant.

Integration

In this “I” stage in which direct communication is possible, the mother is still an object-mother to the infant. The developing baby can only tolerate the difference and separateness of the environment-mother if she first has the experience of the sameness and oneness with the object-mother. Stern (1985), who discusses the emergent self of the infant, posits that the infant begins to understand that there is an outside world due to her sensory experiences of this world. Stern’s emergent-self phase is chronologically parallel to Winnicott’s “I” stage (i.e., approximately within the first three months after the child’s birth); however, Stern argues that the newly-born infant has the nascent ability to socially interact with her environment. As a result, Stern states that there is not an autistic, or “I,” phase. Furthermore, according to Benjamin (1995), “Certainly, from the standpoint of the mother whose infant returns her smile this is already the beginning of reciprocal recognition” (p. 34).

Yet, Winnicott is attempting to elucidate the newborn’s experience, and, specifically, how the good enough mother’s act of holding generates the infant’s experience of being in the world (Khan, 1969/1974). Winnicott (1945/1975) believes that the newborn infant does not yet have the capacity to understand herself as separate from her environment. What emanates from the environment or from the infant are experienced as one and the same to the infant. The newborn is in an unintegrated state. It is the caregiver’s consistent psychological and physical holding of the newborn (i.e., primary maternal preoccupation) that provides the necessary boundaries. These boundaries enable the infant to engage in a safe manner with
herself and her surroundings. Moreover, Winnicott (1960/1974a) states that holding is “a three-dimensional or space relationship with time gradually added” (p. 44). That is, holding is felt by the baby and, because of the reliability over time of the caregiver’s ministrations, the infant has not experienced, or minimally experienced, threats of annihilation to her being.

According to Stern (1985), the infant has developed a Representation of Interactions that have been Generalized (RIG) due to the caregiver’s constancy of affect attunement. A RIG is engendered by a memory—even a felt, implicit memory—of a cumulative, consistent response. If a good enough caregiver has been present, then the RIG developed by the infant is of a benign environment.

Therefore, the psychophysiological support of the caregiver engenders the infant’s achievement of integration, or “I.” The infant’s own psyche—ego—has been nurtured into existence. According to Winnicott (1960/1974a), “‘inherited potential’ is becoming itself a ‘continuity of being’” (p. 47). For Winnicott (1968/1992), inherited potential is defined as an individual’s innate tendencies toward physical and psychological growth. Sander’s (1983) discussion of endogenous biorhythmicity evokes comparisons to Winnicott’s (1960/1974a) ideas regarding inherited potential. Endogenous biorhythmicity is a pattern of impulses (e.g., hunger, tiredness, etc.) emanating from within the infant. Stern (1985) refers to these impulses as vital affects. These affects are vital because they are attached to processes that contribute to the actual life of the infant, such as breathing, eating, and elimination, among others. Good enough holding recognizes, appropriately responds to, and, as a result, reinforces the psychobiological vitality and development of the infant.

The achievement of integration is a salient and necessary component of the capacity to be alone. One of the effects of this capacity is the ability of the infant, child, and adult to return to an unintegrated state. From this unintegrated position, the person experiences access to her vital affects as well as her inherited potential. Unintegration seems like a paradox as
the unintegrated person is relaxed and not reacting to impingements but, at the same time, is a live wire. A hum without the constraints of a melody. It is from this static yet electric state that an individual can create, can make a personal mark on herself and her environment.

According to Eigen (1991),

This “impulse-doing” meant acting out of unintegration, forming oneself anew out of the drift, coming together freshly, seeing things with new intensity, throwing oneself on into the fullness of experiencing, being gripped by doing that will make life meaningful because it grows out of “a basic place.” (p. 76)

If, as Winnicott (1962/1974) indicates, that integration is an essential part of the infant’s maturation process that is based on “an imaginative elaboration of pure body-functioning” (p. 60), what does an infant experience when she is not provided adequate holding? Without reliable attunement, the infant experiences gaps in her going-on-being. She may, states Winnicott, undergo “a pattern of fragmentation of being” (p. 60). This fragmentation sets the child up for the development of psychopathology. Winnicott lists “restlessness, hyperkinesis, and inattentiveness” (p. 61) as possible consequences of fragmentation. Most fundamentally, the child cannot safely unintegrate because she has not experienced integration.

According to Winnicott (1962/1974), the infant (and, later, adult) may also utilize disintegration as a means by which to fend off threats of annihilation. “The chaos of disintegration may be as ‘bad’ as the unreliability of the environment, but it has the advantage of being produced by the baby…it is within the area of the baby’s omnipotence” (Winnicott, 1962/1974, p. 61). Because the individual cannot unintegrate due to not having been consistently minded by the caregiver, she inflicts her mindlessness on the outside world. The chaos experienced by others in her surroundings may unconsciously allow her a
reprieve from environmental impingements. Additionally, as this is generated disorder, its creator may concurrently experience meaningful power and impact despite any negative outcomes.

For example, Ms. K., a single mother of an adolescent girl and preschool-aged boy, experienced an early history of physical and verbal abuse as well as neglect at the hands of her own mother. Ms. K.’s mother was diagnosed with depression and, according to Ms. K., abused prescription drugs. As Ms. K. matured, she was involved in several romantic relationships with men who abused substances and who were also physically abusive toward and neglectful of her. Along with these harmful relationships, Ms. K. underwent significant financial hardship.

When she seemed to be experiencing moments of freedom from abuse and was working towards obtaining a professional education and a career, Ms. K.’s engagement in life seemed intermittent. Her involvement was further attenuated by her consistent use of alcohol and marijuana. However, when Ms. K. found herself close to losing a job, an apartment, or her children, she would become dispassionately galvanized. She became the calm eye of the hurricane, sufficiently knowledgeable in taking the appropriate steps to prevent complete unraveling. In this manner, Ms. K. appeared to provide herself with better care when she was complicit in the destruction.

**Personalization**

The caregiver’s provision of handling allows for the next stage of the infant’s ego development to occur: *personalization*. As the primary maternal preoccupation begins to wear off, the infant begins to experience moments in which her needs are not being quickly and appropriately met. There is a *graduated failure of adaptation* on the part of the caregiver (Winnicott, 1949/1975a). That is, handling is a measured progression of environmental failure. The misattunement is not all at once, or ubiquitous, as this would prove to be
experienced as a traumatic shock to and fragmentation of the infant’s going-on-being. As Winnicott (1960/1965) states, “The infant that has known security at this early stage begins to carry around an expectation that he or she won’t be ‘let down.’ Frustrations—well, yes, these are inevitable; but being let down—well, no!” (p. 32).

During the handling phase, the infant’s natural activity and motility is met with some resistance by the caregiver. Winnicott (1950/1975) views the infant’s motility as instinctual and aggressive. Yet, Phillips (1988) underlines that Winnicott does not necessarily equate aggression with destruction. Aggression is the infant’s “careless loving” of the object-mother (Phillips, p. 107). It is the object-mother’s survival of this ruthless loving, as well as the reliable care of the environment-mother, that engenders in the infant a sense of me and not-me (Winnicott, 1960/1974a). The caregiver’s handling of the infant aids in the infant’s understanding of where she ends and the other begins. According to Phillips, “the infant establishes the existence of a separate external world, a world that by resisting [her] affords [her] the definition of [her] own limits” (p. 109). The combination of experiencing motility with boundary enables the infant to achieve “I Am.”

The infant who experiences “I Am” has achieved personalization, which is psychosomatic collusion, or an indwelling of the psyche in the soma (Winnicott, 1970/1989). As the infant becomes more comfortable within her body, she begins to demonstrate her motility and activity with greater control. The infant is beginning to experience a more realistic understanding of the extent of her power. Therefore, with personalization comes meaningfulness. Davis and Wallbridge (1981) further indicate that personalization allows for instincts to be experienced with the “fully intensity of total involvement…[which] in time movement becomes harnessed in the service of specific goals and purposes” (p. 39). Because of psychosomatic collusion, the individual knows how to produce and distinguish her marks on the environment.
Without adequate handling, an infant (and, later, adult) may experience depersonalization (Winnicott, 1970/1989). The environment has proved misattuned to, and unsupportive of, the infant’s development. No limits, or too many limits, have been experienced by the infant. No limits may be perceived as an abyss to the infant. Her psyche will not indwell in her soma for fear of experiencing a great fall and crash. Too many limits may be felt as impingements, or, in the words of Shakespeare’s Hamlet, as “the slings and arrows of outrageous fortune.” The mind flees from (i.e., dissociates) from the body because the individual does not have the capacity to experience the “full intensity of total involvement” (Davis & Wallbridge, 1981).

Corrigan and Gordon (1995) discuss another effect of depersonalization: precocity. According to these authors, when an infant has experienced environmental failure, this child bequeaths parenting duties to her own mind. The precocious child’s mind provides self-holding as a result of the lack of experience with a self-regulating other (Stern, 1985). The individual has become defensively self-sufficient. However, because there is no psyche-soma collusion, the person’s feelings, thoughts, and actions are characterized by omnipotence and unreality, for the over-burdened ego cannot withstand acknowledging the actuality of an other. Instead, Corrigan and Gordon state, the “precocious child or adult tenaciously holds to the relationship to the mind object [with little basis in actual experience]—an object that can be idealized and adored as well as vilified” (p. 20).

For example, Chris, a 14-year-old, male assessment client was characterized as “clumsy,” “inattentive,” and “blank” by his mother and teachers. I similarly observed Chris tripping and walking into objects on several occasions. He reported having significant “memory gaps” and a poor understanding of time. Additionally, Chris often attempted to refrain from experiencing anger because he believed that his anger could “destroy the world.”
He rigidly thought and spoke about his plan to “overthrow the government” and become an “evil leader” in a “new world.”

Chris’s early developmental life was consumed by loss. His mother reported feeling “in a fog” when Chris was an infant and toddler due to the chronic illness and death of one of Chris’s older siblings. Further, Chris only had intermittent contact with his father, a truck driver who was often on the road. His experience of a lacuna in his formative care seemed to be introjected as a hole with himself. This “holeness” was manifested as dissociation between mind and body—he did not experience himself as a “whole” being. Moreover, Chris often attempted to demonstrate a cavalier disregard of any attachment needs he may have that would potentially bridge this “hole.” As Chris indicated, he did not wish to feel attached to others or to the world because “not caring feels safe.” Therefore, depersonalization served as a protective barrier against Chris’s full, psychosomatic engagement with the real world.

Object-Relating

The third stage in Winnicott’s outline of the ego’s maturational process regards object-relating. In order for the infant to achieve the capacity for object-relating, the caregiver must present objects to which the infant can relate. However, the infant must not initially understand that the caregiver is leaving these objects for her. Winnicott (1953/1986) underlines the salience of the caregiver’s not questioning the origin of the object. There should be no intimation that the object emanates from outside the infant’s control and subjective perception. Davis and Wallbridge (1981) further state that “the object in the most primitive relationship is, to the infant, indistinguishable from [her] own self” (p. 39). There is still no other for the infant, only the “I Am” view and experience.

The caregiver’s consistent, even monotonous, monitoring and meeting of the infant’s needs allows the mother to provide appropriate objects and the infant to experience creating these objects (Winnicott, 1945/1975). The baby continues to feel that she has power—that
she is omnipotent. This engagement with omnipotence builds within the infant a sense of her own agency as well as the security to acknowledge the external world and the other. This infant becomes more attuned to, and demonstrative of, her internal sparks of creativity or, in Stern’s term (1985), *vitality affects*.

According to Winnicott (1963/1974a), an “important basis for ego development lies in this area of the individual’s communicating with subjective phenomena, which alone gives the feeling of real” (p. 188). Object-relating facilitates the infant’s continuity of being because the infant knows that she can meaningfully have an impact on her environment as well as bring about internal changes. Due to her experience with omnipotence, the infant can safely begin to see the other. The baby’s internalization of a primarily benign and controllable environment has provided her with the capacity to tolerate anxiety related to chaos and uncertainty; therefore, says Adler (1989), the baby can now relate to objects. In Stern’s language (1985), the infant has been able to establish a RIG of the self-soothing other; therefore, the other does not necessarily need to be present in order to be evoked.

With this internalization of the constant other, the infant achieves the capacity to be alone. Objects no longer need to be the infant’s projections. The infant has the ability to perceive both subjective objects and objective objects (i.e., the object-mother and the environment-mother, respectively). The baby has achieved “I Am Alone,” which is an “acquisition of a capacity for withdrawal without loss of identification with that from which withdrawal has occurred” (Winnicott, 1963/1974a, p. 188). The external environment is real, not ephemeral or fantastic. If the maturing child leaves a particular environment, she no longer believes that this environment disappears. In a Piagetian term (1954/1999), *object permanence* has been obtained. Environmental consistency begets belief in, not just the going on being of the infant, but in the continuity of environmental being. Object permanence also engenders the child’s trust in her own ability to tolerate and manage changes in the
environment. Solipsism has grown into a lifelong negotiation between the internal and external.

For instance, Alejandro, a five-year-old, male therapy client, continued to manifest extreme agitation at the end of each session, despite having attended multiple appointments. Alejandro’s parents had recently separated, and he rarely spent time with his father. Alejandro’s mother reported that she experienced depression after his birth and had difficulty managing his needs. Additionally, Alejandro witnessed his father’s verbally and physically abusive behavior toward his mother, which had led to intermittent familial separations prior to the most recent, long-term separation. Furthermore, Alejandro had been placed in multiple preschool settings since approximately six months old as his mother, who had just completed high school, was attempting to obtain a professional degree. Alejandro and his mother lived with Alejandro’s maternal grandparents. According to his mother, Alejandro did not receive consistent responsiveness and limit setting from either her or her parents.

As a result of Alejandro experiencing continually shifting and occasionally terrifying environments, he was unable to find consistent objects within his environment to which he could relate and assert his agency. The objects were either not present, or they were overpowering. After several sessions, Alejandro’s ability to relate to me grew; however, once I indicated the approaching session end, Alejandro would begin to cry, hide under my chair, and/or attempt to take with him multiple toys with which he had been playing. Despite my verbal reassurances that the toys and I would be present at his next session, Alejandro continued to insist that he take something of me with him. Alejandro’s need and wish for object permanence was also poignantly demonstrated by his writing his name on a piece of paper. Alejandro then asked me to write my name on the same paper. Afterwards, Alejandro tore the paper in two pieces and gave his name to me and kept my name for himself.
True Self/False Self

As previously indicated, the capacity to be alone is facilitated by a paradox as it occurs in response to the presence of a consistent other (Winnicott, 1958/1974). After having received good enough holding, handling, and object-presenting, the child has internalized the consistent other. Holding has begot being, handling has born experiencing, and object-presenting has instilled agency. This child can begin to tolerate frustration, affectively self-regulate, and control her impulses due to having a resilient, solidly built ego structure. The good enough caregiver has enabled the child to feel secure enough to acknowledge objects within her environment that are not only projections and creations of her self.

Winnicott (1960/1974b) divides the Self into two components: True and False. An individual’s True Self emerges in a state of unintegration in which she is able to be susceptible to her inherited potential and vitality affects. This inherited potential, or id-excitements, is elucidated and manifested by the objects found within the environment. Potential space was the construct created by Winnicott (1953/1986) to describe the intermediate, object-filled area between the Self and its environment. According to Winnicott (1967/2001a), potential space is the location within which the individual “engages in a significant interchange with the world, a two-way process in which self-enrichment alternates with the discovery of meaning in the world of seen things” (p. 113). Bi-directional influence is occurring. Beebe, Jaffe, and Lachmann (2005) further state, “Communication occurs when each person affects the probability distribution of the other’s behavior. We believe that when such communication occurs, cognitive and affective changes also occur” (p. 24).

The individual who can meaningfully interact with objects in potential space is utilizing creative apperception (Winnicott, 1967/2001a). The person is both a receiver and a doer—the antenna as well as the wave itself. Like Stern’s (1985) vitality affects, the individual is open to, and can apply, “rushes.” Benjamin (2002) believes that True Self
“refers to this experience of agency as not reactive but inner determined. We are speaking here not of a reified thing but of a state, an affective state that allows for creativity” (p. 48). Like Winnicott’s potential space, Sander’s (1983) open space between caregiver and child facilitates “the exercise of an individually idiosyncratic and selective volitional initiative” (p. 341). An attuned child-caregiver dyad produces potential space, and a sufficient potential space breeds spontaneous gestures. The more secure the individual, the wider her apperception; therefore, the greater the multiplying of her potential(s).

By contrast, if the child has not experienced an attuned, secure environment in which to develop a strong, foundational ego structure, a False Self may take center stage. Winnicott (1960/1974b) holds that even a “healthy” person must utilize her False Self as a mechanism by with to adapt to social mores. However, a False Self that is consistently present, either hiding or defending the True Self, or tentatively seeking out new worlds in which to express the True Self, limits the individual’s capacity to fully and significantly interact with her environment. According to Hubner (1984), “A disturbance within potential space is a disturbance within the world of meaning, suggestive of conscious or unconscious pain and sorrow related to separation from the primary object” (p. 449).

The impinged upon and/or neglected child has not had the opportunity to internalize the constant, responsive object. Instead, this child has had to quickly and impulsively react as if in a life-or-death obstacle course. The external world is not a vehicle for this child’s True Self expression (Benjamin, 2002). The child does not have the capacity to be alone, nor has she experienced, in Bollas’s (1999) felicitous phrase, generative absence. That is, the lack of a capacity to be alone prevents the individual from experiencing and demonstrating her own creativity. The developmental consequences can be severe. As Corrigan and Gordon (1995) state, “The collapse of the maternal holding environment heralds the foreclosure of the generation of self-experience” (p. 12).
The collapse of the holding environment is perilous to the fullness and stability of the potential space. The potential space of the misattuned to, or neglected, child is narrow and precarious. It is akin to a house of cards, or to the house built on sand in Jesus’s parable of “The Foolish Man.” This child’s ego cannot be open to or utilize her own vitality affects. Winnicott (1960/1974b) indicates, “Id-excitements can be traumatic when the ego is not yet able to include them, and not yet able to contain the risks involved and the frustrations experienced up to the point when id-satisfaction becomes a fact” (p. 141). This child cannot tolerate her own longing or desire because there is no belief in it being fulfilled. There is no waiting when there is no object permanence. Loss, and its denial, are always present when there is no hope for resonance and connection. As Beebe and Lachmann (2005) indicate, the infant who grows up in a chaotic or neglectful environment has not experienced a consistent relationship with a safe other; so, she cannot internalize or represent constancy.

Furthermore, the limited area of potential space establishes a constricted choice of objects with which to relate. There are minimal transitional objects (Winnicott, 1953/1986) from which the child can choose and carry an affective (and effective) reminder of the caregiver. As a result, the neglected child’s choices of transitional objects may appear as rigid to others. Yet, she must attempt to choose a transitional object because, as previously stated, living with loss—her one constant—feels unbearable and must be denied. Hubner (1984) posits that substance and process addictions (e.g., gambling, promiscuity, shopping, among others) are the likely objects adopted by an individual who has experienced emotional deprivation. Addiction provides the neglected child with a simulated “rush,” but not access to, nor a vehicle for, her own vitality affects.

The Matrix of Transference

Winnicott (1958/1974) discusses the matrix of transference in the “The Capacity to Be Alone,” which appears to be one of the healthy results of an infant’s ability to
acknowledge and interact with a real, environmental other. The constant caregiver and the secure infant are the points from which this matrix emanates. Winnicott posits similarity between the matrix of transference and friendship. He does so by distinguishing between “love” and “like,” with “like” being the product of ego-relatedness. If two egos are relating, then there is the presence and acknowledgement of two subjects. Satisfaction or, in Winnicott’s terminology, an ego orgasm is obtained through the satisfactory interaction between two individuals.

By contrast, when an individual is not capable of ego-relatedness, the other remains a projected object to be used according to the individual’s need. The person’s inability to conceive of an environmental other results from the early environment’s failure to provide reliable care to the infant. A fully alive, uncontrollable human feels threatening to the individual who did not have the support and safety to develop a cohesive, resilient ego structure. This individual’s psyche has most likely not fully settled into her soma; therefore, potential psychological threats may be experienced and interpreted as terrifyingly as actual physical threats. The body ego for this person is paramount. It has become an overly developed muscle on which this individual relies in order to control her chaotic environment. The body ego must experience some type of relief in order for this person to feel safe. Winnicott (1958/1974) referred to this bodily release as an id orgasm.

Winnicott (1958/1974) discusses the difference between an id orgasm and an ego orgasm. Object-relating appears to be associated with the id orgasm (Winnicott, 1970/1989). This is due to the object in this action being perceived as an extension of the infant. The baby has placed a part of herself into the object; therefore, she experiences a depletion of energy. As this infant has received minimal ego support and, therefore, has not internalized a belief in object permanence, she may experience waiting for the return of the object as intolerable. It is terribly difficult and joyless to wait for the thing that seems never to come (Phillips, 1993).
When the infant is able to create and subsume that which she had projected, she now has the
energy to become physically excited. The infant has provided herself with the sustenance that
ensures her going-on-being. A fictional example is suggested by the relationship of Don
Draper with his once-secretary, now creative assistant, Peggy, on the television show, *Mad
Men*. Their evolving connection represents a shift from id-relatedness to ego-relatedness.
Don, a 1960s advertising executive, has consistently viewed Peggy as his own creation. She
has been the receptacle for his projections—that is, Don has perceived in Peggy his own
positive and negative qualities. After several years of experiencing an id-relationship with
Don, Peggy balks at his assumption that she would join him at a new agency. In response to
Don’s statement that he is not going to “beg” her, Peggy replies: “Beg me? You didn’t even
ask me…Everyone thinks you do all my work. Even you.” Only later, after realizing that he
has been treating Peggy as an “extension” of himself, does Don begin a collegial and
collaborative relationship with her: “With you or without you, I’m moving on. And I don’t
know if I can do it alone. Will you help me?”

Winnicott (1958/1974) provides another kind of example to differentiate between an
ego orgasm and an id orgasm: a child at play. The child who is able to play in a free flowing,
easy, and focused manner is different, says Winnicott, from a “child with marked manic
defence restlessness [who] is unable to enjoy play because the body becomes physically
involved” (p. 419). The former child has the ability to be preoccupied with the game, to be in,
asserts Winnicott (1968/2001a), a “near-withdrawal state, akin to the concentration of older
children and adults” (p. 51). Yet, this preoccupation is not exclusive for, posits Phillips
(1993), “a productive solitude…is linked with quality of attention,” and, for Winnicott,
solitude could be described “only as a presence” (pp. 40-41). Such pleasurable play occurs
within potential space; therefore, it is an action that is built upon the trust established between
the infant and the good enough caregiver. For Winnicott (1968/2001a), the child at play can
use environmental objects as vehicles by which to meaningfully represent and share her dreams, her vitality affects. Play allows symbolization; therefore, it is also communication between the child and her environment. Within potential space lies the intersection of make-believe and reality.

In Winnicott’s (1958/1974) illustration of children at play, the latter child’s excited bodily state trumps the psyche’s connection to the imagination, as well as to the self of the other. The body ego does so in order to ensure protection against threats of annihilation. A physical climax must occur to satisfy the id needs; the climax offers proof that the child is alive. Winnicott (1963/1974a) underlines the infant’s overwhelming need to experience and exert aliveness if she has been raised by a depressed and, therefore, inconsistent caregiver. Due to the “anti-life factor derived from the mother’s depression…the task of the infant in such a case is to be alone and to look alive and to communicate being alive…to be alive is all” (Winnicott, 1963/1974a, p. 192).

For example, Rosalie, an eight-year-old, assessment client, was in constant motion throughout the testing sessions. Rosalie was an adopted child of parents who were also raising five other adopted children. Prior to the age of five years old, Rosalie lived in multiple foster care placements, after having been removed from her biological parents due to neglect. Her biological parents abused drugs and, consequently, were not cognizant of or meeting Rosalie’s physical and emotional needs. While her adoptive parents were attempting to repair the attachment damage that had been done to Rosalie, the presence of five other children under the age of 12 years old invariably diverted their attention away from Rosalie.

During assessment sessions, Rosalie would also talk to herself while working on a test. She appeared to be boosting her own energy, as manifested in her saying, “That’s right” or “I think I got it.” There was rarely a blank, empty space left on her drawings. The page would be filled with color, people, and flowers, with Rosalie giving voice to her efforts. Her
energy did not seem free flowing; it appeared staccato, a constant stopping and starting, trial and error. When not on the move, Rosalie’s energy seemed completely dissipated. She looked barely present. There was no animation, and she appeared half her physical size. There seemed to be no in-between place for Rosalie, no, in Epstein’s (2001) phrase, capacity for “meditation in action” (p. 25). She was either a sprite or a ghost.

Approaching Winnicott’s (1958/1974) construct of id orgasm from a psychobiological model, Schore (2003b) discusses how “active parental participation in state regulation is critical to enabling the child to shift from the negative affective states of hyper-aroused protest or hypo-aroused despair to a re-established state of positive affect” (p. 11). Schore (1997/2003a) also states that attachment experiences both moderate and are moderated by the “emotion-processing right brain” (p. 126). If the infant has not developed the capacity to be alone via attachment to a reliable caregiver, the child’s sympathetic nervous system may quickly become aroused. This arousal is akin to the body’s response to being in danger. The body is on alert; it needs a physical intervention through which the nervous system is reset, so it can return to its resting state.

When the sympathetic nervous system takes over, and due to its communication with the child’s maturing right brain, the child becomes affectively dysregulated, and her capacity to tolerate frustration decreases. The child may act impulsively to release the heightened tension in the body. The endangered organism has only three paths open to it with which to protect herself and decrease the tension—fight, flight, or freeze. Winnicott’s child (1958/1974) cannot enjoy play because the game is no longer a way with which to connect to the imagination and the creation process, or to another child. The game has become actuality. In the body of the insecurely attached child, it has become life or death.

Another way in which a child who cannot tolerate the sensations of frustration and anxiety may obtain relief is boredom. According to Phillips (1993), boredom is a defense
against desire and waiting. Boredom appears to be withdrawal—a defensive exclusion (Bowlby, 1990). It is a dis-engagement and a dis-association. Winnicott (1958/1974) differentiates between the therapy patient who is silent as a form of resistance compared to a patient who is “being able to enjoy being alone along with another person who is also alone,” a state which he refers to as “healthy” (p. 417). Although both are experiencing aloneness, there remains recognition of the other’s presence. For the neglected child, boredom may feel like much of the same as the early lack and deprivation. However, the bored child is at least experiencing some sense of agency as she deprives herself. Her self-inflicted lack protects her against acknowledging the support the support that had been denied her. As Phillips indicates, “Solitude is a journey, a potentially fatal journey, for an infant in the absence of sufficient maternal care” (p. 28).

**Object Use and the Gift of Reparation**

As previously mentioned, Winnicott (1960/1974a) discussed how the infant’s aggression (i.e., careless loving) toward the mother facilitates the establishment of the me/not-me boundary. The boundary becomes established because the environment has survived the child’s aggression—it exists in actuality. In his article on “The Development of the Capacity for Concern,” Winnicott (1963/1974b) emphasizes the centrality of the infant’s use of the object-mother in order to establish in the infant the general, and generalizable, ability for recognition of the environment-mother. Winnicott states that failure of the object-mother to survive or of the environment-mother to provide reliable opportunity for reparation leads to a loss of the capacity for concern, and to its replacement by crude anxieties and by crude defences, such as splitting, or disintegration. (p. 78)

It is the survival of the other that enables the child to transition from object-relating to object-using. Winnicott (1967/2001b) believes that “the use of an object symbolizes the
union of two now separate things, baby and mother, at the point in time and space of the initiation of their state of separateness” (pp. 96-97). The infant has utilized her motility and aggression to create something new and meaningful out of an environmental object. This object has survived the creation process and has not retaliated. Further, if the object has occasionally not been present or has been significantly damaged by the infant, it has still been attendant enough so that its return is expected, and does not meet with retaliation from the infant. Indeed, the resilient object teaches the child both the parameters of her agency as well as the necessity of her responsibility.

Beebe and Lachmann (2005) posit that a pattern of attachment disruption and repair between caregiver and infant feeds into the infant’s capacity to represent and internalize her interpersonal experiences. Beebe and Lachmann define representations as “relatively persistent, organized classifications of information about an expected interactive sequence” (p. 210). The child’s experience of consistent repair, and the security this consistency provides, allows her to not act defensively. There is no need for withdrawal or attack. Schore (2003b) states that the process of re-experiencing positive affect following negative experience is critical to the child’s learning that negativity can be tolerated and endured and that “infant resilience is [best] characterized as the capacity of the child and the parent for transition from positive to negative and back to positive affect” (p. 11). Therefore, the infant’s aggression remains harnessed in the service of creation (e.g., play and work), not destruction. Moreover, the child’s own reparative overtures and experience of her generative abilities reinforces her feelings of self-worth. For Winnicott (1964/1997a), even with earlier developmental requirements having been appropriately met by the good enough caregiver, “a child needs to give even more than to receive” (p. 97).
Summary

The capacity to be alone emerges in a child who has experienced consistent attunement and support from her caregiver(s). A benign environment is internalized within this child whose creative apperceptions have been perceived by an other. As Benjamin (2002) stated, “Recognition of the specific individual enhances agency, self-cohesion, and ultimately the capacity to recognize the other” (p. 46). The capacity to be alone is a belief in self and other. It is characterized by frustration tolerance, affect regulatory abilities, impulse control, cognitive focus, and collaboration.

In the next chapter, models of adolescent development will be reviewed with the purpose of determining how the capacity to be alone is manifested in this developmental phase. Therefore, particular attention will be given to the attachment experiences, as well as to the emotional, cognitive, and behavioral functioning of adolescents. Additionally, literature discussing the biopsychosocial functioning of adolescents in foster care will be examined to delineate how the lack of the capacity to be alone may negatively affect adolescent development.
Chapter 3

Normative and Non-Normative Adolescent Development

Normative Adolescent Development

Psychological theories regarding normative adolescent development abound and have historically been divided up amongst the sub-theories within the psychology field, such as psychoanalytical, feminist, and cognitive. Under the psychoanalytical rubric, Erikson (1998) discusses how the main task of the 12- to 18-year-old is to search for, identify, and commit to elements of one’s identity. This search is aided by the adolescent’s entry into a widening circle of influences, including school peers and vocational opportunities. If the adolescent successfully navigates this crisis, she will obtain the basic strength of devotion and fidelity: to this identity, to friends and loved ones, and to causes that enhance and reflect the solidified identity. However, if the adolescent is unable to advantageously meet this dilemma, she will suffer role confusion within the greater society.

Like Erikson (1998), Blos (1962) sees adolescence as a “complex, individuation experience…which leads in its final step to a sense of identity” (p. 12). According to Blos, the adolescent determines what is “me” and “not me” through the use of rebellion and experimentation. Since this is an individuation process, the adolescent undergoes isolation and loneliness, primarily through the gradual unraveling of emotional and practical ties to her family. Due to increased interactions with society, the adolescent also must come to terms with her limitations, and how these limitations affect the possible fruition of childhood dreams and fantasies. If an adolescent feels too fearful or panicked during this process, she may attempt to prolong adolescence, which, says Blos, is “an indefinite respite on the way to adulthood, [resulting], like any excessive perseveration on a developmental stage, in the deformation of personality attributes” (p. 223).
Winnicott (1963/1997) also perceives adolescence, in part, as a separation-individuation process, claiming, “The adolescent is essentially an isolate” (p. 147). The adolescent is struggling with identity—with creating an identity that will feel real to her—and is resisting forces that feel false and may foreclose this identity search. Therefore, the adolescent becomes an isolate in order to prevent her tenuous and ambiguous identity from becoming overwhelmed by the influences of others. Paradoxically, the adolescent seeks to engage with peers as a means by which to explore possible identities and their goodness of fit for the adolescent. In this manner, “relationships must first be tried out on subjective objects…as collections of isolates, attempting at the same time to form an aggregate through the adoption of mutual ideas, ideals, and ways of dressing and living” (Winnicott, 1963/1997, p. 147). Because of her uncertainty, the adolescent experiences vulnerability. This feeling of vulnerability is exacerbated by the adolescent’s knowledge that she is transitioning into adulthood and preparing to take over the duties and responsibilities of the caregiver (Winnicott, 1968/2001b). According to Winnicott (1963/1997), “Those looking after adolescents will find themselves puzzled as to how boys and girls can be defiant to a degree and at the same time so dependent as to be childish, even infantile.” (p. 152). Much as in infancy, if the adolescent is provided space, coupled with containment by a non-retaliatory yet confrontational (i.e., clearly defined and mature) caregiver, the adolescent will successfully complete this developmental stage (Winnicott, 1968/2001b).

Feminist theorists have pointed out the discrepancy between the separation-individuation motif of early adolescent theorists and the experience of adolescent girls (e.g., Gilligan, 1982/1993, 1991; Miller, 1976/1986, 1984/1990). Chodorow (1978) posits that the alterity of female adolescent development is due to the presence of the mother as the primary caregiver to children. According to Chodorow, a girl potentially identifies more easily with the mother than does a boy due to gender similarity. Further, Gilligan
WINNICOTT’S “CAPACITY TO BE ALONE” 40

(1982/1993, 1991) and Miller (1976/1986, 1984/1990) underline the impact of contextual socialization on male and female perception of female identity as one that is in relation. In other words, the adolescent girl’s identity is dependent upon the adolescent girl’s relationship to others (e.g., mother, father, friend, romantic partner, among others). Therefore, the importance placed on separation and individuation as a key component of adolescent development potentially pathologizes, or ignores, the maturation process of teenage girls, as well as the more connective elements in development. According to Gilligan (1988/2008), the historical “reliance on male experience in building the model of human growth [has silenced] the female voice” (p. 145). Interestingly, Pollack (1998), through his research on male development, has found that boys and adolescent males also suffer psychologically as a result of their socialization to separate from a nurturing caregiver (e.g., mother) at an early age.

While some developmental theorists focus on the social-emotional aspects of adolescent life, Inhelder and Piaget (1999) studied cognitive processes. These authors posit that the age of 12 years old marks initiation of the formal operational stage of cognitive development, a stage that continues through adulthood. Unlike their childhood counterparts who learn through trial-and-error processes, such as the manipulation of inanimate objects within the environment, adolescents are now able to hypothesize and imagine possibilities not directly evident. Enhanced communication and verbal reasoning skills aid the adolescent’s ability to think symbolically and abstractly. With these advances, state the authors, comes the onset of adolescent egocentrism, in which the adolescent “not only tries to adapt [her] ego to the social environment but, just as emphatically, tries to adjust the environment to [her] ego” (p. 343). As a result, the adolescent may confuse her wishes and ideas with those around her while, at the same time, become confused and influenced by the points of view of others.
Recent research into adolescent development has attempted to tie together these (and more) seemingly disparate strands of theoretical focus. For example, Steinberg and Morris (2001) indicate that “adolescent development is affected by an interplay of genetic, familial, and nonfamilial influences” (p. 89). Developmental psychology approaches to understanding adolescent experiences emphasize the complexity and breadth of the neurobiological, affective, cognitive, and intra- and interpersonal dynamics occurring within this stage. According to Steinberg (2005), the maturation rate of these biopsychosocial elements takes place at different speeds and with the auspices of both dependent and independent structures. “Normative development in adolescence can profitably be understood with respect to the coordination of emotional, intellectual and behavioral proclivities and capabilities, and psychopathology in adolescence may be reflective of difficulties in this coordination” (Steinberg, 2005, p. 69). The capacity to be alone (Winnicott, 1958/1974), a developmental achievement predicated on the existence of a reliable caregiver, allows for the emotional regulation, cognitive focus and flexibility, and the behavioral control and coordination to play and work. Therefore, an understanding of adolescent neurobiology and attachment—two areas associated with the current inclusive view of developmental psychology—will aid in delineating the psychosocial effects of the capacity to be alone in normative and non-normative adolescent development.

**Neurobiology.** Spear (2000), reports: “Adolescence is second only to the neonatal period in terms of both rapid biopsychosocial growth as well as changing environmental characteristics and demands” (p. 428). In terms of brain development and maturation, Cozolino (2006) indicates that the “teenage brain undergoes disorganization and reorganization from the onset of puberty into the early 20s” (p. 44). According to Spear (2007), the purpose of this brain reorganization is to aid the adolescent’s biopsychosocial
capacity to move from the dependency of childhood to meeting the environmental demands placed on adults.

Spear (2007) further argues that the timing, both initiation and completion, of the adolescent period within and across biological species is imprecise; however, its commencement may be linked to hormonal activation. The origination of this stage may occur quickly and abruptly (Tucker & Moller, 2007), and appears tied to changes in the hypothalamus, the brain region connecting the nervous and endocrine systems via the pituitary gland. The hypothalamus controls autonomic functions (e.g., thirst, sleep-wake cycles, hunger, etc.), as well as is related to emotional experience, motor functions, and biological homeostasis.

The association of the hypothalamus to mood and growth and development is promoted by the endocrine system, which is a series of glands secreting hormones into the blood in order to regulate bodily functioning. Within the endocrine system are two subsystems that see a rise in activity during adolescence: the adrenal and pituitary glands (Spear, 2000; Stroud et al., 2009). The adrenal gland secretes hormones (e.g., cortisol and adrenaline, among others) that enable the fight-or-flight response to perceived dangerousness (e.g., increase oxygen and glucose to the brain and muscle) while suppressing non-emergency bodily processes (e.g., digestion and immunity). The pituitary gland facilitates the release of hormones that enable physical and follicle growth and the development of secondary sex characteristics (e.g., testosterone induces growth of testicles, muscles, and vocal cords in adolescent males, and estrogen influences the growth of breasts and the onset of menses in adolescent females). Citing the work of Worthman (1999) and Steinberg (2004), Spear (2007) contends that neural structural changes and rising hormonal levels may bi-directionally impact each other in adolescence (i.e., the hypothalamic-pituitary-adrenal (HPA) axis).
As previously mentioned, the reorganization of the adolescent brain is extensive and significant (Cozolino, 2006; Schore, 2003a; Spear, 2000, 2007). Spear (2000) suggests that the reorganization of the amygdala and prefrontal limbic areas induces the overall reorganization of the adolescent brain. Swenson (2006) highlights the conceptualization of the limbic system as the *feeling and reacting brain*, which mediates between the output mechanisms of the nervous system (i.e., glandular and motoric responses) and the *thinking brain* (i.e., the neocortex, which is part of the cerebral cortex and is involved in sensory perception, spatial reasoning, conscious thought, language, and effecting motor commands). Within the limbic system are a series of nuclei and cortical structures that are functionally and anatomically interconnected, primarily to regulate autonomic and endocrine operations, often in response to emotional stimuli (Swenson, 2006). The hypothalamus is considered part of the limbic system, as is the amygdala (i.e., coordinator of behavioral, autonomic, and endocrine responses to environmental stimuli, such as producing rage and aggression to a perceived environmental attack), the hippocampus (connected to spatial memory and navigation and encoding and retrieving explicit memory), and the limbic cortex. The limbic cortex is part of the cerebral cortex and is related to olfaction, as well as experiencing reward and motivation (Swenson, 2006).

The reorganization of the adolescent brain occurs in several ways (Cozolino, 2006; Schore, 2003a; Spear, 2000, 2007). The number of overall neurons decreases (i.e., loss of gray matter) while there is an increase in white matter. With the growth in white matter, says Cozolino, the “more myelinated fibers bring about stronger, faster, and more efficient connections among different neural networks” (p. 44). The areas directly affected by the increase in white matter include: the corpus callosum, which is involved in hemispheric communication, cognitive and emotional integration, and memory storage and retrieval; the cerebral cortex, the center of cognitive processing; the frontal-hippocampal circuits, related
to the executive functioning skills of planning, foresight, and self-regulation; and the
Broca’s-Wernicke’s circuits, which engenders language understanding and production
(Cozolino, 2006).

Additionally, Schore (2003a) and Spear (2000, 2007) highlight the substantial
synaptic pruning that occurs in adolescence. Spear (2007), citing the research of Woo, Pucak,
Kye, Matus, and Lewis (1997), posits that the pruning may enable a “fine-tuning of neural
connectivity” within particular cortical regions as opposed to across various brain areas (p.
13). Rakic, Bourgeois, and Goldman-Rakic (1994) further speculate “that such pruning is an
example of developmental plasticity whereby the brain is ontogenetically sculpted on the
basis of experience to effectively accommodate environmental needs” (as cited in Spear,

Along with these neural network changes, brain chemistry is also altered during
adolescence. For example, Lidow, Goldman-Rakic, and Rakic (1991) and Lidow and Rakic
(1992) delineate the reduction of the following neurotransmitter systems in adolescence:
dopamine (DA), serotonin (5HT), acetylcholine (ACh), and gamma-aminobutyric acid
(GABA). DA controls arousal levels in many parts of the brain and is a significant factor in
physical motivation and the experience of reward and desire, primarily as part of the
mesolimbic pathway. Serotonin has a salient impact on mood and anxiety. ACh is connected
with attention, learning, and memory. GABA, as the primary inhibitory neurotransmitter,
modulates nervous system excitability. According to Insel, Miller, and Gelhard (1990),
glutamate neurotransmitters, which are the brain’s major excitatory neurotransmitters and
link the neurons responsible for learning and long-term memory, also undergo pruning. As
Steinberg (2005) points out, “there is considerable evidence that the second decade of life is a
period of great activity with respect to changes in brain structure and function, especially in
regions and systems associated with response inhibition, the calibration of risk and reward,
Neurobiological transformation affects adolescent functioning across multiple domains, including emotional regulation, cognition and executive functioning, and behavior and impulse control.

**Emotional regulation.** Thompson (1994) defines emotional regulation as that which "consists of the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one’s goals" (pp. 27-28). Highlighting the research of Larson, Moneta, Richards, and Wilson (2002), and Silk, Steinberg, and Morris (2003), Zimmermann, Mohr, and Spangler (2009) denote adolescence as a developmental stage of acute emotionality linked to major hormonal, physical, social, and cognitive transformations. Additional researchers posit that it is the initiation of puberty—and not of a particular chronological age—that ushers in this heightened emotionality with its concomitant increased reactivity to stressful situations (e.g., Quevedo, Benning, Gunnar, & Dahl, 2009; Spear, 2009; Steinberg, 2005). Further, as neocortical circuits are wiped out and/or remodeled during adolescence, problem-solving reverts to limbic, emotionally-driven brain regions (Spear, 2000; Steinberg, 2005, 2010).

Several studies have underscored the relationship between pubertal onset and emotional reactivity. For example, examining the responses of nine to 15-year-olds to a test that potentially elicits stress reactions due to social performance demands, Gunnar, Wewerka, Fenn, Long, and Griggs (2009) found that 11- and 13-year-old boys and girls had elevated rates (both basal and during the performance) of cortisol production. In another study comparing the stress responses of adolescents (i.e., ages 13 to 17 years old) and children (i.e., ages nine to 12 years old), Stroud et al. (2009) found that the adolescent subjects had higher elevations in cortisol production and diastolic blood pressure during a performance activity and increased systolic blood pressure and sympathetic nervous system arousal in a peer
rejection session than their younger counterparts. Further, Quevedo et al. (2009) observed that mid-/late-pubertal adolescents exhibited greater startle responses to viewing pleasant, neutral, and aversive stimuli than did their pre-/early-pubertal peers. Moreover, mid-/late-pubertal adolescents were noted to have heightened pupillary reactivity and self-reported emotionality to words carrying positive, negative, or neutral valences, compared to pre-/early-pubertal youths (Silk et al., 2009).

It has been hypothesized that the social-emotional system of the brain, which is localized in the limbic and paralimbic areas, is connected to heightened emotionality in adolescence through the process of reward motivation (Steinberg 2005, 2010). According to Cozolino (2006), “There is a change in the brain’s reward circuitry, and this can sometimes lead to confusion, disorientation, and depression” (p. 45). With a reduction of dopamine (DA) in the nucleus accumbens, a collection of neurons within the striatum (i.e., a subcortical part of the forebrain), teenagers may experience less pleasure in relation to positive stimuli (Spear, 2000). Larson and Richards (1994) also concluded that adolescents, who are engaged in the same activities as adults, find these activities less enjoyable than do adults. Millstein (1993) similarly found that 12- to 18-year-olds are less optimistic about obtaining future benefits than are adults aged 18 to 65 years old.

Furthermore, the abrupt physical changes engendered by puberty potentially have an impact on adolescents’ emotional functioning. According to Karp, Butler, and Bergstrom (1998), these “physical metamorphoses can be a source of concern, anxiety, and preoccupation for many teens” (p. 4). These bodily alterations have also been correlated with the onset of panic and anxiety disorders (Pine, Cohen, Gurley, Brook, & Ma, 1998) and increased self-consciousness (Roth, 1999, cited in Quevedo et al., 2009).

Arnett (1999) reports that increased mood disruptions are not atypical during adolescence. Statistics obtained by the Federal Interagency Forum on Child and Family
Statistics, an organization established in 1997, indicated that eight percent of 12- to 17-year-olds were diagnosed with Major Depressive Disorder during 2007. Of those diagnosed, 39 percent received treatment for depression. The National Health and Nutrition Examination Survey (NHANES), which was conducted by the National Institute of Mental Health (NIMH) and the National Center for Health Statistics of the Centers for Disease Control and Prevention (CDC), surveyed 3,042 children and adolescents (i.e., ages eight to 15 years old) between 2001 and 2004. These researchers found that 3.7 percent of the sample had depression, with females more likely than males to have the disorder. This study also found that 0.7 percent of responders had been diagnosed with an anxiety disorder (e.g., Generalized Anxiety Disorder or Panic Disorder). Although Cicchetti and Rogosch (2002) state that most adolescents effectively cope with the developmental demands and changes of this stage, there is an increase in internalizing and externalizing symptoms and diagnoses during adolescence that blurs the “boundaries between normal and abnormal as well as between normative struggles and psychopathology” (p. 7).

**Cognition/executive functioning.** Casey, Tottenham, Liston, and Durston (2005) postulate that the gray matter volume loss and white matter increase that occurs in the adolescent’s brain fine tunes neurotransmitter connectivity and communication, thus creating more efficient thinking processes. Steinberg (2005, 2010) points out that the prefrontal cortex, the area of the brain associated with executive functioning (e.g., self-regulation, attention, planning and problem-solving, working memory, and decision-making, among other functions), matures at a different pace and more gradually than the social-emotional area of the brain (i.e., limbic and paralimbic systems). The disparate rate of brain development, including the functional ascendance of the limbic and paralimbic structures, may explain the strong influence affect has over adolescents’ decision-making and self-regulation capacities, especially during early- and mid-adolescence (Spear, 2000; Steinberg,
Despite the greater salience of affect in adolescence, the pruning and development of the prefrontal cortex ultimately improves teenagers’ cognitive competencies—abstract and hypothetical thinking, future orientation capabilities, memory, and attention—in relation to childhood cognitive abilities (Alloy & Abramson, 2007). According to Keating (2004), “adolescence is an important period for the coordination of a wide array of cognitive and brain systems into a self-aware, self-guided, and self-monitoring system of conscious control” (pp. 73-74). For Keating, the development of executive functioning skills in adolescence is contextually, as well as biologically dependent. With a good enough combination of neurobiological development and environmental influences, adolescents develop enhanced logical competencies, such as the generation and understanding of multiple options and perspectives, and an increased appreciation for the possible outcomes of their choices (Keating, 2004). Along with this capacity for hypothetical thinking, enhanced working memory processes also enable teenagers to keep the present context in mind, which facilitates self-regulation skills (e.g., Cohen & Servan-Schreiber, 1992; Kimberg & Farah, 1993).

Increased capacity for hypothetical thinking, or, in the terminology of Inhelder and Piaget (1999), the formal operational stage of cognitive development, potentially engenders adaptive relational and coping tools. As a result of their abstract thinking capabilities, adolescents can see viewpoints other than their own and understand multiple levels of meaning and ambiguity (Goossens, 2006). With this readiness to perceive others’ perspectives, teenagers become more attuned to and skilled in navigating interpersonal interactions. This ability occurs at an appropriate and advantageous time as peer relationships become exceedingly salient and ubiquitous during adolescence. Williams and McGillicuddy-De Lisi (2000) observed that older teenagers utilize greater cognitive-based coping tools.
(e.g., planned problem-solving and reappraisal) than do their early- and middle-aged counterparts who primarily rely on emotion-focused coping (e.g., avoidance to decrease distress). Additionally, older adolescents had more cognitive flexibility and could access and engage a variety of coping tools (Williams & McGillicuddy-De Lisi, 2000).

Behavior/impulse control. Steinberg and Morris (2001) point out that the majority of research into adolescent behavior since the early 1900s has focused on understanding, predicting, and mitigating problem behaviors. Adolescence has historically been viewed as a time to get through, hopefully with as few scrapes as possible. This problem-focused approach has led to a dearth of studies into normative adolescent development (Steinberg & Morris, 2001). And, while some authors caution against the pathologizing of the adolescent developmental stage (e.g., Cicchetti & Rogosch, 2002), many researchers have found that teenagers, as a whole, engage in riskier and more impulsive behaviors than children and adults (e.g., Clayton, 1992; Spear, 2000; Steinberg, 2008, 2010; Steinberg & Morris, 2001).

Increased impulsivity and risk appears connected to the neural rewiring that occurs during puberty (Chambers & Potenza, 2003; Spear, 2000; Steinberg, 2008, 2010). According to Chambers and Potenza, the prefrontal cortex, nucleus accumbens, and thalamus are involved in a connective cycle, which these authors refer to as primary motivation circuity (PMC). This system encompasses perception of novelty and reward as well as engagement in cost-benefit analyses. Consequently, the authors link this system to risk-taking and impulsive behaviors (e.g., gambling and substance abuse, among others). Dopamine (DA) is a neurotransmitter significantly involved in understanding reward and risk and then generating motor functions to respond to this understanding. As previously mentioned, the reduction of DA in the nucleus accumbens may cause teenagers to experience less pleasure to a positive stimulus (Spear, 2000). Since DA neurotransmitters respond to novel stimuli and natural rewards, adolescents may need to seek out and engage in a greater number of new and
unknown exploits compared with adults in order to achieve a feeling of satisfaction. In their review of the genetic and non-genetic factors contributing to alcohol abuse in adolescence, Saraceno, Munafò, Heron, Craddock, and van den Bree (2009) found that decreased DA activity and metabolization is correlated with increased risk of developing an alcohol addiction. Furthermore, serotonin (5-HT) and DA neurotransmitters mature at different rates during adolescence, with DA metabolizing at a quicker rate than 5-HT (Chambers & Potenza, 2003). Serotonin is associated with inhibition of impulsivity. Therefore, 5-HT neurotransmitters do not yet have the power to limit the novelty-seeking drive of DA neurotransmitters.

Adding to teenagers’ vulnerability to engaging in risky and impulsive behaviors is the aforementioned differential maturation of the thinking (i.e., prefrontal cortex) and feeling (i.e., limbic/paralimbic systems) brains (Steinberg, 2005, 2010). Steinberg (2010) refers to this disparate development as a *dual systems model* to understanding teen risk-taking. Summed up by Romer (2010), “the prefrontal cortex and its connections with other brain regions are thought to be structurally inadequate to provide the control that is optimal for adolescent behavior” (p. 264). Chambers and Potenza (2003) discuss action-oriented decision-making, which is a threefold process that includes taking in sensory information, constructing a meaning and making judgments about the information, and planning and implementing a behavioral response to the stimulus. The prefrontal cortex is the major structure underlining the second phase of the process (i.e., evaluation and decision-making), while the limbic and paralimbic systems are highly involved in sensory intake and motoric output. Therefore, the circumscribed and inchoate influence of the prefrontal cortex belies the heightened emotional sensitivity and seemingly rash and potentially dangerous behaviors of teenagers (Romer, 2010; Steinberg, 2010).

Further compounding the effects of neural development on adolescent behavior are
the widening contexts in which teens find themselves. Straus (2007) posits that one cannot determine what constitutes normal versus abnormal behavior in adolescents unless one understands the environments, and their pressures, to which the teens are responding. Adolescents navigate new and changing circumstances, such as attempting to obtain employment as well as academic involvement (i.e., transitioning from middle school, to high school, to college preparation). The variable conditions—likely socioeconomically dependent—with which teens interact may potentially be perceived as negative by adolescents, leading to depression and anxiety and/or oppositional and resistant behaviors (Goossens, 2006). Adolescent behaviors are also significantly influenced by their peers with whom teenagers have increasing contact through both circumstance and choice (Spear, 2000; Steinberg & Morris, 2001). Accordingly, state McElhaney, Allen, Stephenson, and Hare (2009), adolescents “increasingly regulate their own activities…[which] takes adolescents literally farther from home—as teens begin to function more autonomously, they engage in a wider range of activities and interact with a broadening social circle” (p. 373).

Behavioral manifestations of these neural and contextual changes in adolescence are numerous. Steinberg (2008) posits that teenagers and young adults are more likely than their adult counterparts (i.e., over 25 years old) to “binge drink, smoke cigarettes, have casual sex partners, engage in violent and other criminal behavior, and have fatal or serious automobile accidents” (p. 79). Some of the findings from the 2009 National Youth Risk Behavior Survey (YRBS), which is conducted by the CDC and involves a representative sampling of ninth- to 12th-grade public and private students in the U.S., include: 28.3 percent of students rode in a vehicle driven by someone who had been drinking alcohol one or more times 30 days prior to the survey; 31.5 percent of responders participated in one or more physical fights during the previous year; 19.9 percent of teens were bullied on school property over the last 12 months; 13.8 percent of participants seriously considered attempting suicide, and 6.3 percent
attempted suicide, during the prior year; 72.5 percent of students had at least one alcoholic
drink in their lifetime; 41.8 percent drank alcohol at least once 30 days prior to the survey;
and 36.8 percent of responders used marijuana at least once in their life; 46 percent reported
engaging in sexual intercourse during their lifetime; and 13.8 percent had sexual intercourse
with four or more partners over their lifetime. The CDC found that these numbers held study
from 2007 to 2009, except for slight statistical decline alcohol intake over the last 30 days
and physical fighting during the previous year.

Yet, as these numbers indicate, the majority of teens do not necessarily engage in
juvenile crime, substance use, and sexual practices, among other areas, asserts that reports of
youth engagement in risky behaviors has been greatly exaggerated and/or misreported by the
media and special interest groups. For instance, the Federal Bureau of Investigation (FBI)
found that the number of youth under the age of 18 years old arrested for all criminal
offenses in 2009 was 1,161,830 compared to 7,099,760 offenders over the age of 18 years
old. Additionally, the FBI noted a 20 percent decrease in adolescent offending from 2000 to
2009. Furthermore, a 2009 national survey conducted by the Substance Abuse and Mental
Health Services Administration’s Office of Applied Studies (SAMHSA OAS) found that 41.7
percent of young adults (i.e., 18 to 25 years old) and 36.3 and 19.2 percent of older adults
(i.e., 26 to 34 years old and 35 years or older, respectively) engaged in binge drinking (i.e.,
five or more drinks at one time) compared to seven percent of 14 to 15 year-olds and 17
percent of 16 to 17 year-olds. This same survey noted an inverse relationship between
parental involvement with and monitoring of adolescents and adolescent substance use (i.e.,
alcohol, nicotine, and illicit drugs). Highlighting the 2000 National Household Survey
results, Males (2003) reports that states in which more adults drank, smoked, used drugs, and
attended alcoholic rehabilitation had a higher number of youth who were more likely to
follow in these same footsteps. These findings seem to suggest that the relationship between parent and teen is paramount in determining whether or not the adolescent will engage in risky behaviors.

**Attachment and Adolescent Development.** The experience of attachment, both prior to and during adolescence, significantly influences adolescent thoughts, feelings, and behaviors (Cole & Deater-Deckard, 2009; McElhaney et al., 2009; Morris, Silk, Steinberg, Myers, & Robinson, 2007; Shumaker, Deutsch, & Brenninkmeyer, 2009; Zimmermann et al., 2009). According to Bowlby (1990), an adolescent who has experienced a secure attachment with a caregiver as a child is able to seek out and develop peer attachments as a teenager. This willingness to engage in interpersonal relationships is based on the adolescent’s felt sense of being lovable, as well as on a belief that others will be accepting and responsive, like this teen’s early caregivers (Bartholomew & Horowitz, 1991). The wish and opportunity for peer relationships increases in the adolescent stage while dependency on adult caregiving decreases but does not extinguish (Bernat & Resnick, 2009; McElhaney et al., 2009; Meeus, Iedema, Maassen, & Engels, 2005; Steinberg & Morris, 2001). The tools necessary for the creation and maintenance of adaptive peer relationships include emotional regulation, behavioral control, and cognition (e.g., abstract thinking, problem-solving skills, and language understanding and expression, among others). The development of these tools is largely predicated on the adolescent’s early attachment history.

Consistent and predictable attunement between caregiver and infant, a hallmark of attachment, also significantly promotes infant brain development (Cozolino, 2006; Perry, 2008, 2009; Schore, 2003a, 2003b). The brain initially contains undifferentiated neural networks that are dependent upon the reciprocal relationship between brain chemistry and the infant’s environment to mold these networks into an organized, efficient, and mature structure (Perry, 2008). Within this model, organization begets organization. That is, if the
caregiver’s response to the infant is patterned and in sync with the infant’s cues, the infant’s brain—which is at its most plastic and, therefore, highly sensitive to environmental input—develops in a functional and timely manner (Perry, 2008).

Another way in which relationship affects brain development is through the process of language acquisition. According to Cozolino,

The ability to link feelings and words does not come automatically but relies on relationships to build connections between separate neural networks dedicated to affect and language…Language, in combination with emotional attunement, creates the opportunity to support neural growth and network integration. (pp. 231-232)

Overall cognitive capacity was also found to be associated with attachment. Highlighting studies conducted in 2000 with Romanian orphans, aged 31 months and under, Nelson, Zeanah, and Fox (2007) report that mean scores on the Bayley Mental Development Index (MDI) were 65 in the institutionalized group compared with 103 for a never-institutionalized Romanian sample.

Emotional regulation is another capacity that is engendered by the connection between neural organization and attachment experiences (Schore, 2003b). Through affective synchrony, the caregiver matches the affective output of the child, including engaging with the infant when the infant is stimulated, or disengaging with the infant when the infant is experiencing high levels of non-optimal stimulation and requires a moment of solitude (Schore, 2003b). A contributing factor to the dance of attunement is the steps the caregiver takes to enable the child to stay within the affective range between hypo- and hyperarousal. As Schore states, a caregiver cannot be perfectly attuned to the infant; however, if the caregiver “self-corrects and in a timely fashion reinvokes her psychobiologically attuned regulation of the infant’s negative affect state,” the child’s autonomic system can recover
from its stress response (p. 39). This consistent regulation and re-regulation of the infant will create an autonomic memory in the adolescent; that is, the adolescent will have the psychobiological means with which to manage stressful life events.

If, however, there has been early misattunement between infant and caregiver, attachment and co-regulation of affect may be learned at a later time. For instance, in their research with 48 adolescents who had severe behavioral problems (e.g., self- and other-directed violence and school truancy), Osbuth, Moretti, Holland, Braber, and Cross (2006) found that the use of an intervention model (i.e., Connect Parent Group) that increased the caregivers’ capacity to attach and attune to their adolescents facilitated a decrease in the youths’ maladaptive externalizing behaviors. More importantly, in terms of highlighting the link between attachment and the co-regulation of emotion, these researchers noted that both the caregivers and adolescents reported a significant decrease in the adolescents’ experience of negative affect (e.g., depression and anxiety) once the intervention was completed.

According to Schore (2003b), in securely attached adolescents and adults, “or those in interaction with securely attached individuals who can act as interactive regulators, unconscious internal working models can become more complex” (p. 174). Therefore, co-regulated modulation of anxiety may enable a teen who is insecurely attached to experience affective relief in the presence of an other, which may subsequently lead this teen to develop proximity-seeking, as opposed to ambivalent or avoidant strategies.

An additional way in which attachment, brain development, and affective regulation connect is by the brain-to-brain interaction occurring between caregiver and infant in which the right hemisphere of both participants’ brains is engaged (Schore, 2003b). This area of the brain is linked to visual and prosodics emotional information processing and expression; therefore, the better a caregiver is able to read, understand, and respond to the infant’s affect, the infant’s capacity to engage in these same activities with others is enhanced (Schore,
2003b). And, as Perry (2008, 2009), points out, since the structure of the brains of adolescents are dependent upon early (i.e., pre-aged five years old) brain maturation, the adaptive development of the right hemisphere in infancy neurally promotes the ontogenesis of a teen who can accurately perceive her own emotions, as well as the affect of others.

Attachment also aids in emotional regulation through the modeling provided by the caregiver to the child. Citing the work of Gottman, Katz, and Hooven (1997), Morris et al. (2007) report that “parents’ own beliefs regarding emotions, their own parent–child relationship and attachment status, and their ability to control their own emotions, affect emotion socialization and the ways in which parents interact with children and other family members” (p. 364). Within this model, the child learns about emotional regulation through observation (i.e., social referencing) of the caregiver’s affective response to environmental stimuli. If a caregiver appropriately and effectively contains and expresses her emotions, the child (and, later, teen) can better learn to do so. According to McElhaney et al. (2009), the adolescent’s ability to construct positive peer and romantic relationships may be tied to the teen’s comfort with emotional experience and expression. Additionally, the child and adolescent is more capable of engaging the cognitive structures that engender learning when she is in an environment in which emotions do not cause the caregiver significant stress (Dodge & Pettit, 2003). As a corollary, the caregiver’s hyperarousal can potentially cause the same physiological reaction in the teen; thus, the feeling brain will usurp the thinking brain, leading to an affective experience that Perry (2006) describes as “fear without understanding.”

When adaptive emotional regulation skills combine with mature cognitive capacities, the proximity-seeking and exploration behaviors related to early secure attachment manifest as confidence and competence during the teen years (Bowlby, 1990). For example, Scharf (2001) reports that securely attached teens engage more effective coping strategies than
insecurely attached adolescents. Similarly, Aspelmeier and Kerns (2003) assessed first-year college students and found that a self-reported secure attachment style was linked to less self-reported anxiety about academic performance, as well as to increased willingness to seek out challenges and to ask others for help. Moreover, Greenberger and McLaughlin (1998) found that securely attached adolescents appear to engage in positive support seeking and active problem solving to a greater degree than insecurely attached individuals.

Securely attached adolescents who maintained relatedness to their parents while attempting more autonomous behaviors seemed to experience positive self-esteem and ego development (Allen, Hauser, Bell, & O’Connor, 1994). Secure attachment to parents has also been associated with higher levels of adolescent identity development (Shumaker et al., 2009). Resnick et al. (1997) further observed that adolescents’ experience of connectedness to their parents served as a protective factor against emotional distress, suicide, violence, substance use, and early sexual initiation. Secure attachment between the adolescent and her primary caregiver(s) seems to be associated with a range of protective factors (e.g., increased self-esteem, emotional regulation capacity, and a higher level of comfort interacting with peers, among others) that facilitate the adolescent’s adaptive functioning across social, emotional, behavioral, and cognitive domains.

The increase and reinforcement of adaptive social skills is significantly valuable to the teen. Larson, Richards, Moneta, Holmbeck, and Duckett (1996) discuss the ever widening social contexts in which adolescents find themselves along with the salience teens place on creating close friendships and romantic relationships. In their review of adolescent attachment research, McElhaney et al. (2009) found that attachment security has been further associated with positive peer relational abilities, including overall friendship quality, popularity, social acceptance, friend and romantic intimacy, trust, and consistent boundaries. Interviewing 374 adolescents, Doyle, Lawford, and Markiewicz (2009) observed that
attachment insecurity between the teens and their fathers was associated with attachment insecurity in friendships. Insecure attachment with the mother appeared linked to insecure romantic relationships. Additionally, these authors found that insecurity with a best friend was significantly connected to insecurity with a romantic partner (Doyle et al., 2009). As these research findings suggest, secure attachment, whether engendered in the infant-caregiver relationships or in later safe relationships experienced by the teens, enables adolescents to engage in healthy, collaborative relationships, cope with stresses and/or seek out others who will provide support, and believe in their own efficacy and value. If secure attachment is associated with positive biopsychosocial outcomes in adolescence, how do adolescents who have not experienced early or later securely attached relationships and their concomitant positive effects on brain development fare?

**Non-Normative Adolescent Development**

As Steinberg and Morris (2001) indicate, the research into adolescent development has primarily focused on factors that lead to maladaptive development, as well as on the problem behaviors of teens. The problematic behaviors exhibited by the adolescent do not manifest overnight or occur in a vacuum. Furthermore, atypical, maladaptive functioning occurs across multiple domains, including emotional regulation, attachment, and cognitive achievement, among others. Sroufe, Carlson, Levy, and Egeland (1999) conducted a statistical regression analysis on data describing attachment and adolescent pathology. These authors found that insecure infant attachment history significantly accounted for 14 percent of variance in adolescent pathology. According to 2010 findings from the National Institute of Child Health and Human Development Study of Early Child Care and Youth Development (NICHD SECCYD), the quality of non-parental care (i.e., center, relative, and non-relative) prior to the age of 54 months old was significantly associated with cognitive and academic functioning at 15 years old (Vandell et al., 2010).
This research underlines the observation of Cicchetti and Rogosch (2002) who state, “Attention to developmental pathways emerging earlier in development that eventuate in psychopathology or maladaptation in adolescence is critical for understanding variation in trajectories operating for different individuals” (p. 11). That is, if the teen has experienced less than good enough caretaking as an infant and child, this sets up in the teen a biopsychosocial predisposition (i.e., diathesis) to developing psychopathology when experiencing stress, as well as heightened reactivity to stress. Insufficient and misattuned caretaking may be experienced, perceived, and construed by the child/adolescent as abuse (e.g., physical, sexual, and emotional) and neglect (e.g., physical and emotional). De Bellis (2001) refers to the investigation of trauma and neglect on biopsychosocial development as developmental traumatology.

**Effects of Trauma and Neglect on Neurobiological Development.** The brain development of infants and children, and subsequent emotional, cognitive, behavioral, and social maturation, is significantly affected by early abuse and neglect (Cozolino, 2006; De Bellis, 2005; Perry, 2006, 2008, 2009; Schore, 2003a). Perry (2008) differentiates between trauma and neglect in terms of neurological sequelae. From a neurobiological standpoint, the neglected brain does not receive the patterned, repetitive activity required to stimulate organization (Perry, 2008). As Perry (2008) indicates, neglect is usually global, that is, it takes the form of physical, cognitive, and emotional deprivation. Furthermore, neglect is often a chronic condition or stressor (De Bellis, 2005). Neglected children, compared to children who have been abused, were observed to have more severe cognitive and academic problems, social isolation, and internalizing (although not externalizing) behaviors (Hildyard & Wolfe, 2002). Moreover, infants who experienced neglect combined with failure to thrive (FTT) exhibited lower cognitive functioning than infants who had experienced either neglect or FTT (Mackner, Starr, Jr., & Black, 1997).
Although neglect tends to fall under the rubric of trauma (Cozolino, 2006; De Bellis, 2005; Perry, 2008), Perry highlights a distinctive key component of traumatic experiencing: chaotic overstimulation. The neural structures and functions that work together to moderate stress responses—the autonomic nervous system as well as the endocrine and immune systems (i.e., HPA axis)—are overtaxed by constant, intense stress-inducing experiences (De Bellis, 2003). For abused infants and children, the stress-responses system becomes hypervigilant and overly reactive (Perry, 2008). Despite this delineation between the understimulation accorded neglect and the overstimulation attached to abuse (i.e., physical, sexual, and emotional), the neglected child’s stress-response system can still become overly reactive due to its need to reassert biological homeostasis (De Bellis, 2003). As De Bellis states, “Infants have been known to aspirate and die from the stress of severe and continued unanswered crying” (p. 154).

Structural abnormalities within the brain resulting from abuse and neglect are multifold. Cozolino (2006) reports that the release of cortisol, a stress-reducing hormone, can “trigger hippocampal neurons to work harder and harder, until they eventually run out of energy, collapse, and die” (p. 235). That is, if cortisol, which is a neurotoxin, floods the infant’s brain with little relief or modulation provided by the environment, the infant’s brain structures can actually shrink. Decreased hippocampal size in turn impedes conscious learning, emotional and cognitive memory storage and recall, and limited amygdala modulation (Cozolino, 2006; Perry, 2008). As previously noted, the amygdala is the brain center in which sensory information is given a valence; motoric responses are geared to respond in an appropriate manner to this valence. For example, fear often begets running or fighting. Due to circumscribed hippocampal functioning, the amygdala of the abused child is chronically activated. This then “impairs the development of the prefrontal cortex leading to problems with the normal age-related acquisition of behavioral and emotional regulation,
including the inhibition of impulsive behaviors” (De Bellis, 2005, p. 161). Therefore, a consistently stressed child cannot accurately perceive and respond to potential threats because most situations may feel threatening; this child does not have the conscious (i.e., explicit), or unconscious (i.e., implicit), recall to draw on a time when a stressful event was handled effectively. This child’s overactivated reactions to circumstances are likely out of sync with the environment, and can seem reckless and impulsive. Moreover, results of poor prefrontal cortical region development frequently include inattention, limited focus, and impaired executive functioning, together resulting in learning disabilities and poor academic achievement (De Bellis, 2005).

Cozolino (2006) also links decreased hippocampal size to dissociative processes. Citing the research of Swinton (2003), Cozolino states that hippocampal deficits negatively impact the development and organization of the parietal lobes, an area of the brain that takes in and processes visual-spatial stimuli. The parietal lobes connect the “senses with motor abilities and creates the experience of a sense of our body in space” (Cozolino, 2006, p. 41). Individuals with reduced hippocampal volume may have significant difficulty experiencing their interactions with the physical environment, almost as if they are observing themselves in space as opposed to being themselves in space (Perry, 2008). For example, in a study comparing hippocampal volume between two groups (i.e., women with a childhood history of sexual abuse versus women without a sexual abuse history) of socio-demographically similar women, Stein, Koverola, Hanna, Torchia, and McClarty (1997) found reduced hippocampal volume and increased utilization of dissociative symptoms in adult women survivors of childhood abuse. The trauma survivors appeared disassociated from the physical experience of their lives.

Schore (2003a) describes another route through which dissociative processes are reinforced. Early, intense, and repeated caregiver misattunement to the infant’s needs results
in an infant who experiences prolonged negative affect. This infant cannot rely on relational modulation of this overwhelming affect; therefore, she must resort to autoregulatory modes (Schore, 2003a). Autoregulation is driven by the autonomic nervous system (ANS), which is a collection of sensory and motor neurons located in the brainstem and responsible for life-maintaining activities (i.e., breathing, heart rate, blood pressure, and body temperature). An infant who experiences significant terror and fear prior to the age of three months old will have no other option except to use brainstem-mediated reflexes and reactions (i.e., decreased heart rate and blood pressure, as well as increased stress-hormone and endogenous opiate release) in order to manage intolerable internal and external dysregulation (Perry, 2006, 2008). If this primitive stress modulation mode becomes the default coping tool for the infant, limited utilization of more cognitively advanced coping strategies may then thin and parcellate the axons that relay information between the ANS and the orbitofrontal cortex. The orbitofrontal cortex is an area of the brain related to determining reward and decision-making (Schore, 2003a). As a result, dissociation trumps cognitive appraisal of environmental cues, leaving this infant—and, later, adolescent and adult—“dis-associated from both the external and the internal environment” (Schore, 2003a, p. 213). Others may perceive the teen who relies on dissociation as inattentive, cognitively impaired, forgetful, withdrawn, inconsistent, and impulsive. However, this teen’s ability to attend to external demands is compromised as all of her psychic energy is, often unconsciously, consumed by regulating internal affective states.

Deficits in orbitofrontal cortex structure and functioning also lead to problems with pain awareness (Schore, 2003a); thus, potentially leading to problematic behavioral manifestations. The endogenous opioid system (EOS) is activated when an organism is experiencing extreme stress, and the chemicals it releases (e.g., endorphins and dynorphins, among others) decreases perception and reaction to pain, as well as potentially increases pain
tolerance (Schore, 2003a). For some traumatized adolescents, cutting and the utilization of other nonsuicidal self-injury (NSSI) may be related to EOS regulation in several ways: (a) A means by which to “autoregulate out of the altered pain sensitivity associated with the elevated opioid activity of the dissociative state” (Schore, 2003a, p. 219); (b) Increasing internal, physiological experiences of relief, thereby reinforcing the use of NSSI, sometimes to the point of these behaviors becoming a physical addiction (Grossman & Siever, 2001); and (c) Inducing dissociative or altered consciousness states that, in turn, precipitate NSSI (Saxe, Chawla, & van der Kolk, 2002). NSSI appears caught in a functional loop with dissociation; that is, cutting enables dissociation and is also the way in which an individual can once again feel real and physically present. To illustrate, Dubo, Zanarini, Lewis, and Williams (1997) found that child neglect strongly predicted the later emergence of NSSI, such as cutting and burning. Interestingly, the studies conducted by Harlow, Harlow, and Suomi (1971) with rhesus monkey infants similarly found that monkeys that were raised in total social isolation for the first six months also engaged in self-mutilatory behaviors when reaching puberty (as cited in De Bellis, 2005).

Child abuse and neglect, especially within the first two years of life, also leads to circumscribed corpus callosum development (Becker-Weidman, 2005; Schore, 2003a). The corpus callosum, a bundle of neuronal axons connecting the right and left hemispheres of the orbitofrontal cortex, has been found to be smaller in abused children compared to non-abused children (Becker-Weidman, 2005). Limited communication between the right and left hemispheres produces “an interhemispheric organization in which facial expressions, bodily states, and affective information implicitly processed in the right brain would be inefficiently transmitted to the left hemisphere for semantic processing” (Schore, 2003a, p. 228). Consequently, the traumatized child, adolescent, and adult has significant difficulty cognitively understanding and addressing her feelings, visual perceptions, and bodily
sensations. Cicchetti, Ganiban, and Barnett (1991) observed that maltreated toddlers are unable to talk about their emotions and internal states to a considerable degree.

Alexithymia, a deficit in emotional understanding and expression, is a common symptom of trauma and, in neurological studies, such as those conducted by Jessimer and Markham (1997) and Dewaraja and Sasaki (1990), may be another manifestation of poor right-to-left collosal transfer. Individuals with alexithymia exhibit the following emotional, cognitive, and behavioral symptoms: impaired capacity to assign meaning to emotions, social avoidance and isolation, somatization of affective experiencing, poor self-care and self-regulation, and increased impulsivity (Schore, 2003a). Considering the normative brain maturation occurring during adolescence, which already fosters an increase in impulsive and risk-taking behaviors, the adolescent with limited corpus callosum development is potentially at even greater risk for engaging in behaviors that may be dangerous to herself and/or to others. Decreased corpus callosum white matter myelination and signal intensity has also been found in children and adolescents diagnosed with bipolar disorder (Barnea-Goraly, Chang, Karchemskiy, Howe, & Reiss, 2009; Caetano et al., 2008). Therefore, limited interhemispheric communication may neurologically underpin the rapid affective, behavioral, and personality shifts that occur with adolescents who have experienced early neglect and/or abuse.

**Insecure Attachment.** As research from the above section indicates, brain development is context-dependent (Cozolino, 2006; De Bellis, 2005; Perry, 2006, 2008, 2009; Schore, 2003a); therefore, it is relationship-dependent. Brain maturation, with its impact on emotional, cognitive, and behavioral functioning, is significantly associated with early attachment experiences. Neurobiology and attachment are in a profoundly symbiotic relationship. For instance, Schore states that an infant who must rely on the autoregulatory state of dissociation for stress relief will be less likely to seek out relationships to obtain aid
for emotional regulation. Additionally, these early strategies are difficult to unlearn. If, as Cozolino observes, the adolescent tasks of creating peer relationships and delineating self-image and societal roles require a brain that is structurally plastic, increasingly organized, and functionally flexible, how will the adolescent who endured early attachment dysregulation and deprivation fare with these challenges?

To answer this question, a substantial body of research has investigated the affective, cognitive, and behavioral manifestations of adolescent attachment status (i.e., secure, insecure-avoidant/dismissive, insecure-ambivalent/preoccupied, and insecure-disorganized). Main, Kaplan, and Cassidy (1985) described preoccupied caregivers as those who were so focused on their own dependency needs that they neglected the needs of their children. Adolescents who are designated with an insecure-ambivalent/preoccupied attachment status likely have poor self-esteem and self-concept, and, therefore, “strive for self-acceptance by [attempting to gain] the acceptance of valued others” (Bartholomew & Horowitz, 1991, p. 227). As a result of this combination of a negative view of self and heightened reliance on others, these teens are significantly desirous, yet distrustful, of relationships (Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Main et al., 1985). There are several studies connecting attachment to the capacity for emotional regulation concluding that adolescents with insecure-ambivalent/preoccupied status experience increased stress, anxiety, and loneliness with leaving home and transitioning to college (Larose & Bernier, 2001), experience significant distrust, loneliness, hostility, anxiety, and dissatisfaction in their close relationships (Larose & Bernier, 2001; Seiffge-Krenke, 2006), and feel heightened anxiety, dependence, and jealousy, as well as minimal satisfaction in romantic relationships (Collins & Read, 1990; Davila, Steinberg, Kachadourian, Cobb, & Fincham, 2004; Tracy, Shaver, Albino, & Cooper, 2003).

Adolescents with an insecure-avoidant/dismissive attachment status are likely present
as detached and isolated from, as well as potentially hostile to, interpersonal relationships (Ainsworth, Blehar, Waters, & Wall, 1978; Main et al., 1985). They tend to be dismissive of relationships due to a low opinion of oneself and a negative, distrustful view of others (Bartholomew & Horowitz, 1991). Teens who have been found to have insecure-avoidant/dismissive attachment styles also experience significant anxiety, loneliness, and mistrust within close relationships (McElhaney et al., 2009). In research conducted by Howard and Medway (2004) and Seiffge-Krenke and Beyers (2005), adolescents who felt interpersonally insecure employed avoidant coping mechanisms to a high degree, which resulted in an increased risk for negative outcomes (e.g., experiencing chronic stress). The use of avoidance appears self-protective—a defense against relying on others due to experiencing unmet needs at the unmindful hands of early caregivers. According to Allen and Land (1999), minimal parent availability may subsequently minimize a child’s motivation for relational exploration and intimacy with peers. McElhaney et al. cite a considerable number of studies underlining avoidant/dismissive adolescents’ disengagement from and limited responsiveness to parents, peers, and romantic partners. Indeed, Bartholomew and Horowitz (1991) and Larose and Bernier (2001) further observed that others, in turn, view the avoidant teen as cold and hostile.

Adolescents who appear to meet the criteria of the insecure-avoidant/dismissive designation also seem to have significant difficulty with communication. They may misunderstand interpersonal interactions, leading to distorted, inappropriate responses, or display hostile physicality and language that circumvents adaptive, cooperative communication (McElhaney et al., 2009). Cozolino (2006) and Schore (2003a) both describe the insecure-avoidant/dismissive child as someone who is un-minded and left to her own devices to manage her external and internal stress without environmental support. Consequently, this child’s receptive and expressive language capacities, including semantic
understanding and meaning making, as well as her ability to seek out others for the purpose of affective regulation, may be markedly impeded. If, as Allen, Porter, McFarland, McElhaney, and Marsh (2007) indicate, “secure attachment in adolescence is measured…in terms of the ability to coherently talk about attachment experiences and affect” (as cited in Shumaker et al., 2009, p. 94), then impaired language capacity combined with an avoidant attachment status may lead to considerable affective, cognitive, and behavioral dysregulation in adolescence.

Problematic, erratic, incoherent, and often fear-inducing communication and behaviors on the part of the caregivers contribute to the development of insecure-disorganized/disoriented attachment strategies in children (Hesse & Main, 2000). Infants and children who are afraid of their primary caregivers employ incongruous, contradictory, disordered, and autoregulatory approaches to managing their attachment relationship to their caregivers, and to reduce anxiety (Main & Solomon, 1990). The disorganized child is in an interpersonal catch-22 with her parent. According to Sroufe (2005), children with disorganized attachment, “in the face of confusing and frightening caregivers…had been confronted with the irresolvable conflict of striving to flee from the source of fear and yet flee to the source of fear—the caregiver” (p. 361). This uncertainty and considerable distrust of others as safe havens in which to obtain respite and regulation may explain why disorganized/disoriented attachment in infancy has been linked to dissociative tendencies and disorders in adolescence and adulthood (Carlson, 1998; Liotti, 1999; Sroufe, 2005).

Sroufe (2005) also found a link between early disorganized attachment status and poor impulse control and conduct disorder in adolescence. Further, disorganized attachment has been significantly correlated with schizotypal and borderline personality disorder diagnoses in adolescence (Westen, Nakash, Thomas, & Bradley, 2006). Schizotypal
personality disorder is characterized by excessive social anxiety and paranoia of others, while borderline personality disorder is partially defined by a heightened fear of abandonment, as well as unstable and inconsistent interpersonal relationships. These personality disorders seem expectable and appropriate responses to a disconcerting, intermittently unmindful, and relationally disturbed early environment.

Insecure attachment status has a reciprocal and damaging relationship with brain maturation. For instance, Spangler and Grossmann (1999) found heightened cortisol levels in infants categorized as disorganized compared to children defined as secure after the children were asked to interact with caregivers and strangers in an experimental setting. As the stressed brain manages the demands of childhood, it will likely have much more difficulty in adolescence. As noted earlier, the teen brain undergoes significant rewiring and pruning during puberty, with the goal of increasing cognitive efficiency and capacity, such as the development of abstract thinking skills (Cozolino, 2006; Schore, 2003a, Spear, 2000, 2007; Steinberg, 2005, 2008, 2010). A child who experienced caregiver rejection and loss may, as a teen with the ability to hypothesize, generalize an expectation of rejection to peers. According to Hammen (1992), insecurely attached adolescents may “believe they are not worthy and subsequently fail to anticipate responsiveness in new relationships (as cited in Shumaker et al., 2009, p. 100). Allen and Land (1999) also argue that advances in meta-cognitive and critical thinking during adolescence increase and reinforce harsh views of self and others that were originated at an earlier time. The authors claim that these negative perceptions of self and others increase the risk for the development of depression. Additionally, as Shumaker et al. point out, teens may resort to engaging in maladaptive behaviors (e.g., fighting, substance use and abuse, among others) to respond to the negativity they perceive in others.

There are times when insecurely attached teens experience real, and not just
hypothesized, interpersonal rejection and hostility. A maladaptive loop may occur in which the child and, later, teen acts in ways that keep others away, which then reinforces the individual’s expectations that others are not reliable. As Schore (2003a) states, an insecurely attached infant who has no expectation of receiving help will not engage in proximity-seeking behaviors that induce others to provide comfort. Klimes-Dougan et al. (2007) similarly observed that parents of acting out teens were dismissive of their child’s emotional displays, thus leading to further externalizing behaviors on the part of the adolescent. Peers also contribute to this proximity-rejecting cycle. According to Cole and Deater-Deckard (2009), for example, school-aged children become adept at noticing and avoiding peers who engage in extreme emotional and behavioral displays (e.g., aggression, isolation, and emotional lability) that are not viewed as socially appropriate. Therefore, peer relationships become another attachment avenue cut off to the insecurely attached teen.

Interpersonal interactions typically generate anxiety for insecurely attached adolescents. Shaw and Dallos (2005) state that the caregiver-child relationship is “a base in which to understand, rehearse, and manage the strong affect that might be associated with managing new relationships” (p. 418). Attachment behavior patterns—secure, avoidant, preoccupied, disorganized—are characterized by more or less effective emotional regulation capacities within intimate relationships (Zimmermann et al., 2009). Adolescents with insecure and disorganized attachment statuses have limited ability to experience, modulate, and express strong affect primarily because they did not have the experience of being emotionally regulated by a consistent, reflective caregiver in childhood. These teens may become overwhelmed with relational demands because they find little or no peace in seeking out others for the purpose of affect regulation. Most fundamentally, they cannot rely on adaptive internal soothing functions because a dependable caregiver was not present to instill these functions. As a result, adolescents with insecure and disorganized attachment are at a
greater risk for developing depression (Allen and Land, 1999) and/or in engaging in behaviors that disrupt social connections (Cole, Michel, & Teti, 1994).

**Adolescents in Foster Care.** Adolescents in foster care are a prime example of individuals who, with histories of neglect, trauma, and disrupted attachments, may experience significant anxiety both in and out of relationship with others. The Child Trends DataBank provides the following definition of foster care:

- A living arrangement for children who a child protective services worker or a court has decided cannot live safely at home. Foster care arrangements include non-relative foster homes, relative foster homes (also known as “kinship care”), group homes, institutions, and pre-adoptive homes.

As has been discussed, the secure base provided by an early reliable caregiver engenders in the child and, later, teen the capacity to effectively manage affect and the competency and confidence to meet relational, academic, and work challenges (Schofield and Beek, 2009). If an adolescent is in foster care, her placement presupposes environmental deficits related to the provision of such a secure base. The adolescent in foster care faces the often harrowing task of understanding and surviving a personal history typically colored with abuse, neglect, and/or traumatic loss, coupled with meeting and negotiating the biopsychosocial changes that occur in adolescence. Lamentably, this adolescent will likely not be motivated (Siegel, 2001) to seek out others to help with the management of this task, nor will she have the resources to manage it herself. Hughes (1997) observed six attachment-related factors that impeded the capacity of later care providers to help children and adolescents who had been adopted or who were in foster care: enduring repeated child abuse, hypervigilance and mistrust, negative self-evaluation, unresolved loss of birth parents, limited experience of mother-child dialogue, and resistance to new socialization experiences.

In a similar vein, Schofield and Beek (2009) highlight several interpersonal and
internal dilemmas with which the fostered adolescent will struggle: (a) The advent of puberty and the increased engagement in romantic relationships may cause significant anxiety due to the earned mistrust of intimate relationships, as well as to the possibility for becoming a parent; (b) The fostered teen may be less likely to seek out support from potentially reliable and caring adults currently in her life; and (c) A chaotic and/or neglectful environment may later produce an incoherent understanding of personal history, which, in turn, will have a deleterious effect on identity development. In their qualitative study of 12 youths who had aged out of foster care, Mulkerns and Owen (2008) found that these adolescents identified as self-sufficient, separate, and independent; yet, they also felt alone and had an unmet desire for peer support and a “safety net” during the emancipation process. These youths appeared to be caught in the paradox of both wanting and resisting relationships with others as manifested in their belief that “seeking aid from others was incompatible with maintaining self-esteem” (Mulkerns & Owen, 2008, p. 436).

Several studies underline how disrupted attachments, traumatic loss, abuse/neglect, and attendant poor self-esteem affect the fostered adolescent’s functioning in the following domains: emotional regulation, cognition and executive functioning, and behavior and impulse control.

**Emotional regulation.** Adaptive strategies of emotional regulation are a product of positive attachment experiences (Bowlby, 1990; Schore, 2003a). Fostered adolescents are often deprived of these positive experiences. Thus, teens in foster care are generally at greater risk for developing disorders characterized by affect dysregulation. According to the Child Welfare League of America (1997), adolescents living in foster or group homes are approximately four times more likely to be diagnosed with a serious psychiatric disorder than their counterparts who are living with biological families. In a 2000 U.S. survey, Pilowsky and Wu (2006) similarly found that fostered adolescents had significantly higher rates of
depression and anxiety symptoms and were approximately four times more likely to attempt
suicide in the prior year compared to their non-fostered peers. In their 2006 meta-analysis of
research studying the well-being of fostered children and adolescents, Landsverk, Burns,
Stambaugh, and Rolls Reutz observed that these youths were five times more likely than a
community sample to exhibit symptoms that required mental health evaluation and/or
treatment. In England, Meltzer (2003) found that 45 percent of five- to 17-year-olds in foster
care were diagnosed with a mental disorder. Berrier (2001) characterizes the adolescent in
foster care as being in limbo—a state between the teen’s current placement and the
possibility of being reunified with her family of origin. According to Berrier, depression may
be one result of this stuckness. Kagan (1996) also lists depression and schizophrenia as two
common diagnoses given children and adolescents who have been placed outside of their
home.

Furthermore, Stanley (2007) found that foster care providers (i.e., relatives and
non-relatives, as well as residential staff) identified anxiety, fearfulness, low self-esteem, and
self-injurious behaviors as mental health concerns of the adolescents under their supervision.
Norris and Maher (2009) state that self-harming behaviors (e.g., running away, cutting,
disordered eating, and substance use and abuse) occur with greater intensity and frequency in
children and adolescents in foster care compared to their counterparts in the general
population. Norris and Maher postulate that foster youth engage in self-harming behaviors
particularly to regulate intolerable affect related to feelings of loss. According to the authors,
however, self-injury often induces anxiety in the caregivers, and this anxiety engenders
misattuned, as well as potentially blaming and harmful, reactions to the adolescent. The
self-injurious teen experiences the caregiver’s response as incongruent and, therefore,
rejecting. This feeling of rejection fuels further self-harming. An interesting finding in
Stanley’s research underscores the cycle hypothesized by Norris and Maher. Foster care
providers expressed significantly more concern with self-injurious behaviors than did the adolescents engaging in the behaviors.

Adolescents between the ages of 18 and 21 years old appear to be at greater risk for developing and/or worsening psychiatric disorders when they begin to “age out” of foster care. Burgeoning and tenuous attachment relationships with foster parents may end abruptly once the state funding sources shift and the late adolescents/young adults are expected to manage practical responsibilities on their own (e.g., budgeting, living arrangements, obtaining employment, among others). Transitioning youth are significantly at risk for experiencing emotional and social problems, such as homelessness, unemployment, school drop-out, and incarceration (Collins, 2001; Courtney & Dworsky, 2006; Dworsky & Courtney, 2009). Cheung and Buchanan (1997) observed that individuals leaving foster care showed increased risk for depression and a higher incidence of emotional and behavioral problems. Dixon (2008), who interviewed 106 young adults, in the U.K., after they had exited care, found that mental health problems doubled (i.e., 12 percent to 24 percent) from the first interview (i.e., 3 months post-care) to the follow-up interview (i.e., 15 months post-care). Dixon observed a prevalence of depression and stress, including four percent of participants who attempted suicide prior to the follow-up interview. In their meta-analysis of 29 studies that examined the long-term effects of foster care, McDonald, Allen, Westerfelt, and Piliavin (1996) similarly found that children and adolescents who spent time in care generally had poor mental health outcomes as adults; further, the presence of emotional and behavioral problems were unabated and relatively stable from childhood to adulthood.

The emotional dysregulation experienced by children and adolescents in foster care also engenders and exacerbates poor health functioning. According to Salovey, Rothman, Detweiler, and Steward (2000), “Negative emotional states are thought to be associated with unhealthy patterns of physiological functioning, whereas positive emotional states are
thought to be associated with healthier patterns of responding in both cardiovascular activity and the immune system” (p. 111). The immune system of an abused and/or neglected infant is potentially compromised due increased cortisol production and decreased protein production; thus, “sustained high levels of stress partly explain why early negative experiences in parenting and attachment have a lifelong impact on physical health…” (Cozolino, 2006, p. 222).

Research conducted by Felitti (2009), in collaboration with the Centers for Disease Control and Kaiser Permanente (i.e., the Adverse Childhood Experiences Study), appears to underline the above assertions. Within this community sample, Felitti observed that the experience of childhood adversity was significantly correlated with physical illness in adulthood. This result was primarily mediated through two mechanisms: the neurobiological impact of stress on later physiological functioning and the choice of poor coping tools to manage stress (e.g., overeating, using substances and smoking, among others). Furthermore, higher numbers of adversities were strongly related to more critical health outcomes (Felitti, 2009). In terms of fostered children and youth, Hansen, Mawjee, Barton, Metcalf, and Joye (2004) found that these individuals suffered from more acute and chronic illnesses than their same-aged counterparts, even when controlling for socioeconomic status. Hansen et al. argue that early abuse and neglect, which precipitated the foster placement, may potentially account for these higher rates in foster youth.

Despite unfavorable outcomes related to biopsychosocial health, a number of adolescents in foster care define themselves as self-reliant. This history of, and motivation for, taking care of themselves may, for some, serve as protective factor against developing social-emotional problems (Samuels & Pryce, 2008). Yet, resilience seems better engendered and reinforced through supportive relationships with others (Collins, 2001; Samuels & Pryce, 2008). Fortunately, many fostered youth appear to have the potential to develop secure
attachment relationships with their caregivers, and this experience may facilitate positive emotional outcomes. For example, Schofield (2002), who conducted a qualitative study with 40 young adults who had grown up in foster care, observed that several of the participants had the capacity to seek out, sustain, and value interpersonal relationships, as well as connections to social networks, such as school, extracurricular organizations, and sports teams. In their meta-analysis of post-care effects, McDonald et al. (1996) more specifically found that children placed in foster homes rather than in group settings, and the stability and extended length of the foster home placement, predicted enhanced life satisfaction and a general sense of well-being for post-care adults.

Foster placements and moves are also related to outcomes. For example, Stein (2006) observed that fostered adolescents, who had experienced fewer placement moves and had a safety net of caregivers facilitating the teens’ transition to independent living, were more likely to “move on” in an adaptive manner than adolescents who had undergone multiple moves and had less support. Additionally, Cashmore and Paxman (2006), who interviewed young adults approximately four to five years after leaving foster care, observed that individuals who had felt securely attached to their caregivers during foster care experienced more positive long-term outcomes.

It appears that adolescents in foster care benefit from attachment strategies and experiences that replicate in tone the interactions between caregiver and infant (Schofield, 2002). Thus, the foster parent’s own attachment history and status is significant. For example, Dozier, Stovall, Albus, and Bates (2001) found that increased capacity for children in care to form secure attachment relationships with their foster parents was predicated on the foster parents’ secure attachment status, and not on time of placement. This finding was reinforced by Ponciano (2010), who observed that foster mothers with high levels of maternal sensitivity were significantly more likely to create secure attachments with their foster
children than foster mothers identified as having low maternal sensitivity.

**Cognition/executive functioning.** Adolescents in foster care also struggle in the domain of cognitive and executive functioning—a struggle that is often initiated at a very young age. For instance, assessing 18- to 21-year-olds who had been in care on a continuous basis for at least five years prior to aging out, Festinger (1983) found that 32 percent of males and 20 percent of females had moderate to severe learning problems upon discharge from care (as cited in McDonald et al., 1996). In their meta-analysis, McDonald et al. observed moderate support for the assumption that multiple placements would negatively impact educational achievement. Simms (1989), who evaluated 113 children between the ages of one month old and six years old, found that 61 percent of the participants were delayed in one or more domains of a developmental assessment. Kagan (1996) posits that children and adolescents in out-of-home care are often diagnosed with learning and developmental disabilities, as well as with executive functioning-related deficits (e.g., inattention). Similarly, Child Welfare of America (1997) cited evidence that approximately 20 percent of children living in out-of-home care have developmental and learning disabilities. This organization also reported that, in 1988, 30 percent of Illinois school-aged foster children were receiving special education services.

These earlier studies are corroborated by more recent research. For example, Courtney, Dworsky, Lee, and Raap (2010) looked at the outcomes of young adults (ages 23 to 24 years old) who had been out of care for at least four years. These researchers found a continued persistence of educational deficits from late adolescence through the transition out of foster care. At the time of this evaluation, approximately 25 percent of participants did not have a high school diploma or its equivalency. Compared to a representative national sample of 23- to 24-year-olds, the post-care young adults were less likely to be enrolled in school, less likely to be pursuing postsecondary education, and more likely to be enrolled in a
two-year college rather than a four-year college. In their study of Norwegian children attending fifth through seventh grades, Iversen, Hetland, Havik, and Stormark (2010) found that 12 percent of children in contact with child welfare had general learning difficulties compared to 0.4 percent of their age-matched peers.

McDonald et al. (1996) identified some protective factors that may encourage academic achievement in foster children and adolescents, such as congruent educational aspirations and expectations between child and foster parent (Triseliotis, 1980), as well as the presence of one long-term caseworker (Palmer, 1976). This last protective factor may be difficult to meet due to the potentially transitory and shifting nature of foster care, which may impede consistency of care (Simms, 1989). Furthermore, multiple moves, and subsequent shifting school sites, may exacerbate cognitive and learning problems by contributing to gaps and irregularities in the fostered youth’s education (Zetlin, Weinberg, & Shea, 2010). In light of the current economy, adolescents in foster care, with poor educational outcomes, are particularly vulnerable. They will likely have even more trouble finding meaningful employment than youth who were not in foster care. Courtney and Heuring (2005), in their review of studies conducted between 1981 and 2002 with former foster youth, found that young adults aging out of foster care were unemployed and relied on public assistance at a higher rate than youth in the general population.

**Behavior/impulse control.** The combination of adolescent brain maturation, which increases the risk of impulsivity (Spear, 2000; Steinberg, 2008, 2010), negative effects of early poor and disruptive attachment experiences (Cozolino, 2006; Schore, 2003a), and out-of-home placement may interact to engender serious acting-out behaviors in teens in foster care. According to Shields, Cicchetti, and Ryan (1994), when compared with children who have not been abused, adolescents who experienced abuse and/or neglect tend to regulate emotion using strategies that are more aggressive, both physically and verbally.
Dixon (2008) likewise observed that young adults transitioning out of care had significant problems with anger management, aggression (i.e., verbal, physical, and sexual), hyperactivity, alcoholism, and criminal offending.

McDonald (1996) reports that repeated changes in placement appear related to increased criminal activity on the part of young adults who had been in foster care (Ferguson, 1966; Kraus, 1981). In a similar vein, Courtney et al. (2010) observed that both young adult males and females, approximately four years post-care, had significantly higher cumulative levels of criminal justice system involvement compared to their counterparts in the general population. Evaluating 278 African American males between 11 and 16 years old, Ryan, Testa, and Zhai (2008) found that the participants who had already experienced multiple placements, and who expected to be transitioned among multiple sites, were more likely to receive delinquency petitions compared to youths who were in stable settings. Perhaps not surprisingly, positive attachment to foster parents and commitment to a religious organization served as protective factors against obtaining a delinquency petition (Ryan et al., 2008).

Research also distinguished between youth placed in foster care with strangers versus individuals placed in kinship care. Both McDonald and Ryan et al. highlight the finding that youths who continue to have contact with their families of origin engaged in delinquent and criminal behaviors at a greater level than adolescents who were not placed in kinship care. Moreover, Dworsky and Courtney (2009) identified delinquency and a propensity to run away as strategies employed by foster youth. These strategies increase the risk that these youth will become homeless once the adolescent ages out of foster care.

The capacity to securely attach to individuals, communities, and organizations that can provide social-emotional support serve as a powerful protective factor against the development of behavioral and conduct problems. The fostered adolescent may never have developed this capacity in infancy and/or childhood. Steinhauer (1974) describes a path in
which “abused and neglected children who are repeatedly moved from one home to another eventually lose hope, stop caring about others, and become violent themselves” (as cited in Kagan, 1996, pp. 194-195). Adolescents may look to other marginalized youths for attachment; however, the currency driving the connection may be similar experiences with violence and aggression. For some, gang involvement may provide the fostered adolescent with a relational framework while, at the same time, earning the adolescent respect and a feeling of competency based on community or neighborhood control (Kagan, 1996). The association between gang involvement and foster care is strong. For example, in their assessment of adolescents in a residential treatment facility, Danyko, Arlia, and Martinez (2002) found that foster care placement prior to the age of five years old was significantly associated with later gang affiliation (as was enduring at least one form of abuse and a posttraumatic stress disorder diagnosis).

Two other areas in which foster adolescents engage in risky behavior at a greater rate than their non-fostered peers are substance use/abuse and unprotected sex, leading to teen pregnancy. For example, Ward, Henderson, and Pearson (2003) found that U.K.-based adolescents in foster care were at increased risk for substance misuse and more frequently used cannabis, cocaine, heroin, solvents, and alcohol compared to same-aged peers not in out-of-home care. Based on the reports of young adults who had newly transitioned out of care and their caseworkers, Dixon (2008) observed that 18 percent of the young adults misused drugs and alcohol at three months post-care, and 32 percent had significant problems with substances 15 months post-care. Studying the 2000 U.S. National Household on Drug Abuse database, which had a sample size of 19,430 12- to 17-year-olds, including 464 fostered adolescents, Pilowsky and Wu (2006) found that the teens who had foster care histories were significantly more likely to use illicit drugs and to become dependent on alcohol and drugs compared to their peers. These findings were consistent for the years of
2002 and 2003, according to the National Survey on Drug Use and Health (NSDUH), which was conducted by the SAMHSA OAS (results published in 2005). The NSDUH report also found that fostered youths had significantly higher rates of illicit drug use compared to teens who had not been in care.

Adolescents in, or who have been in, foster care also appear to have higher rates of pregnancy compared to the general population. Courtney and Dworsky (2005) found that approximately half of the 732 post-care females (aged 19 years old) they interviewed had been pregnant at least once, which is a significantly higher number than same-aged females in the general population. At a follow-up evaluation, conducted approximately four years later when the participants were 23 to 24 years old, more than 75 percent of the post-care young women had been pregnant at least once compared to 40 percent of the females in the general population (Courtney et al., 2010). Sixty-one percent of post-care males aged 23 to 24 years old reported impregnating a female partner compared with 28 percent of males in the general population (Courtney et al., 2010). While impulsivity associated with adolescence may play a role in these teen pregnancy estimates, yearned for attachment and intimacy (Kagan, 1996), as well as a desire to experience relational competency and achievement (Basow & Rubin, 1999), may increase the risk that adolescent females in foster care will consciously choose to get pregnant. Interestingly, Dworsky and Courtney (2010) found that the extension of care beyond 18 years old and fewer overall foster placements were negatively correlated with the likelihood of teen pregnancy. These findings suggest that adolescent girls in foster care who are securely attached to attuned caregivers may feel less motivated to create the opportunity for positive attachment experiences by having a baby.

The Capacity to Use Alone Time in Adolescence

According to the literature reviewed in the above sections, adolescents who have experienced early secure attachment are more likely to effectively and constructively use
alone time than adolescents with insecure attachment statuses. Through these early positive attachment relationships, the infant (and later child and adolescent) experienced emotional regulation due to the timely, appropriate ministrations of the caregiver. Experiences of frustration were attenuated by the caregiver’s attunement. As the child repeatedly experienced this dependable care, her implicit and explicit memories of confidently anticipating and receiving soothing engendered within her the capacity to soothe herself in situations where the other was not available. Therefore, the securely attached child may struggle with challenges presented by the outside world; however, this child can modulate the stress engendered by these challenges, thus increasing her ability to respond to and meet demands in a focused, planned, and productive manner. It is this pathway—from the felt sense of consistent relational attunement to the belief in and practice of one’s agency—that serves as a roadmap for understanding the development of Winnicott’s (1958/1974) capacity to be alone construct.

However, prior to a more in-depth discussion of the model generated by Winnicott’s (1958/1974) capacity to be alone concept and its relationship to the extensive research on adolescent development and developmental traumatology (De Bellis, 2001), a general review of adolescents’ perception and use of alone time is necessary. Galanaki (2004) differentiates between aloneness (i.e., the objective state of being on one’s own), loneliness (i.e., a subjective feeling often experienced as painful), and solitude, which is “a state of voluntary aloneness, during which personality development and creative activity may take place” (p. 436). For example, Galanaki, whose definition of solitude is analogous to Winnicott’s idea, conducted a study with 180 second, fourth, and sixth graders. This researcher found that the second graders had limited understanding of a generative aloneness; however, the value placed on solitude increased significantly by sixth grade. Larson (1997) also observed that older adolescents tended to have more positive perceptions of, and to choose solitude more
frequently, than younger adolescents (i.e., 50 percent of ninth graders compared to 36 percent of fifth graders). The adolescents’ ability to choose solitude, and the activities with which they wished to fill this alone time, was a salient contribution toward making the solitude enjoyable for the older adolescent (Larson, 1997). Additionally, Larson found that an intermediate amount of time spent in solitude by older adolescents, as opposed to too little or too much time, facilitated psychological adjustment and better academic performance. Goossens (2006) also underlines the salubrious effects to the adolescent who experiences a balance of solitude and time spent with others; solitude offers the particular benefit of self-reflection and emotional regulation.

Yet, in the case of some adolescents, alone time is not voluntary, nor does it occur within optimal time segments. For instance, Hersch (1998) states that teens, raised in an environment with the increasing existence of one-parent families and families with two working parents, “are growing up with no adults around, a deficit of attention, and no discussion about whether it matters at all” (p. 19). Hersch relays the following statement of a 16-year-old girl, “You basically have a life of your own” (p. 21). Pollack (1998) similarly argues that adolescent boys feel “lonely” and “abandoned,” primarily due to their socialization to individuate from parents and solely rely on themselves and their peers for guidance. According to a 15-year-old boy interviewed by Pollack, “I guess it’s hard being a guy because there are so many things that a normal person would do that you are not allowed or expected to do” (p. 173). Girls feel alone, too. For example, Straus (2007), who claims that many adolescent girls are alone approximately six hours a day, cites several studies highlighting that too much alone time is associated with a variety of negative outcomes, including early involvement with sex, drugs, alcohol, and the legal system (Office of Juvenile Justice and Delinquency Prevention, 1999), poorer academic achievement (Afterschool Alliance, 2004; Schneider & Stevenson, 1999), and lower self-esteem, as well as emotional
and physical anhedonia (Csikszentmihalyi, 1997). In a more recent study, Barnes, Hoffman, Welte, Farrell, and Dintcheff (2007) found that teens who spent a considerable amount of time alone, and not engaged in a productive activity, were significantly at risk for using illicit drugs and engaging in sexual activity. Conversely, the more time spent in family activities served as a protective factor against adolescents engaging in sexual activity and delinquent behaviors, as well as using drugs and alcohol (Barnes et al., 2007).

Adolescents in foster care appear to be a group that is at a heightened risk for experiencing an inordinate amount of alone time. Being alone for these teens may be involuntary; however, it may also become a choice. For instance, Jackson et al. (2010) studied whether or not foster care youth (ages 14 to 17 years old) derived emotional support from their religious beliefs and spirituality. While just over half of those surveyed indicated that they pray or seek help from others when they undergo harmful experiences (i.e., 59 percent and 56 percent, respectively), 67 percent of respondents indicated that they choose to be alone. In another study, Browne (2002) found that foster care youth who had been sexually and physically abused as children, or who experienced conflict with one foster family leading to a crisis placement with another foster family, were significantly less likely to emotionally invest in close friendships than youth who had successful placements. They were also more likely to isolate from others and blame themselves when experiencing a problem compared to their study counterparts (Browne, 2002).

Adolescents in foster care, due to their histories of traumatic loss and attachment disruptions, may further experience significant anxiety interacting with others and, therefore, refrain from engaging in intimate relationships. The insecurely attached foster youth in Andersson’s (2009) longitudinal study, characterized as either ambivalent/preoccupied or avoidant/dismissive, often felt lonely; yet, they also tended to minimize the need to be in relationships with others. According to one respondent interviewed by Andersson, “Me and
relationships just don’t go together” (p. 23). As foster youth become adults, insecure attachment status, limited relational competency, and a propensity to favor aloneness as a safety strategy may be sustained. The long-term effects are also noteworthy. For instance, Cook-Fong (2000) observed that adults who had been in foster care during childhood and adolescence reported significantly less marital satisfaction and more social isolation than their same-aged peers who had never been placed in out-of-home care. In Galanaki’s (2004) terms, these studies seem to highlight that fostered youth have more experience with “aloneness” and “loneliness” than with “generative solitude.”

Summary

This chapter reviewed normative adolescent development, including brain maturation and its effect on emotional regulation, cognitive and executive functioning, and behavioral regulation. Adolescent attachment experiences were also examined. Both neurological development and attachment were considered from an ontogenetic perspective; that is, positive early attachment experiences will facilitate adaptive brain maturation, thus engendering more effective regulatory capacities in adolescents. On the other hand, undergoing early attachment trauma negatively alters neurological development, which, subsequently, hinders the development of regulatory competency. Adolescents in foster care often experience early attachment disruptions due to enduring abuse and neglect, which leads to out-of-home placement(s). The resulting deficits in emotional, cognitive, and behavioral functioning, coupled with a history defined by transition and loss, may interact to create teenagers who have significant difficulty being, and constructively using, aloneness. In the following chapter, I will discuss how the foster adolescent’s limited experience of being alone in the presence of a reliable other (Winnicott, 1958/1974), as operationalized in terms of emotional regulation, cognitive capacity and executive functioning, and impulse control, impedes the foster adolescent’s experience of the self as a creative and generative being.
Chapter 4

The “Capacity to Be Alone” Grows Up

An Object Relational-Developmental Framework

The capacity to be alone, as elucidated by Winnicott (1958/1974), is a psychological achievement engendered by the consistent, attuned presence of the good enough caregiver. The environmental provision of holding, handling, and object-presenting within the first two years of an infant’s life enables the child to experience a continuity of being that is both mental (i.e., integration) and, then, psychosomatic (i.e., personalization; Winnicott, 1962/1974). The caregiver’s presence facilitates the present-ness of the child. The child can experience her self and her environment (as well as her self within her environment) with tolerable anxiety, and, consequently, she can interact with her environment with creativity and agency (i.e., object-relating; Winnicott, 1962/1974). The capacity to be alone is predicated on integration, personalization, and object-relating, which are developmental milestones tied to emotional, cognitive, and behavioral regulation capabilities.

As discussed in the previous chapter, infant-caregiver attachment bi-directionally interacts with infant neural development (Bowlby, 1990; Cozolino, 2006; Schore, 2003a, 2003b; Siegel, 1999, 2001). The brain develops in a hierarchical, bottom-up fashion, beginning with the brainstem, which is responsible for autonomic processes (e.g., breathing, heart rate, among others), and ending with the prefrontal cortex, the site for higher cognitive functioning (e.g., attention, planning, problem-solving, and abstract thinking). For the infant who experiences attunement, reflection, and good enough care, neural networks develop adaptively and robustly (Perry, 2008, 2009). For an infant who undergoes the continual uncertainty of a chaotic, unreliable, withholding, and/or abusive environment, the physiological stress response system, which develops early in the brain hierarchy, is
over-activated, leading to weak neural architecture that becomes easily overwhelmed by perceived stressors and traumas. According to the National Scientific Council on the Developing Child (2010), the brain development of a child who experiences persistent fear and anxiety is negatively impacted and altered, potentially resulting in difficulties with affect regulation, relational competence, behavioral regulation, and learning.

The object relational-developmental framework combines the theories of Winnicott, specifically the capacity to be alone (Winnicott, 1958/1974), and the attachment-based neural development and developmental traumatology research (Bowlby, 1990; Conzolino, 2006; De Bellis, 2001, 2002; Perry, 2008, 2009; Schore, 2003a, 2003b; Siegel, 1999, 2001). This integrated framework delineates how environmental deprivations have contributed to the externalizing and internalizing behaviors engaged in and experienced by adolescents who are in foster care (see appendix A).

As the experience and effects of the environment take precedence in this framework, the model must begin by looking at the caregiver’s past and current environments. According to Winnicott (1960/1974a, 1962/1974), the caregiver must have the ability to identify with the infant in order to meet the infant’s needs. Attunement requires imagination, as well as the tolerance to be affectively connected to the infant, no matter the infant’s emotional presentation. Winnicott (1956/1975) defines this affectively-regulated imaginal process as primary maternal preoccupation. Interestingly, Winnicott (1968/2001a) similarly characterizes the play of a young child as a “preoccupation…[a] near-withdrawal state…[that] inhabits an area that cannot be easily left, nor can it easily admit intrusions” (p. 51). Primary maternal preoccupation appears to be play—the caregiver role-playing the part of infant, and serving as a role model for the infant on the kinesthetic pleasures of play.

The ability to play is founded on the capacity to be alone (Winnicott, 1958/1974), as play is the manifestation of subjective thoughts, feelings, impulses, and motivations given
physicality according to the objects available in an environment (Winnicott, 1968/2001a). The capacity to be alone involves the recognition that one is separate from the environment and from others. Having the knowledge that one’s surroundings are not under one’s total control requires the affective regulation to manage the anxiety of uncertainty. As play provides a way to connect the self to the other (and environment) through the doing of playing, play likely engenders anxiety. “The thing about playing is always the precariousness of the interplay of personal psychic reality and the experience of control of actual objects” (Winnicott, 1968/2001a, p. 47).

Playing involves risk and, therefore, belief in one’s ability to go-on-being. To play, one must be in the unintegrated state (Winnicott, 1958/1974), a “resting state out of which a creative reaching-out can take place” (Winnicott, 1968/2001c, p. 55). One reaches out if there is an expectation of being given to and/or met. In the parent-infant attachment literature (National Scientific Council on the Developing Child, 2007), the concept of serve and return, in which the baby produces babbling, gestures, and facial expressions to elicit parental attunement, underlines a belief in a consistent, responsive environment. However, a child cannot regress to an unintegrated state in order to engage in play if the child has not first experienced integration, which is the result of holding (Winnicott, 1958/1974) and adequate parenting (Hunter, 2001). Without holding and attunement, the infant experiences too much anxiety and few moments of integration; thus, unintegration is a state to be assiduously avoided. A trust in a benign environment has not been internalized. Unintegration may be experienced as psychic death to a child who has minimal familiarity with the feeling of going-on-being (Winnicott, 1962/1974).

It is salient to note the psychosomatic nature of play, especially as the body is intimately and necessarily involved in the doing of play. Play often requires the motoric manipulation of objects, and it also potentially engenders physiological experiences of
excitement (Winnicott, 1968/2001a). If physiological arousal becomes too intense as a result of playing, the discomfort of the body may cause a psyche-somatic dissociation because the child cannot tolerate this discomfort (Winnicott, 1964/1992). The body is felt as persecutory and dangerous (Corrigan & Gordon, 1995); thus, a child may disconnect her psyche from her body to ensure a sense of going-on-being. Two results may occur: fragmented, mercurial ideas with no tether grounding them to reality; or, meaningless and arbitrary-seeming impulsiveness and emotional reactivity. According to Phillips (1993), “benign solitude,” which is replenishing and generative, occurs when one is “reliably alone in the presence of the body and its thoughts”—the body is a “sufficient holding environment” (p. 32). For the body to become a reliable, trustworthy holding environment, the caregiver(s) must first—and continuously—establish the initial holding environment for the infant. The psychosomatic nature of play is facilitated by the belief the child has in her reliable, attuned surroundings (Winnicott, 1964/1992), a belief that can then be transferred to the framework of her own body.

Potential space is a concept significantly related to play and to the object-relational developmental framework. Potential space is a “hypothetical area,” existing between the internal psyche and “inherited potential” of the individual and the actual objects found in the outside world (Winnicott, 1953/1986, 1970/2001). It is an intermediary location—one that also presupposes the acquired knowledge that there is a me and not-me. This is the area of object-presenting, object-relating, and object usage. This is the place of play. If the caregiver can allow the infant to separate out, to not simply be an extension of the caregiver’s own needs, the possibility for intersubjectivity arises. The more enriching the environment provided by the caregiver, the greater the potential space (Winnicott, 1970/2001). The potential space is created both by what the caregiver brings, as well as to the trust facilitated in the infant by the caregiver’s reliable presence, which induces the child’s reaching out.
Akin to the paradox of the capacity to be alone, which is an achievement founded on being in the presence of the other (Winnicott, 1958/1974), potential space is connective tissue linking two separate beings. It is the area of symbolism in which two individuals can communicate with one another, or in which an individual can apprehend and make meaning of her cultural context (Winnicott, 1970/2001). Potential space is positioned within and between the self and the other and is a mixture of these play areas.

The capacity to play, and the development of potential space (i.e., the playground), is the result of the infant’s confidence in the caregiver (Winnicott, 1968/2001a). A reliable, attuned caregiver provides holding, handling, and object-presenting, thus contributing to the development of an individual who experiences relative comfort in her body and who can interact with her world in a meaningful and purposeful manner. However, if the caregiver has not experienced good enough care in his or her life, he or she will consequently be hard-pressed to provide good enough care to the infant. Winnicott (1963/1974a) describes a depressed mother who cannot conceive of having a “live child” who has specific needs outside of the mother that require attention. Because this mother is incapable of imaginatively putting herself in the place of her baby, the infant must be subsumed into the mother’s place (i.e., self). The task of the infant in this predicament is to animate and/or resuscitate the mother. An infant who experiences such demands will experience significant difficulty in achieving integration, personalization, and object-relating. As a result, the following competencies are put at risk: emotional experiencing, awareness, and regulation; attention, concentration, and mindfulness; and purposeful, consequential, and meaningful doing.

**Adolescence and Rebellion**

According to Winnicott (1968/2001b), adolescence is “where the successes and failures of baby and child care come home to roost” (p. 143). Like Erikson (1998), Winnicott (1963/1997) views adolescence as a time of “personal discovery [in which] each individual is
engaged in a living experience, a problem of existing, and of the establishment of an identity” (p. 145). This description mirrors early infantile development. “A living experience” is akin to the experience of going-on-being that an integrated infant, who has been adequately held, achieves. Existence is conceptualized as a three-dimensional being in a three-dimensional location. To exist is to be in and to act upon one’s world; therefore, existence is predicated on personalization, which is the development of a bounded, psychobiological being. Winnicott (1968/2001c) states, “Only in being creative does the individual discover the self” (p. 54).

The self—the response to the question, “Who am I?”—is (optimally) an identity experienced as agentic, idiosyncratic, and True (Benjamin, 2002; Sander, 1983; Winnicott, 1960/1974b). It requires of the individual the capacity to relate to and utilize objects in the potential space. Such a creative, dynamic identity is facilitated by play.

This process of adolescent personal discovery has specific and special features attached to it. Winnicott (1963/1997) similarly compares the rapid emotional and physical growth taking place with the onset of puberty to the significant and accelerated advances occurring in infancy and early childhood, a claim reinforced by Spear’s (2000) review of adolescent biopsychosocial development. However, unlike the infant or toddler, the adolescent has the strength and physicality to cause considerable damage to her surroundings, and to her self, while on her identity search (Winnicott, 1963/1997). Whether the achievement of a personal identity in adolescence is the result of internal, family, or societal expectations, or, more likely, a combination of all three, adolescence is considered the staging area prior to taking on the full responsibility of adulthood. Further, for Winnicott (1968/2001b), the adolescent has the power, proximity, and encouragement to contemplate and enact taking her parents’ place. Winnicott states, “In the total unconscious fantasy belonging to growth at puberty and in adolescence, there is the death of someone…and personal triumph as something inherent in the process of maturation and in the acquisition of
adult status” (p. 145). While these fantasies and expectations bring with them the promise of gains in power and status, they are also comprised of loss (e.g., the actuality of the parental home).

It is essential to point out that Winnicott (1968/2001b) is referring to unconscious fantasies of death, not to actual patricide or matricide being contemplated and undertaken by the adolescent. According to Winnicott, “Unconscious fantasy [is] the material that underlies playing” (p. 145). As previously discussed, the capacity to play requires a foundation of trust in a benign, reflective, and responsive environment. Consequently, Winnicott views normative adolescent rebellion as a result of good enough care—a type of care that must be maintained throughout the rebellion. As such, Winnicott underlines the responsibility of the caregivers not to relinquish authority or react in a retaliatory manner toward the adolescents in their care. Resignation of the parental identity, as well as of the beliefs and actions that constitute a subject in his own right, induces the adolescent to prematurely take the reins, foreclosing on her playful attempts at self-definition. Parental vengeance, on the other hand, collapses the potential space, and a False Self may be necessitated on the part of the adolescent in order to manage environmental restrictions (Winnicott, 1960/1974b). Parental handling, with its recognition of the subjectivity of both the caregiver and the adolescent, is required for successful negotiation and fruition of teen rebellion.

As discussed above, rebellion in adolescence appears to be closely aligned with Winnicott’s (1950/1975) conception of motility in infancy. The infant’s increasing experience of motility, which Winnicott also defines as aggressive, occurs in the handling phase. During this stage, the caregiver’s preoccupation with the infant is no longer all encompassing, and the infant is occasionally left to experience moments of anxiety before the caregiver provides the necessary reparative balm. The infant begins to feel the presence of an
outside world that is not under her complete control—there are limitations and boundaries to her power. Consequently, the infant’s experience of going-on-being now has a physical vessel in which to continue the journey. The infant has achieved personalization (i.e., psychosomatic collusion). The developing ego, now ensconced within the developing body, begins to search out objects within her environment that she can use to create ways in which to manifest her Self (Winnicott, 1968/2001c, 1969/2001). For Winnicott, aggression, creativity, and advancement of the True Self are inextricably linked (Phillips, 1993).

In adolescence there is a return to the handling phase due, in part, to the rapid physiological changes occurring at this time (Winnicott, 1963/1997). According to Phillips (1993), “part of the adolescent project is to inhabit and be inhabited by [one’s own] body” (p. 30). Neurobiologically, the teen’s capacity to feel real in—inhabit—her body may be compromised by neuronal changes (Chambers & Potenza, 2003; Spear, 2000; Steinberg, 2005, 2008, 2010). For instance, a decrease in dopamine (DA) production in a section of teen brain seems to limit the pleasure an adolescent feels toward positive stimuli (Spear, 2000). The teen may have to actively seek out new and novel opportunities in which to experience her body as pleasurably alive, or else dissociate from her body to manage experiences of unthinkable anxiety (Winnicott, 1966/1997).

Moreover, adolescents, unlike infants, do not overtly look to parents to provide the handling necessary to feel real in their bodies (Phillips, 1993). Subsequently, teen behaviors, at least to parents, may appear arbitrary, abrupt, and, potentially, disruptive. To clarify this confusion, Steinberg (2010) posits a dual systems model to understand teen risk-taking behaviors. The maturation of the feeling brain (including neural areas responsible for emotional reactivity, motivation, and motoric responsiveness) occurs earlier, once pubertal status has been attained, than the development of the thinking brain, which is associated with
attention, planning, verbal communication, and cognitive attribution. Therefore, teens may act before they think, and they may have difficulty articulating the motivation underlying their actions. This is why adolescents, to experience the achievement and agency related to psychosomatic collusion, must continue to feel the management of an external caregiver, despite teen protest and denial (Winnicott, 1956/1997). Phillips highlights the adolescent’s wish for and defiance of the caregiving framework in his description of a teen patient who learned how to swim once he realized that the water enabled him to float.

The adolescent’s search for objects with which to demonstrate the True Self is another factor emphasizing the creative nature of rebellion. Winnicott (1966/1997) states, “Your adolescent children…are more concerned with not betraying themselves than with whether they smoke or not, or whether they do or do not sleep around. It can be seen that for them…the false solution is OUT” (p. 112, author’s emphasis). The adolescent is attempting to seek out objects in her environment that square with the True Self (Phillips, 1993). As previously described, the child, in order to play, must have the capacity to unintegrate—to be open to internal and external chaos—without being overwhelmed by anxiety (Winnicott, 1958/1974). The “bored” adolescent (Phillips, 1993) is struggling through the doldrums, a phase marked by futility and uncertainty (Winnicott, 1963/1997). Enough actual time and a solid framework are the two masts that enable the adolescent’s navigation through this period (Winnicott, 1963/1997, 1968/2001b).

Peers, and organizations of peers (e.g., sports teams, extracurricular clubs, among others), are, for the teen, more palpable outlets in which to find creativity-inducing objects than parents. Several authors highlight the significant availability and influence of peers to the adolescent (McElhaney et al., 2009; Spear, 2000; Steinberg & Morris, 2001). Yet, despite the wish to create groupings around mutual interests, the adolescent is, says Winnicott (1963/1997), an isolate. That is, the adolescent may not be playing with peers because there
is risk in allowing the other to be fully an object. After all, an object has the power to contribute in to—to change—the subject (Winnicott, 1969/2001). As previously noted, adolescents must undergo the personalization process once again due to the significant biopsychosocial changes that occur in this stage of development (Winnicott, 1963/1997). The psychosocial boundary of the teen is porous. This places the adolescent at risk for being greatly influenced by an object/person that is incongruent with the adolescent’s True Self.

Chamber and Potenza (2003) posit that playing also morphs into experimentation during adolescence. For Winnicott (1963/1997), there are teenagers who have the capacity for play—for internally-driven, outwardly-facilitated creativity—however, the aforementioned psychosomatic challenges associated with adolescence (e.g., puberty), as well as the increase in novel socialization opportunities potentially engender anxiety, overwhelming the ability to unintegrate and play. Instead, adolescents actively experiment—try on and hypothesize—identities. It is through consistent and continual personal experiences of being in relationship with others (e.g., peers, mentors, teachers, and parents) no matter the current identity manifestation—relationships characterized by holding, handling, and object-presenting—that the adolescent once again achieves the capacity to play. Through play, the teen’s identity can be permeated with and buttressed by the True Self.

Adolescents in Foster Care and The Antisocial Tendency

In his paper on “The Antisocial Tendency,” Winnicott (1956/1997) posits that adolescent delinquency is a hopeful gesture that “compels the environment to be important” (p. 123). It is an “acting out,” and “where the acting out is strongly compulsive, it relates to an environmental letdown in the particular individual’s experience” (Winnicott, 1964/1997b, p. 157). According to Winnicott (1956/1997), the deprivation was real—it actually occurred and is the “pinpoint[ed] trauma and the sustained traumatic condition” (p. 124). Delinquency and violence come from a belief, likely based on at least minimal experience, that
environmental care (i.e., reflection and recognition) is possible. The adolescent may have a lived experience of this care somewhere in her history, potentially from interactions with a teacher, mentor, and/or religious leader, if not with her parent(s). The delinquent adolescent wishes, unconsciously, to reanimate the holding environment and its promise of attunement. Her acting out is a sign of hope based on her longing to feel again the holding she had, even momentarily, experienced.

The antisocial tendency is different from adolescent rebellion. The rebellious adolescent has the power to say “No” or “Yes” to objects in her environment, due to having experienced good enough care (Winnicott, 1968/2001b). Indeed, the (continual) existence of a framework presupposes the advent of rebellion. The antisocial tendency, on the other hand, is an attempt to locate or to prod into existence a holding environment in which rebellion can eventually take place. It is important to note that Winnicott (1956/1997) does not conceive of the antisocial tendency as a psychiatric diagnosis. It is an attempt to find holding so that the True Self can come out and play. In this frame, the antisocial tendency is an appropriate response to loss of care. The greater the antisocial activity—the more it causes a nuisance to others and to society—the more prolonged and pronounced the deprivation experienced by the one carrying it out, and the more desperate the call for containment and response (Winnicott, 1956/1997).

The antisocial tendency can show up in several ways, such as lying, stealing, dissociation, self-harm, and/or violence (Winnicott, 1956/1997, 1965/1997). The type and consistency of the antisocial act is related to the timing of the deprivation, a factor that will be considered in greater detail below. It is a tendency within all individuals, laying dormant until a loss awakens the need to once again obtain the object by acting in such a way as to bring the object back into one’s life. The object is necessary for the intersubjective matrix (Benjamin, 1995), which is a connection establishing a framework that makes separation
possible. If what was lost is returned or rediscovered, the antisocial act will cease because it is no longer needed. For example, if an adolescent in foster care is placed with foster parents who can provide empathic and consistent care, it is likely that this teen’s externalizing and internalizing behaviors will decrease over time.

However, if there continues to be loss, or if the loss occurred at such an early stage that the individual (i.e., infant or child) cannot cognitively and affectively mourn the loss, the antisocial tendency will become more entrenched. McDougall (1989) refers to these entrenched behavioral manifestations as “activity addictions”—that is, a habitual use of and reliance on action and physicality to ward off the experience of emotional arousal and anxiety. If the resulting behaviors become increasingly serious, they may lead to the structural interventions proffered by society, such as psychiatric hospitalization or imprisonment (Winnicott, 1956/1997, 1958/1997). Traumatological research reinforces Winnicott’s views on the epigenetic effects of trauma on development. Timing, intensity, and repetition of the trauma(s) (e.g., neglect, abuse, loss) interacts with brain maturation, resulting in later affective, cognitive, and behavioral difficulties (Cicchetti & Rogosch, 2002; De Bellis, 2001; Perry, 2006, 2008, 2009; Schore, 2003a). Adolescents act out proportionately to discover the safety that they cannot provide for themselves. In their communities, juvenile detention centers and prisons, residential and addiction treatment centers, and psychiatric inpatient hospitals offer the ultimate holding for those teens who have lost the most, for the longest time.

Keller (2008) describes working with the aggression of children and adolescents in foster care. Aggression is a double-edged sword for the foster child. On the one hand, it is an attempt to induce the care that was delinquent, or absent, in the foster child’s biological family. However, because the foster child/adolescent may not feel like a “real” part of the foster family, the aggression has a significant amount of fear attached to it. Foster parents are
often required to survive a level of destruction that may be more intense and damaging than the adolescent rebellion experienced by good enough caregivers (Winnicott, 1968/2001b). The destructive foster adolescent is asking, “Is there a framework that can hold me?” (Winnicott, 1956/1997). Keller has often seen the repercussion of a lack of survival (i.e., holding) on the foster parent’s part—displacement of the foster child/adolescent to another foster home. The foster adolescent’s fear is once again realized—she has the power to “kill” others and is, therefore, bad, unlovable, and uncontainable.

Thus, the foster child’s continuity of care, which is integral to experiencing a continuity of being, is again broken, sometimes repeatedly. The concept, as described by Winnicott, of “for ever starting again” leaves the foster child little time (or room) for play. This consequence was aptly described to Liebmann and Madden (2010) by a young adult who had aged out of foster care:

If you jump from foster home to foster home to foster home, if they just randomly move you, . . . like they did us, it’s just like, it throws you completely off balance and then like if you were feeling secure then you are completely insecure because you don’t know where you are at or who you are with. (p. 258)

Hunter (2001) similarly discusses the “strain of leaving one sort of world for another” endured by foster children (p. 129). Hunter relates the story of Hannah, a 15-year-old foster child who “wrestled with an overwhelming sense of having nowhere to belong” and “profound dislocation” (p. 130). Another girl, Elizabeth, as reported to Brown and Seita (2009), not only became parentless as a result of foster placement, she was no longer a sister to her siblings who were placed separately. “One at a time, I had lost all connection to family. ‘Who am I?’ I remember asking myself those lonely years in placement. The answer remained elusive” (p. 122). Managing overwhelming loss and disruption leaves little room
for play spaces.

By contrast, Winnicott (1967/2001b) describes potential space as a location engendered by the infant’s confidence in “the dependability of the mother-figure or environmental elements, confidence being the evidence of dependability that is becoming introjected” (p. 100). Potential space is a place of both connection and difference. It is akin to the string in a game of Cat’s Cradle. Two people take turns making varying patterns with the string. The patterns are epigenetic as the shape of succeeding patterns is predicated on the string’s current format. No change can occur in the game without a partner because there is no one providing ideas and objects with which to create. Additionally, the lack of the other means that only one is left to support the string. It is a self-holding characterized by limited creativity. The foster adolescent has most likely endured the limitations of a partner-less potential space. Early deprivation and lack of holding, coupled with placement changes, prevent the foster adolescent from internalizing dependability because there has been little actual experience with a consistent, attuned caregiver. Further, the ever-changing environments make it extremely difficult for a foster adolescent to latch onto (and use/create with) any object. As Paul, a former foster child, writes, “Children must develop healthy root systems to thrive. Root systems do not develop in transient lifestyles” (Brown & Seita, 2009, p. 39). The rootless-ness and dislocation experienced by Paul, and the fostered youth mentioned in the above paragraph, perturbs their sense of self because they are not a part of any frame. As a result, there are few, if any, objects with which they can develop and assert their True Self (Winnicott, 1967/2001b).

Without a consistent holding environment, which also includes handling and object-presenting, the True Self may go underground. Liebmann and Madden (2010) share a poem written by an 18-year-old girl in foster care that includes the lines: “Forget about the fake smile you see. Can you see what lies inside of me…Can you find the real me? I hide so
quickly” (p. 260). Similarly, Omar, a teen living in a group home, discusses his shame about not having a family, saying, “I was almost two people in one. During the day in school I pretended I was like everyone else…” (Desetta, 1996, p. 121). Both of these teens are relentlessly on alert for assaults to their sense of going-on-being; therefore, their ability to be alone, unintegrate, and play, which sparks and exposes the True Self, is severely damaged. Then again, for these teens, they may not have had this capacity to begin with, especially if they experienced early environmental deprivation and trauma.

The hypervigilance shared by many foster teens highlights a cognitive manifestation of the False Self. A mind that must work overtime in order to try to ensure security will have limited time, energy, and opportunity to engage in play and work. Winnicott (1965/1989) describes the pathway from the infant’s experience of environmental deprivation to the development of an ever alert mind. Due to inadequate holding,

…the baby survives by means of the mind. The mother exploits the baby’s power to think things out and to collate and to understand. If the baby has a good mental apparatus this thinking becomes a substitute for maternal care and adaptation. The baby “mothers” himself by means of understanding, understanding too much (p. 156).

Hunter (2001) discusses Jody, a nine-year-old girl in her second foster placement, who “circled around the [therapy] room taking out one toy after another, her play fitful and distracted, her wariness of [Hunter] discernible, her restlessness constant” (p. 153). To manage her anxiety in session, Jody cut pieces of molding clay into smaller and smaller pieces as if dissecting it; however, she did not create a symbol with the clay. Her approach to the clay was all analysis, and no synthesis. This is a typical use of “play therapy” without actual “play” involved in it. Jody also controlled the room with her constant talking, joyless repetitious enactments, and insistent direction of the therapist’s activities. By breaking clay
down into its essential “clay-ness,” and by dictating the dynamics of the therapeutic relationship, Jody attempted to create an environment in which she could know what to expect. Jody left no room for surprise, or for her (or the therapist’s) spontaneous gesture.

There was a rigidity to Jody’s approach, and if Hunter (2001) ventured to interrupt this rigidity (e.g., by slowing her down or reflecting Jody’s presentation), Jody reacted with anger and withdrawal. The comfort provided by knowing has an aspect of the antisocial tendency about it. With knowing comes certainty and structure, a reestablishment of a framework that was damaged by misattuned and insufficient care. Reliability is found in one’s perception, if nowhere else. Yet, for foster youth who experience multiple placements, which necessitates adaptation, a reliance on knowing may be significantly undermined.

Even for foster adolescents who appear cognitively competent struggle under the pressure to maintain certainty. Danita, a former foster child, describes her difficult transition from elementary and middle school, where she achieved academic success, to obtaining poorer grades at a magnet high school:

I went from the honor roll to struggling to maintain a C average. I found myself competing with other smart kids who knew how to study and who worked hard for their grades. I had minimal study skills and even less self-discipline. (Brown & Seita, 2009, p. 61)

John, another former foster youth, became depressed and suicidal when he underwent the shift from high school and foster care to college and independent living. John writes,

As I embarked on [entering college]…I did so with a great sense of fear and no support system at all. I once again felt abandoned in almost all ways. I was adjusting to something new on my own, as I had so many times before. I did not know what to expect and was not successful in making friends to help me through the transition to adulthood. (Brown & Seita, 2009, p. 20)
Elizabeth, like Danita and John, also faced a transition—graduating from college into a professional life (Brown & Seita, 2009). She attended classes, studied constantly, and worked several jobs; however, even though she was in her final semester, Elizabeth had no plan for what came next. She did not give herself the room to explore what she could possibly be. When a future possibility fortuitously presented itself, Elizabeth could think about nothing else other than securing this opportunity. Her fantasizing about obtaining an internship was as single-minded as her approach to completing college. In Winnicott’s words (1971/2001), Elizabeth was “unable to distinguish between fantasying, which paralyzes action, and real planning, which has to do with looking forward to action” (p. 33). The thinking processes of these former foster youth appear rigid.

This rigidity seemed to increase in direct proportion to the instability of their environment. Danita, Elizabeth, and John underwent the same school transitions that most children and adolescents undergo; however, school transitions for foster youth, which include a loss of place and persons (e.g., teachers and coaches), may consciously and/or unconsciously remind foster adolescents of prior traumatic losses (e.g., biological and foster parents). Van der Kolk (1996) states, “Traumatized patients experience current stressors with an intensity of emotion that belongs to the past, and has little value in the present” (p. 188). Van der Kolk notes a high comorbidity rate of posttraumatic stress disorder and attention-deficit/hyperactivity disorder. This indicates that anxiety engenders difficulties with attention and stimulus discrimination, promoting rigidity. Furthermore, Fish-Murray, Koby, and van der Kolk (1987), who compared the cognitive development of maltreated six- and 11-year-olds with non-maltreated peers, found that maltreated children struggled with flexibly manipulating and symbolizing information, as well as with recognizing the perspectives of others more than children in the control group. These authors posit that “autonomic nervous system arousal and steady state anxiety caused by conditioned fear and
anticipatory frustration inhibited the ability to make guiding plans, to play with alternative approaches, or to anticipate probabilities at age-appropriate levels” (Fish-Murray et al., 1987, p. 101).

Difficulties with symbolization, information manipulation, planning, attention, and multiple perspective taking impede a child’s, and adolescent’s, ability to play. Further, play requires the integration of new experiences and learning. As Stien and Kendall (2003) claim, play consists of both accommodation—the child’s readjustment of “internal models of the world…to the realities and demands of the environment”—and assimilation—the child will align the environment and present situation with her “existing cognitive framework and current needs and desires” (p. 124).

Play is the interaction of the internal with the external; it is the stuff of potential space (Winnicott, 1953/1986, 1970/2001). As previously described, Jody, like many foster children in therapy, could not symbolize or create, that is, she could not play (Hunter, 2001). Similarly, 15-year-old Naomi, another client, had a limited capacity to perceive and acknowledge people in her external world who did not behave in ways that confirmed her internal beliefs that others are deficient and abusive, and that she had little power to do anything about it.

[Naomi’s] perception of her foster mother as uncaring, lazy, and neglectful is a distortion of the present into the shape of the past. Her perception of herself as a helpless victim manipulated by more powerful others is similarly a distortion of reality. (Hunter, 2001, p. 123)

For Naomi, both she, and others in her life, had a circumscribed capacity for growth and development. Naomi did not feel safe enough to modify her assimilative processes. She did not have the freedom, born of early attunement and structure, to leave her self open to surprise and possibility. Nor did she have the confidence in others to hold her through the
Despite the limited creativity, rigid thinking, and circumscribed identity development generated by a ubiquitous False Self presentation, the story of Angelique, an adult woman looking back on the neglect and abuse she endured that eventually led to foster placement, highlights how a False Self also enables attachment (Brown & Seita, 2009). According to Winnicott (1960/1965), one job of the False Self is to promptly acquiesce to and manage the demands of the caregiver. With this compliance comes continued attachment. Angelique writes,

I wore a paper mask, through which no one could see the real me. I was a good student and never drew negative attention to myself. This made me acceptable to peers and teachers alike. I blended in so well that no one knew about my home life. (Brown & Seita, 2009, p. 45)

Even when actual bruises marred her mask, Angelique lied to save her mother’s face, as well as their connection.

A reactive concealment of the True Self is also illustrated by Vasser’s work with an African American boy, referred to as “Tony,” from Detroit, Michigan (Schaer & Vasser, 1995). Vasser provided inpatient and outpatient therapy to Tony from the age of seven to 12 years old. Tony self-describes as a “player” who has the ability to immediately read, mold himself to, and manipulate his surroundings. Vasser reports feeling “discomfort” by Tony’s chameleon-like ability to effectively mimic the therapist’s gestures and demeanors; however, Tony is also greatly liked by the hospital staff due to his “savoir faire.” Schaer and Vasser refer to Tony’s abilities to ingratiate himself to others as “working for the mother,” which is a state “where the mother remains narcissistically invested in her infant only as long as the infant gratifies her” (p. 137). Although a “player,” Tony’s hypervigilance, which is due to a lack of reciprocal mirroring and attunement, prevents him from the experiencing the
relaxation needed to play and, thus, to enliven his True Self. Both Angelique and Tony appear to be constantly functioning as mirrors. They are attempting to mirror the idealized wishes of the others (e.g., to be effective and loved caregivers, teachers, and therapists, among others) in order to maintain connection. This capacity to shift presentations in order to fit current circumstances may impede identity development, along with True Self exposure.

Understanding, fostering, and integrating one’s identity are significant tasks of adolescence (Blos, 1962; Erickson, 1998; Gilligan, 1982/1993, 1991; Levine & Kline, 2007; Miller, 1976/1986, 1984/1990; Shumaker et al., 2009; Spear, 2000; Steinberg & Morris, 2001; Winnicott, 1963/1997, 1968/2001b). Janet Fitch’s novel, “White Oleander,” poignantly describes the arduous task of identity development experienced by a teen who has undergone several foster placements. Astrid enters foster care at the age of 12 years old after her mother, Ingrid, commits murder and is incarcerated. Over the course of five years, Astrid lives in five foster homes and one group home. Astrid tries on the identity that best ensures her continued presence within each foster home. At her final face-to-face meeting with her mother, Ingrid asks Astrid, who is now 17 years old, to lie for her in court—to put on another show. Ironically, during this conversation, Ingrid expresses disapproval about Astrid’s current physical appearance. Astrid responds, “I can look however you want” (p. 367). Despite Astrid’s claim, Ingrid is not contented. The missing (and missed) mother says to the missing daughter: “You used to have a certain delicacy about you. A transparency. You’ve become heavy, opaque,” (p. 367). It seems that Astrid’s True Self has gone underground.

Notably, the journey toward a False Self occurred over a long time. The imprisonment of her mother at the age of 12 years old and her subsequent foster placements were not Astrid’s original experiences with loss. She learns that her mother left her with a neighbor for approximately a year when Astrid was just a toddler. Ingrid states that she left because she could not endure young Astrid’s “spider”-like, clingy desires. Ingrid could not
handle Astrid. “I looked up at her, my mother,” thinks Astrid, “this woman I had known and never really knew, this woman always on the verge of disappearance” (p. 369). Because of her belief in and experience with her mother’s leaving, Astrid cannot relax, unintegrate, and play. She is a reactor constantly on alert for impingements. Furthermore, in terms of her True Self and identity, Astrid has become, like her mother, the disappeared.

It is necessary to discuss here how Winnicott’s (1953/1986) theory of the transitional object relates to play and what a transitional object may become for one who cannot play due to a lack of environmental provision. The transitional object is an affective and effective reminder for the child of the primary caregiver. The caregiver provides it; however, the child ostensibly and unquestionably creates it. For Winnicott, a true transitional object becomes, to the child, more important than the caregiver. It becomes this powerful because the child has begun to experience and internalize the presence of the consistent carer. The transitional object marks and extends the play area. It accompanies the child on her travels and is under her control. Over time, the particular transitional object loses its power, its “meaning, and this is because the transitional phenomena have become diffused…over the whole cultural field” (Winnicott, 1953/1986, p. 259). The transitional object facilitates play because it enables the motility and agency of its creator. It also facilitates dialogue because it becomes symbolized—a thing that two individuals can meaningfully talk about when they have the cognitive capacity to do so. Winnicott highlights the relationship of the transitional object to play, artistic creativity and appreciation, religious feeling, and dreaming; however, he also indicates that “fetishism, lying and stealing, the origin and loss of affectionate feeling, drug addiction, the talisman of obsessional rituals” may be linked to the object as well (p. 259).

The latter view of the transitional object seems connected to Winnicott’s conception of the antisocial tendency (1956/1997, 1965/1997). If the antisocial tendency occurs to engender or resuscitate the lost environmental framework, the transitional object is only
important to the child in its ability to recall or reclaim the missing caregiver. It is not a true transitional object because the child cannot blithely disregard the caregiver in favor of the object. There is no caregiver to disregard. The caregiver has become too important due to his or her absence. In a similar vein, Phillips (1993) claims that such individuals are controlled by the things for which they are waiting. Agency and creativity are not the results of the deprived child’s relationship with a transitional object. The pseudo-transitional object and, more significantly, loss, control the child. In this scenario, consistent longing, and its manifestations in addiction and compulsion, replaces the transitional object.

Foster adolescents typically experience multiple losses. Loss initiates their status as foster adolescents; that is, they are defined by loss. This is depicted in “White Oleander,” when Astrid says to Ingrid, “I was always waiting for you, Mother. It’s the constant in my life. Waiting for you” (p. 375). Foster adolescents may utilize stealing, violence, self-injury, and substance abuse to force into existence a framework within which they will receive care. Yet, if they continue to experience loss and deprivation, they may come to depend on the vehicle of their antisocial tendency. After all, the vehicle has been imbued with the longing, which is their only connection to the missing. The process and/or substance addiction becomes the framework. This describes Craig, a 15-year-old Latino male who ran away from his foster home after stealing money from his foster mother, who states, “Stealing. To be honest with you, I used to love stealing. It was the main thing I was good at” (Desetta, 1996, p. 43). A 16-year-old girl living in a group home reports her long history of stealing, saying that the act gives her “a natural high…it gives me the biggest rush. I feel reckless” (Desetta, 1996, p. 144). This teen indicates that her biological family has a history of drug and process (e.g., stealing) addictions. In grappling with her need to steal, she posits, “In all addictions you are hurting yourself in some way. Because of my past and my family situation, it’s as if I need an addiction” (Desetta, 1996, p. 145). This adolescent girl is attempting to connect with
her family, with those she lost, through addiction, even though she recognizes the harm she
does to herself and to others. Her identity as a “stealer” facilitates a link to her past, as well as
to her parents. These actions underline Hunter’s claim (2001) that adolescence is the stage in
which “looked-after children reveal how impelled they feel to renew links with birth parents
no matter how abusive or destructive such relationships may be” (p. 117).

Self-injury may be another way in which foster adolescents reestablish (or initiate) a
connection to who and what has been lost. Motz (2010) theorizes self-harm as a hopeful
action akin to Winnicott’s view (1956/1997) of the antisocial tendency. According to Motz,
the cutting away of the skin coupled with the nurturance received by caregivers (e.g., friends,
healthcare professionals, among others) is a way for the individual to remember, through the
body, the experience of early loss and the wish for reparation and attendance. Danita, who
entered foster care at the age of seven years old after enduring years of physical and verbal
abuse by her mother, brought the abuse with her. The abuse was her way back home. Danita
writes:

Since I was no longer suffering abuse, I began to perform self-
mutilation…The pain was all I had left of my family, and I missed them,
especially my brothers and sister, so, to remind myself of them, I would cut or
scrape myself to cause a scab, and then pull the skin off, one layer at a time. If
that did not suffice, I stuck pins in my hands or feet, anything that helped me
stay in touch with them, so painful were my separation feelings. (Brown &
Seita, 2009, p. 57)

Similarly, Bollas (1992/2003) reports the thought process of an adult women with whom he
worked in a psychiatric inpatient hospital:

Shall I take my body, then, my hospital body with its new wound, to a doctor
for attention? Will the mama nurse barely see it and give me her soothing
female creams, or has it gone too far? Have I lost her, this pure mummy who
soothed me? (p. 139)

In another compelling narrative, Hunter (2001) recounts the experiences of Paula, a
teenager who would show her cuts to her foster parents in a way that said, “Look what
happened to me. Call yourselves parents?” (p. 101). It seems that, for Paula, a “shadow of the
past was falling on the present” (Hunter, 2001, p. 135). The current caregivers were being
asked to witness and endure Paula’s pain and anger, the only tethers to her early history.
Likewise, Gilligan (2004) discusses Abby, a 13-year-old girl from an abusive home who
utilized self-harm and suicidal gestures to obtain the holding environment that was not
present in her biological home. According to Abby, she did not wish to kill herself; she
wished to be noticed and heard. She desired what had been denied her up until this point:
reflection and attunement. Unfortunately, the foster care system is not well-prepared to repair
these compounded losses. As a youth on the verge of emancipation from the foster care
system reports to Liebmann and Madden (2010), “You have to work really, really hard to get
support and what you need from the system” (p. 259).

Gilligan (2004), like Motz (2010) and Winnicott (1956/1997), focuses on the
hopefulness of the self-harm employed by adolescent girls. Gilligan claims that when the
language of violence is used by teen girls to “command attention and respect, it thus becomes
important to recognize their experience of themselves as powerful and to encourage their
hope for relationship” (p. 134). Indeed, the potency and agency attached to the self-injury
seems to instill in it the quality of a transitional object. For Paula, Abby, and the woman with
Furthermore, these individuals had the cognitive capacity to make meaning of the self-harm;
that is, self-injury symbolized their wish for a holding environment. How do these instances
relate to the pseudo-transitional objects mentioned above—objects that are born of loss and
facilitate addiction? What enabled these women and girls to utilize symbolic processes?

Winnicott (1950/1997) discusses how, in order to be of therapeutic benefit to the “deprived child,” the mental health professional must assess the depth, timing, dose, consistency, and type of the deprivation. More recent researchers of the psychobiosocial sequelae of trauma reinforce Winnicott’s focus on assessment to aid in symptom comprehension and treatment (Cicchetti & Rogosch, 2002; De Bellis, 2001; Perry, 2006, 2008, 2009; Schore, 2003a). Understanding the specifics of the deprivation (e.g., when it occurred, for how long, by whom, etc.) may illuminate why some foster children and adolescents are able to use and acknowledge their symptoms as a symbol and/or language, while others have little cognitive understanding of their physiological, emotional, and behavioral experiencing. For example, Winnicott (1965/1997) relays the words of a 17-year-old girl who was once “compelled” to steal and now feels “compelled” to lie:

You see it’s pathetically easy to deceive people and I’m a wonderful actress; I don’t mean that I could act on the stage, but once I get caught up in a deceit I can carry it through so well that no one can know. The thing is, it’s often compulsive and meaningless. (p. 262)

For this girl, it appears as though the deprivation that she experienced occurred prior to the object-relating phase of her ego development (Winnicott, 1962/1965). Because she is unable to relate to and, subsequently, use objects in the external world to communicate her phenomenological experiences, her thoughts and her behaviors are dis-associated. Therefore, her actions seem meaningless both to herself, as well as to others. This example is akin to Giovacchini’s description (2001) of the anger an 18 year-old male, who had undergone early neglect and verbal and physical abuse by his parents, felt toward his therapist, who attempted to interpret the client’s actions and physical manifestations of anxiety. Giovacchini states that this male adolescent “felt he was not being understood as the treatment was trying to ascribe
meaning to something that has no meaning” (p. 14).

Winnicott (1965/1997) defines dissociation as a “partial disintegration…characteristic of the antisocial boy or girl” (p. 258). There is not a whole person present to be aware of the dissociated states that may be occurring (Winnicott, 1971/2001). That is, if the trauma is experienced prior to psychosomatic collusion of the infant’s developing ego (Winnicott, 1970/1989), the infant’s cognitive and physiological functioning does not become entwined. Subsequently, the infant reacts either intellectually or physically in order to manage the anxiety engendered by an impinging (e.g., neglectful, abusive, inconsistent) environment (Winnicott, 1949/1975b). Schore (2003a) indicates that dissociation manifests a “disruption of the monitoring and controlling functions of the consciousness” (p. 220). This lack of communication between the body and the mind accounts for Winnicott’s description (1965/1997) of a 14-year-old boy who does not seem to understand why he is stealing, lying, and acting aggressively toward others. Winnicott (1965/1997) says of this teen, “He was aware of something that he was unable to avoid by deliberate effort…he suffered from a compulsion, which he could not explain, and he could not believe in what he found he had done under this compulsion” (p. 258). As Levine and Kline (2007) point out, dissociation is involuntary.

An individual experiencing dissociation, which disengages the mind from the body, may further feel as though she inhabits un-reality. According to Schore (2003a), as a result of traumatic abuse, “the individual dissociates not only from the external world, from processing external stimuli associated with terror, but also from the internal world, that is, painful stimuli originating within the body” (p. 216). Ogden, Pain, and Fisher (2006) additionally underscore the “trancelike or dreamlike” nature of dissociation in which the individual experiences a reduced capacity to attend to both internal states and external phenomena. These researchers further describe how an individual in a dissociated state
physiologically time travels to when the trauma occurred, causing a loss of somatic connection to the here-and-now (Ogden et al., 2006). Moreover, Winnicott (1971/2001) discusses how dissociation can manifest in the utilization of fantasy, which “interferes with action and with life in the real or external world” (p. 31). As previously discussed, Winnicott differentiates between play, which is creative, symbolic, and reality-based, and the unproductiveness and unreality of fantasy.

Yet, dissociation does not necessarily entail neurophysiological immobility and inaction. A dissociated individual may be experiencing high levels of sympathetic and parasympathetic arousal (Ogden et al., 2006). Schore (2003a) refers to dissociation as an “autoregulatory mode” in which the individual, who expects little or no support from the environment due to a lack of early holding, must rely on the efforts of her own autonomic nervous system (ANS) to provide psychobiological relief from anxiety and stress. An overworked ANS can lead to long-term affective dysregulation and subsequent cognitive and behavioral difficulties (e.g., inattention, depersonalization, increased impulsivity, and reduced problem-solving skills, among others). A dissociated person may be moving and doing, but there is no agency because there is minimal planning, intention, and cognitive engagement. Winnicott (1971/2001) describes a woman patient who was highly dissociative as follows:

…the main part of her existence was taking place when she was doing nothing whatever. Doing nothing whatever was perhaps disguised by certain activities, which she and I came to refer to as thumb-sucking. Later versions of this took the form of compulsive smoking and various boring and obsessive games. These and other futile activities brought no joy. (p. 29)

A former foster youth who was attending a four-year college similarly states,

…I kept to my rigid way of getting through college, very disciplined, not
getting into a lot of social life…I should have taken some time off, but I never gave myself that option…a great cost was not developing a social life. (Hines, Merdinger, & Wyatt, 2005, p. 390)

These illustrations are akin to McDougall’s characterization (1989) of “activity addiction” as a “drug-like relationship” to work and a plethora of other exertions in which the individual may not be interested. People with activity addiction “are continually involved in ‘doing’ rather than in ‘being’ or ‘experiencing’” (McDougall, 1989, p. 97).

Dissociation, as defined by mind-body disconnection, minimal psychoaffective engagement in the here-and-now, and the utilization of unconscious and unmediated autoregulation capacities, appears to be a major experiential component of adolescents in foster care. The prevalence of dissociation in these adolescents may be amplified by the normative brain reorganization and pubertal changes occurring during this developmental stage (Conzolino, 2006; Schore, 2003a; Spear, 2000, 2007). According to Schore, the pruning of gray matter that occurs in the adolescent brain may further thin down already weak cortical-subcortical connections, which were the result of a “brain that in infancy had to chronically shift to hypometabolic survival modes” (p. 297). An adult who had undergone more than 13 foster placement moves as a child and adolescent states, “…after a while I shut everything down emotionally, and things didn’t matter…you don’t want to come apart around strangers, so you just put up a thick skin…it starts to make you numb” (Unrau, Seita, & Putney, 2008, p. 1261).

In another account of dissociative coping, Rosalind, looking back on her childhood and adolescence marked by emotionally and physically neglectful parenting as well as repeated kinship and institutional placements, states,

As with the previous moves and the ones to come, people just picked me up and dropped me off and I, in turn, had no reactions, no sense of loss or even
any confusion about moving to a new neighborhood and new school. I just did what people told me to do, like a robot. (Brown & Seita, 2009, p. 144)

Rosalind later refers to herself as a “dead child walking” (Brown & Seita, 2009, p. 149).

Claudette also underwent multiple placements in kinship and foster care due to her mother’s medical illness and subsequent prescription medication addiction, alcoholism, and death. According to Claudette,

Speculation and wishfulness often take the place of adult guidance and forward thinking for foster children…In foster care, you do a lot of daydreaming… Daydreams are all that remain when you have no control over the everyday reality of your life. (Brown & Seita, 2009, p. 135)

This lack of psychoaffective engagement with their surroundings also manifested as significantly limited memory of their childhood and adolescence for both Claudette and Rosalind (Brown & Seita, 2009). Early childhood neglect and abuse may negatively impact hippocampal maturation, which is an area of the brain associated with long-term memory consolidation and spatial navigation (Conzolino, 2006; Perry, 2008). Therefore, the poor memory and dissociative processes experienced by Claudette and Rosalind likely have neurobiological underpinnings.

Furthermore, adolescents in foster care may utilize chemical substances (e.g., alcohol, marijuana, among others) as a means of extending and reinforcing their dissociative symptoms. Craig, the 15-year-old male who, as previously mentioned, stole from his foster mother, describes his experiences of smoking “weed” as follows: “I finally had a chance to escape and go on my own little adventure. Whenever things got bad for me, all I did was gather up some money to buy a fat Phillie and my problems were gone” (Desetta, 1996, p. 43). Hunter (2001) discusses the role of substances for Marilyn, a 15-year-old female who was living in therapeutic foster care after having been placed in a secure psychiatric inpatient
unit for attempted suicide as a result of a drug overdose. Marilyn, who also had a history of committing theft, underwent sexual abuse by her brother and physical abuse and emotional neglect by her mother. According to Hunter,

Drugs seemed to offer [Marilyn] a way to get “out of her head” and to change the only thing she could: herself…The pain of knowing [the helplessness she had experienced] was such that [Marilyn] could prefer to destroy her own apparatus for knowing her own mind. (pp. 97-98)

In a similar vein, Eliott, an 18-year-old male who had lived in several group homes and teen homeless shelters, reports that drinking alcohol was his method of dealing with the verbal and physical abuse that his mother directed toward him. Eliott states, “I tried to bottle up my feelings by drowning them in alcohol” (Desetta, 1996, p. 190).

Winnicott (1949/1975b) indicates that an infant who has not yet achieved psychosomatic collusion in her ego development—that is, the “I Am” phase (Winnicott, 1962/1974)—will react to environmental impingements through use of the body or the mind (i.e., dissociation). Winnicott (1963/1989) names several “primitive agonies” that an infant, and later child, adolescent, and adult, may experience if good enough holding and handling had not occurred. He defines these experiences as “primitive agonies” because they occurred when the infant was still absolutely dependent on the caregiver and had not yet known or established the me/not-me boundary (Winnicott, 1963/1989). This infant could not understand that the deprivation was occurring in the environment as there was no environment apart from the infant. The infant could only experience a gap (i.e., death) in her going-on-being (Winnicott, 1962/1974). Included in that list of primitive agonies are “a return to an unintegrated state,” “loss of psychosomatic…indwelling,” and “loss of sense of real” (Winnicott, 1963/1989, pp. 89-90), all of which appear to be dissociative in nature.

Without psychosomatic collusion, a person also may not perceive or experience her
impact on the environment. The “I Am” phase engenders a sense of personal responsibility in
the held infant as the infant recognizes that her wishes, impulses, and ideas may negatively
affect others—that is, those who are not-me (Winnicott, 1966/1997). The adolescent in foster
care who experiences dissociation may utilize, often with minimal or no conscious
awareness, several body-based strategies to establish the me/not-me boundary as well as
psychosomatic collusion and a psychophysiological presence in the external world.
Self-injurious behaviors may be one of these strategies. For example, in their review of
literature related to NSSI, Klonsky and Muehlenkamp (2007) report a significant correlation
between dissociation and self-injury. These authors refer to self-injury as a “feeling
generator” that disrupts the experienced “unreality” and “nothingness” of dissociation (p.
1050).

Norris and Maher (2009) discuss a female adolescent, Casey, who had endured
childhood abuse and was currently living in a residential setting. After consuming a
significant amount of alcohol (i.e., precipitating a dissociative state through substance use),
Casey “severely” cut her arms, which led to physical restraint and management by the
residential staff and medical hospitalization. Similarly, Doctors (1981) describes Carrie, a
15-year-old girl, as one who utilized cutting “to concretely demarcate her disintegrating body
boundaries” (p. 456). According to Doctors, Carrie, when calm, communicated her
phenomenological experiences of “being torn to pieces…and feeling abandoned at the same
time” (p. 456). Carrie appeared to use cutting as an attempt at self-holding—a “putting
together” that dissipated internal tension while protecting the environment from her rage,
engendered by early environmental deprivation, which has “flowed over” (Tustin, 1981).

Perhaps paradoxically, both Casey and Carrie utilized cutting (i.e., self-holding) to
reestablish their body boundaries. Their use of self-injury also elicited holding from the
environment in the form of residential treatment workers who would physically contain
Carrie and Casey to prevent further self-injury. Similar efforts to enliven environmental holding were noted in the behaviors of Tom, a 14-year-old boy who had entered long-term residential treatment after experiencing very early neglect and abuse as well as multiple placements in foster and adoptive care and psychiatric hospitalization (Robison, Lindaman, Clemmons, Doyle-Buckwalter, & Ryan, 2009). According to these authors, “If Tom’s anxiety was not addressed” by his counselor firmly holding his hand or touching his shoulder, Tom “became defensive, talked louder, and attempted to provoke a reaction from other clients” (p. 297).

The story of Tom illuminates how violence directed toward the environment may relate to Winnicott’s concept (1965/1997, 1971/2001) of dissociation as an early (i.e., preverbal) antisocial defense in which the whole person is not present to acknowledge and contain dis-associated behaviors and feelings. Stein (2009), who has evaluated and treated both abused and neglected children and incarcerated adult violent offenders (the majority of whom had endured considerable abuse and neglect as children), states that “violent crime is a kind of dissociated enactment” (p. 323). In her research, Stein has found in a significant number of violent offenders no premeditation and often little memory or limited cognitive understanding of their aggressive acts. Similarly, Field (2002, 2005), in her studies of aggression in U.S. adolescents, observed a strong relationship among adolescent violence, body dissociation, and a history of minimal physical affection provided by caregivers. Silberg and Dallam (2009) note an increase in comorbid disorders related to dissociation during adolescence, including conduct disorder and self-mutilation, among others. While these studies were not directed at foster populations, foster youth likely experience greater exposure to abusive and neglectful conditions that engender such dissociation, and the resulting use of violence.

Without mind-body connection—the achievement of “I Am”—violence (e.g.,
physical force, action, or treatment) may serve the dual functions of establishing somatic, kinesthetic attachment to the other while, at the same time, differentiating the self from the other through establishment of the body ego. As Winnicott (1964/1997b) posits

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\text{...in violence there is an attempt to reactivate a firm holding, which in the history of the individual was lost at a stage of childhood dependence. Without such a firm holding a child is unable to discover impulse, and only impulse that is found and assimilated is available for self-control and socialization. (p. 157)}
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For example, Kenyetta, a 19-year-old female who had been through multiple group home placements, seemed to utilize fighting as a way to define body boundaries. Kenyetta attacked a girl who “thought she was all that” (Desetta, 1996, p. 168). It was as if this other girl’s belief in herself took up all of the space, permeating Kenyetta’s insufficient body boundary and, therefore, overwhelming Kenyetta’s felt sense of going-on-being. Kenyetta manages this experience of annihilation by annihilating the other; thus, Kenyetta once more has the room to be. Similarly, according to Toth’s (1997) account, Damien, a 13-year-old male who was removed from his mother due to neglect, enters a group home engaging in “boundary-testing games…when [the staff is] kind, [Damien] is hard; when they are tough, he is gentle” (pp. 34-35). For Damien, there is no moderation, no experience of or trust in a firm framework that he can experience as non-retaliatory and supportive. Damien either pushes out or collapses in, whatever it takes to define the frame in order to protect his untenable, and undeveloped, sense of self.

In the “I Am” stage in infancy, the “psyche and the body have the same places in space” (Winnicott, 1955/1997, p. 192); play emerges from this state. As previously discussed, one of these areas in which the psyche-soma lives and interacts is potential space, which, says Winnicott (1967/2001a), facilitates the development of the True Self, as well as
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the True Self’s communication with objectively-perceived others. For Winnicott (1968/2001a), play takes place in the potential space and involves the body. However, dissociation, with its mind-body split, prevents playing (Winnicott, 1964/1992). Without the capacity to play—to feel connected to and relevant within the environment—the ability to create, plan, and produce is significantly impeded. In their qualitative study of 22 adults who had undergone multiple foster placements in their childhood and teen years, Unrau et al. (2008) found a significant narrative theme related to loss of power over one’s personal destiny. According to one of the respondents, an adult who had been placed over 28 times,

> It was the unknown of how long I would stay somewhere else and with whom and who I was going to be. I never got to set any goals because life always took over. I found I was always living in chaos and just surviving. (p. 1259)

The use of violence may be an attempt to find and manifest the True Self through experiencing a sense of kinesthetic agency. Fonagy and Target (1999) describe what occurs when a child’s identity feels diffuse and easily influenced due to the caregiver’s inadequate and inaccurate reflection of the child’s presentation(s). Per these authors, the “sense of self is fragile and readily threatened, and the pathological amplification of the intentional stance, aggression, may become the only way in which the individual can see himself existing in relation to others” (p. 58). Just as the individuals who use self-injury to feel real (i.e., grounded in their bodies), persons who direct violence outwards may be attempting to accomplish the same physiological feat. In response to why she fights, a 16-year-old girl from Philadelphia stated, “Why you gonna take me seriously if I don’t show you that I’m in charge of myself? That I’m no joke. You ain’t gonna respect me until you know that what I say is for real” (Ness, 2010, p. 45).

Similarly, Sebastian, a teen who was placed in a group home due to the violence he committed toward others, would “imagine he was the winning fighter [in a street fight,
boxing match, etc.], the one administering the beating, and he’d feel much bigger, stronger, powerful, and capable” (Toth, 1997, p. 50). Sebastian became more physically aggressive when his older sister moved home to take care of their mentally ill mother. The increase in aggression was tied to Sebastian’s experience of being overruled and controlled by his sister. Twelve-year-old Sebastian utilized violence against his sister and mother as a means to assert his authority, strength, and manhood. As a result of his violence, Sebastian was removed from the home. In the assertion of his manhood on the environment, he lost his mother—the person he loved most. Therefore, violence became more of a habit—an addiction—fueled by the traumatic loss of and continuous craving for his mother. What was once his vehicle for feeling self-efficacy and controlling others now became his taskmaster. Sebastian reports to one psychotherapist, “I feel like killing someone.” Upon the therapist’s inquiry of who and why, Sebastian responds, “Don’t know…just someone. It doesn’t matter…I just do” (Toth, 1997, p. 68). He is no longer capable of symbolizing his aggression—there is no forethought or afterthought, just thoughtlessness.

The capacity to search for and express one’s identity, especially an identity enlivened by one’s True Self, is predicated on an environment that validates, mirrors, and enhances the embodied identity. Winnicott (1967/2001a), describing how an infant sees herself in the eyes of a good enough caregiver, states, “the mother is looking at the baby and what she looks like is related to what she sees there” (p. 112). However, if the infant has a longstanding experience of “not getting back what they are giving…[her] own creative capacity begins to atrophy, and…[she looks] around for other ways of getting something of [herself] back from the environment” (Winnicott, 1967/2001a, p. 112).

The search for reflection, coupled with the use of violence to define body boundaries, may also lead a foster youth toward gang involvement. Craig, the 15-year-old adolescent who ran away from his placement, refers to his “crew” as his “family” (Desetta, 1996). This
family “adopted” Craig, gave him a new name (i.e., “Shorty”), and an object toward which to
direct his propensity to steal (i.e., cars). According to Craig, “I thought I was so cool. I
thought that I was finally going to be who I really wanted to be” (Desetta, 1996, p. 41).

The connection between longing for a family and gang affiliation was similarly noted
by a young adult who had lived in a New York City group home as a teen.

What’s happened in foster care [is that it] has become very gang-
infested…Because these kids are looking for the assimilation of the family
thing…And what these gangs are doing are assimilating themselves to be
family…If you go into any group homes today, it’s most likely, I would say,
50 percent of the group home is gang-related. (Freundlich, 2003, p. 99)

The conflation of “family membership” with “gang identity” for some adolescents in foster
care throws into sharp relief Winnicott’s (1956/1997) differentiation between normative
adolescent rebellion and the antisocial tendency; the teen who has experienced good enough
care has the freedom to say, “No.” As Guishard-Pine, McCall, and Hamilton (2007) observe,
“freedom can only be appreciated once one feels safe in having it” (p. 53). A firm yet
non-retaliatory framework provides the support and opportunity for an adolescent to have and
express her own ideas, as well as to engage in self-determination. However, without this
scaffolding, a teen must attempt to define her own boundaries and identity. This is a
predicament described by Eigen (2007) who writes, “Under pressure of great wrongs, an ego
grounded to fight…preempts boundless space and becomes a boundless fighter” (p. 420).

Yet, gangs are about the group’s identity—an identity shaped by the experience of
socioeconomic, community, and personal deprivation. According to Axelman and Bonnell
(2006), “gangs provide a sense of community through the fulfillment of needs not met in the
inner city” (p. 118). The gang forms itself into an organization that can respond to this
deprivation. Because the deprivation may have been extreme, the gang’s structure may be
rigid and constricted, often to the detriment of its members. For instance, Bouchard and Spindler (2010) indicate that individuals’ enactment of delinquent behaviors increase while in a gang; however, these same individuals’ delinquent behaviors decrease during pre- and post-gang affiliation. These authors also discuss how members must follow and embrace the gang’s mores or forfeit the status granted them by gang involvement. One young adult who was previously placed in a congregate care facility reported that teens, especially younger teens and children, were “bullied” into becoming members of a gang (Freundlich, 2003, p. 99). According to another youth in this same study,

Once you are in the gang, it’s hard to get out, and they want you in a gang because you are smart or because you know how to fight…[If] you don’t want in it, they will pound you and pound you and pound you until you come in. That happened to me. (p. 99)

With violence being one of the few actions privileged in a gang, individual members have less opportunity—and potential space—to find and utilize others objects that would manifest and enhance additional qualities and aspects of their True Self.

Summary

This chapter reviewed the object relational-developmental framework put forth by this author as a means by which to understand the experiences, emotional awareness and presentation, cognitive functioning, and behaviors of adolescents in foster care. A supported caregiver is more capable of providing attunement and holding to an infant than a caregiver who has little or no support. If the infant experiences sufficient holding, handling, and object-presenting from the environment, the child can internalize her experience of a benign environment along with her felt sense of going-on-being. With this internalization come the capacities to tolerate frustrations, to engage in meaningful ways with the environment, and to initiate and sustain purposeful actions, all elements of Winnicott’s (1958/1974) capacity to be
alone. The child and adolescent who can utilize generative solitude has the ability to play and work (i.e., manifestations of the True Self). By contrast, infants and children who experienced relational and environmental deprivation did not internalize a sufficient holding environment and, therefore, have suffered significant anxiety due to environmental attacks on, and gaps in, their sense of going-on-being. These children have minimal abilities to tolerate frustration and stress, meaningfully attend to and interact with their environment, and engage in constructive and productive behaviors. Adolescents in foster care often fall into this latter category and, as a result, will employ maladaptive coping strategies (e.g., dissociation, cognitive rigidity, self-harm, fighting, stealing, gang involvement, etc.) to manage their experiences of early deprivation(s). The following chapter will discuss how this object relational-developmental framework can serve as a guide for delineating interventions that will provide foster adolescents with a holding environment that facilitates their relational, emotional, cognitive, and behavioral competencies.
Chapter 5

Clinical Implications

we seek beyond history

for a new and more possible meeting.

-Audre Lorde, “Outlines”

…it is joy to be hidden but disaster not to be found.

-D. W. Winnicott (1963/1974a, p. 186)

The object relational-developmental framework discussed in the previous chapter suggests points at which interventions may be made to benefit the fostered adolescent. The primary treatment option to be discussed here will be the provision of psychotherapy, which is a dyadic relationship that can offer the adolescent opportunities to experience, possibly for the first time, a holding environment (Winnicott, 1962/1965). Despite this focus, mention must also be made of treatment strategies that mediate larger social and environmental demands. Many researchers already considered in this dissertation (e.g., Bowlby, 1990; Stern, 2004; Winnicott, 1964/1992) not only highlight the interpersonal, mutually regulating relationship that occurs between the infant and primary caregiver, but also emphasize the need for this relationship to be valued and protected by others. According to Bronfenbrenner (1979), who outlined an ecological systems theory of human development that examined how the caregiver-infant dyad is affected by the community and greater social/cultural institutions and events, “To assert that human development is a product of interaction between the growing human organism and its environment is to state what is almost a commonplace in behavioral science” (p. 16). Therefore, interventions that enable the caregiver (i.e., foster parent) to provide good enough care to the child are as salient, if not more so, than the treatment provided by a therapist to a teen who has already endured neglect, abuse, traumatic loss, and out-of-home placements.
Psychotherapeutic Treatment of Fostered Adolescents

If, as Winnicott (1968/2001c) states, “psychotherapy is done in the overlap of the two play areas, that of the patient and that of the therapist” (p. 54), the therapist must provide the adolescent patient with the necessary preconditions (i.e., holding, handling, and object-presenting) that facilitate play. What follows are key intervention components that the therapist can provide to facilitate the fostered teen’s psychoaffective experience of a holding environment.

Consistency and continuity. If play is born out of the capacity to be alone (Winnicott, 1958/1974), then the first step to engendering this capacity in a youth who has experienced substitute care is to connect the teen to a consistent, reliable caregiver. Wilkinson (2010) observes of trauma survivors that, “deep-seated relational trauma requires sustained treatment in depth to effect change, thereby requiring a dependent experience over time for these patients” (p. 152). A teen who has been mistreated and undergone multiple placements will likely have a great deal of difficulty feeling as though she can depend on another, especially on an adult who is in, what can be construed as, a parental, authority role (e.g., therapist). Consequently, the length of the treatment—with longer intervals being more beneficial than shorter intervals—seems a key component in establishing and maintaining a holding environment for fostered adolescents.

As we have seen, Winnicott (1960/1974a) states that holding is “a three-dimensional or space relationship with time gradually added” (p. 44). For a teen who has experienced misattunement, neglect, abuse, and shifting, transitory residences, compounded by losses, continued interaction with a therapist who is capable of providing attunement may engender in this teen a sense of her continuity of being (Winnicott, 1960/1974a). Clausen (2009), a member of A Home Within, an organization that provides long-term, pro bono therapy to current and former foster children, found significant symptom reduction (i.e., depression,
anxiety, dissociation, and sleeping, eating, and school problems) for children who had reached the midpoint of their treatment (i.e., 12 to 24 months). Waln, a former foster adolescent who had endured emotional neglect, physical abuse, and multiple placements, obtained the necessary framework, and dependability to heal, when he was eventually placed in reform school. Waln reports:

I needed that full 18 months of structured guidance to change my attitude and gain the maturity to think beyond the moment. Any time less, and the entire change process may not have taken hold. Behaviors do not change instantly…

(Brown & Seita, 2009, p. 13)

Dr. Waln Brown is now a clinical and research psychologist who founded the William Gladden Foundation, a research, educational, and publishing organization that examines issues related to child and family adversity (e.g., foster care, abuse and neglect, and delinquency, among others).

The continuity of the holding environment engendered by the relationship between a fostered teen and a single attuned therapist corresponds with the consistent, predictable attunement between a caregiver and infant, which promotes adaptive, healthy neural development (Cozolino, 2006; Perry, 2008, 2009; Schore, 2003a, 2003b). According to Perry (2006), the brain is at its most plastic and malleable state during the first three years of life. The autonomic nervous system, which controls unconscious, visceral functions (e.g., heart rate, digestion, blood pressure, and arousal states, among others), is associated with the lower brain regions (i.e., brainstem and diencephalon). By three years old, a child’s autonomic reflexivity can be fairly fixed and rigid. If an infant has experienced significant misattunement (e.g., neglect, abuse, and traumatic loss) that has not been repaired, then the child, and later teen and adult, may have an autonomic system that is easily stressed (Schore, 2003a). The autonomic system is linked to emotional and cognitive functioning; thus, a
stressed individual, such as a fostered teen, may experience considerable emotional
dysregulation, impaired cognitive functioning, poor frustration tolerance, and minimal
impulse control. Perry (2006) argues,

> The number of repetitions required to change brainstem neural organization is
> far greater than the number required to change the cortical neural organization.
> In other words, it is easier to change beliefs than feelings. It is not that a child
> won’t change; it is just that change will not occur unless sufficient repetitions
> are provided. (p. 43)

Yet, the teen brain undergoes significant restructuring, and “the long-term plasticity
of the brain in adolescence…offers opportunity for psychotherapeutic interventions to have
greater impact” (Stortelder & Ploegmakers-Burg, 2010, p. 503). Therefore, a treatment
relationship with one therapist, who has engendered trust in a fostered adolescent due to
dependable treatment over a significant length of time, might be able to offer the teen an
ample number of good enough relationship repetitions to moderate the effects of such early
developmental trauma. Moreover, limbic system development during adolescence outstrips
frontal cortex maturation, thus engendering increased emotionality with limited executive
functioning control (Steinberg, 2010; Wilkinson, 2010). According to Wilkinson, “the
availability of a good enough parent or teacher who knows when to say ‘no’ may be of
crucial importance in helping a young person to develop the internal ability to control
impulsive behaviors” (p. 36).

This principle may also apply to the treatment relationship in which a fostered teen,
who has likely experienced boundary violations and chronic instability, can participate in a
reliable, consistent framework. Furthermore, adolescence, with its concomitant neural
reorganization, may be an opportune moment for therapeutic intervention. Adolescent neural
reorganization includes increased myelination and synaptic pruning, leading to augmented
communication among brain regions (Cozolino, 2006; Schore, 2003a; Spear, 2000, 2007). If an attuned therapeutic relationship is in place, adaptive neural integration can lead to improved self-regulation (Siegel, 2003). If a solid, caring relationship does not exist, the capacity for rapid learning, which is a result of better myelination and synaptic pruning, may instigate and/or reinforce maladaptive coping tools. Wilkinson reports that “eating disorders, self-harming, and suicidal behaviors may emerge at this stage as the brain becomes as easily programmed to patterns of abuse as to patterns of achievement” (p. 37).

**Empathy.** If, as Steinberg (2010) and Wilkinson (2010) indicate, adolescent emotional maturation occurs at a quicker rate than cognitive advances, individual psychotherapy with a fostered teen must take into account this unsynchronized development. Empathy is critical for providing affective support and attunement to a fostered teen. Levine (2010) describes empathy as the ability to “resonate with the sensations and emotions of others…[to] be able to feel the same things as those around us feel” (p. 42). According to Zanocco, DeMarchi, and Pozzi (2006), sensory empathy enables the therapist “to get in contact with [the client] through physical sensations, phantasies in the body, harmony of rhythms…” (p. 146). Damasio (2003) argues that the “brain can simulate certain emotional body states internally, as happens in the process of turning the emotion sympathy into a feeling of empathy” (p. 115). As these explanations illustrate, empathy is an experiential, felt sense of knowing how another person feels. Thus, empathy is a salient intervention from the object relational-developmental perspective.

Chapter Two defined Winnicott’s concept (1956/1975) of primary maternal preoccupation, also salient to this discussion. Winnicott (1960/1974a) describes how mothers identify with “the baby that is growing within them, and in this way they achieve a very powerful sense of what the baby needs” (p. 53). With this knowledge, a mother ministers to her infant in an attuned, sensitive manner, and it is these ministrations that initiate the infant’s
ego development. By minimizing threats to the baby’s experience of going-on-being, the mother affords the infant the opportunity to link together *islands of experience* (Greenspan & Lieberman, 1989) steeped in feeling, and then later knowing, that one is cared for. Empathy provides therapists a route by which they can supply the fostered teen with primary maternal preoccupation, a provision that may have been missing from this adolescent’s early and current life.

The empathic process works in a manner similar to Winnicott’s concept (1956/1975) of primary maternal preoccupation. According to Winnicott (1963/1974a), the caregiver responds to the infant through direct communication, which is implicit and nonverbalized. Orlinsky and Howard (1986) state that the “nonverbal, pre-rational stream of expression that binds the infant to its parent continues throughout life to be a primary medium of intuitively felt affective-relational communication between persons” (p. 343). For Winnicott (1954/1975), dynamic psychotherapy enables the patient to return to regressed, preverbal states where the patient can experience an absolute dependence on the therapist. If the patient’s dependency needs are met in a good enough manner by the therapist, early environmental failures may be repaired. The therapist’s use of empathy—that is, holding—provides the adolescent with right brain-to-right brain communication that is prevalent, and necessary, between the primary caregiver and infant (Schore, 2003a).

The usefulness of empathy for engendering affective and subsequent cognitive development in fostered teens is demonstrated by Frances, a 16-year-old female with an early history of neglect and multiple foster placements (Drapeau, Saint-Jacques, Lépine, Bégin, & Bernard, 2007). Frances is described as socially withdrawn and oppositional; however, these behaviors appear to change after working with a specific, attuned mentor. Frances states,

> Well, that I met my special education teacher. The one I have now. Because the other ones, in my opinion, they didn’t know what to do... It helped me to
mature, to be less of a pain. Because when nobody understands you, forget it, you just get mad. (Drapeau et al., 2007, p. 986)

Another story that highlights the importance of empathy is that of Tom, a 14-year-old who entered a Theraplay residential center after enduring neglect, abuse, and multiple foster placements and psychiatric hospitalizations (Robison et al., 2009). Theraplay is an attachment-based approach that includes “sensitive attunement to the child, contingent responsiveness, warmth and nurturance, mutually enjoyable interactions, dyadic regulation of emotion at a preverbal level, and stress-reducing physical contact” (Robison et al., 2009, p. 293). Tom experienced and internalized the empathic care that he received in this setting. This internalization is illustrated by the shift in his personal narrative from “I belong in a trash can” to “I deserve a family” (Robison et al., 2009, p. 303). Tom’s belief in the significance of his being is also seen in his response, as a 17-year-old, to his current foster mother. The foster mother holds Tom’s face and his gaze, reassuring him that he is loved and safe, and Tom leans into his caregiver as an infant would mold into her mother.

**Body-based, kinesthetic treatment.** In addition to empathy, therapies that include kinesthetic elements may be crucial in providing the fostered youth with beneficial, adaptive sensory experiences. Adolescents in foster care likely have a long history of traumatic experiences, including multiple losses, abuse and neglect, and constant, involuntary relocations, among other examples. According to van der Kolk (2006),

…One of the most critical factors that renders a situation traumatic is the experience of physical helplessness—the realization that no action can be taken to stave off the inevitable. Trauma can be conceptualized as stemming from a failure of the natural physiological activation and hormonal secretions to organize an effective response to threat. (p. 282)
Barker (1991), in her novel *Regeneration*, which considers the treatment provided to “shell shocked” World War I soldiers by the British psychiatrist, Dr. W. H. R. Rivers, also describes the somatic origins of trauma. Barker writes,

Pilots, though they did indeed break down, did so less frequently and usually less severely than the men who manned observation balloons. They, floating helplessly above the battlefields, unable either to avoid attack or to defend themselves efficiently against it, showed the highest incidence of breakdown of any service…it was prolonged strain, immobility, and helplessness that did the damage… (p. 222)

Levine (2010) further supports this perspective by positing that “until the core experience of trauma—feeling scared stiff, frozen in fear or collapsing and going numb—unwinds and transforms, one remains stuck, a captive of one’s own entwined fear and helplessness” (pp. 73-74).

Winnicott (1949/1975a) addresses the psychosomatic nature of trauma in his discussion of the caregiver’s handling of the infant. In the handling phase, there are gradual interruptions in the caregiver’s attunement with the baby. In the good enough environment, these lapses are repaired in a timely manner so the infant does not experience annihilation threats. The handling phase is concomitant with the infant’s growing sense of her own motility and environmental impact. Thus, if the caregiver’s misattunement and/or neglect are sustained, the infant’s motility may become frozen or dissociated. In Winnicott’s terms (1970/1989), the infant does not achieve personalization (i.e., psychosomatic collusion); instead, she experiences depersonalization.

The personalization of youth who have been placed out of their original homes may be impaired. They may feel like a card being shuffled in a deck as they move from one placement to the next. This experience of uncontrollable uncertainty, likely initiated by early
 Abuse and neglect, is further reinforced when foster adolescents age out of care and are expected to handle things on their own. According to 20-year-old Magdalane, a former foster youth, “I feel like the system is our parent until you turn 21 and then, when you turn 21, they forget about us and we are left to fend for ourselves. It’s difficult. I’ve had to make my own plan…” (Liebmann & Madden, 2010, p. 256). Maurice, a former foster child and adolescent, writes about the devastation caused to one’s sense of self-efficacy by trauma:

Abuse, neglect, violence, abandonment, and other painful experiences have a way of eroding self-confidence and stifling the belief that someday “things will get better.” Too many foster children give up while they are still in the system, and many more fail to adapt when they transition to the “real world.”

(Brown & Seita, 2009, p. 81)

As a result of longstanding impingements to the psychosomatic collusion (i.e., mind-body integration) and agency of fostered youth, these individuals would significantly profit by interventions that enhance their sense of productivity and self-efficacy. Several researchers and practitioners advocate for psychosomatic approaches to facilitate, in Winnicott’s conceit (1970/1989), the embodied intention of personalization (e.g., Haven, 2009; Levine, 2010; Ogden, Minton, & Pain, 2006; Ogden, Pain, et al., 2006; Perry, 2006; van der Kolk, 2006; Wilkinson, 2010). According to Ogden, Minton, et al., a sensorimotor approach “to traumatic memory addresses the incomplete defensive responses, which, when completed, foster a sense of mastery and ‘triumph’ that then facilitates the execution of more adaptive mental actions and the formation of autobiographical memory” (p. 248). Levine’s (1997, 2010) treatment approach—Somatic Experiencing—utilizes the safe framework of a therapeutic relationship as a base from which the client can “supplant the passive responses of collapse and helplessness with active, empowered, defensive responses” (Levine, 2010, p. 75). For instance, Levine (2010) might encourage a client who, while remembering a
traumatic experience, is sitting in a slumped, constricted manner to stand up. This physiological experience of expansion engages the “arousal branch of [the] nervous system,” thus preventing the activation of the “shutdown response…[which perpetuates] the mortifying feelings of shame and defeat” (Levine, 2010, p. 188). The Trauma Center at Justice Resource Center, founded by Dr. Bessel van der Kolk, also currently researches and advocates for the use of physiological and kinesthetic interventions (e.g., yoga, teen theater-based programs, and neurofeedback, among others) in the treatment of trauma (see http://www.traumacenter.org/research/research_landing.php). Similarly, Emerson, Sharma, Chaudhry, and Turner (2009) note preliminary positive results in their use of Trauma-Sensitive Yoga to decrease posttraumatic symptoms in adult survivors of trauma.

From a neurobiological perspective, kinesthetic interventions can reach and modify the lower brain regions, such as the brainstem and diencephalon, where trauma responses, through the mediation of the autonomic nervous system, originate (Haven, 2009; Perry, 2006; Wilkinson, 2010). According to Ogden, Pain, et al. (2006), “Sensorimotor interventions that directly address the body can work to process implicit-type memories, to challenge procedural learning, and help to regulate dysregulated autonomic arousal” (p. 267). The Neurosequential Model of Therapeutics (NMT), developed by Perry (2006, 2009), intervenes with the child/adolescent at the neurodevelopmental stage where the child first experienced trauma. Like Levine’s (1997, 2010) Somatic Experiencing approach, Perry (2006) underlines the significance of interventions that can reset and/or establish an optimally rhythmic autonomic nervous system, such as dance and music production. As a result, the individual with a longstanding history of trauma, may begin to live in a body that is not consistently on high alert (e.g., hypervigilant and/or engaged in activity/substance addictions to ward off emotional awareness) or predisposed to dissociative, hypoaroused states. Therefore,
expressive therapeutic modalities (e.g., art, dance, music) and interventions that include touch (e.g., massage, acupuncture) are beneficial complements to long-term psychotherapy.

While Field (2010) asserts the usefulness of massage and touch for decreasing depression symptoms as well as increasing attentional capacities and immunity, kinesthetic modalities likely also induce personalization (Winnicott, 1970/1989); the second achievement in Winnicott’s (1962/1974) ego developmental process. Positive, healing touch provides the sensation of holding—that is, bringing the individual into a healthy, substantive experience of her body. Productive, goal-directed movement further allows the individual the opportunity to experience her vitality and to make use of her own body. For instance, the Attachment, Regulation, Competency (ARC) model for working with children and adolescents who suffer from complex trauma focuses on reinforcing, and building off of, the interests and strengths (e.g., arts, sports, academics, etc.) of the client (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005).

As an example, in their qualitative study on attachment and resiliency in foster youth, Schofield and Beek (2009) discuss Leroy, who, with the support of his foster mother, achieved successes in art and sports. According to Leroy, “I have to have something to work towards—I just want to be the best I can” (p. 262). A foster parent whose foster child completed a six-week group that utilized mindfulness practice and expressive therapies reports, “I’ve noticed that since he has done this [group]…he smiles in the mirror a lot, like he’s confident in himself…you can see it…the way he…walks and everything…like he pulls himself up” (Coholic, Lougheed, & Lebreton, 2009, pp. 40-41). A foster girl in this same study states, “When I finished [the group] I was…happier and more focused on stuff…I got to be myself, that’s not usual…[usually] I try to be somebody else” (Coholic et al., 2009, p. 41).
Affective-cognitive integration. For the fostered girl quoted by Coholic et al. (2009), the safe framework in which she could express her feelings and thoughts in a kinesthetic, creative manner provided opportunities for her True Self to emerge (Winnicott, 1960/1965). Psychotherapy with foster youth must, like this group, create a potential space where the teen can learn to interpersonally interact in a meaningful, cooperative manner. The construction of the therapeutic potential space is a mutual one. And play, which is the free flow presentation of and relation to objects for the purpose of eliciting the adolescent’s spontaneous gesture, is the goal. The more appropriate, evocative, and attuned objects (e.g., reflections, clarifications, interpretations, metaphors, feeling states, and kinesthetic actions) offered by the therapist, the more likely fostered teens will discover vehicles with which to express their True Self. In this way, the adolescents’ burgeoning creativity is facilitated by the therapist (Winnicott, 1953/1986, 1967/2001a, 1970/2001).

Winnicott’s (1958/1974, 1960/1974b, 1962/1974) assertion that object-relating, which requires the capacity to symbolize and make meaning, follows the more sensate, affective achievements of integration and personalization appears to have neurobiological support. According to Perry (2006), the brain “organizes and grows in a sequential fashion—starting from the lowest, most regulatory regions…and proceeding up through the more complex parts of the brain responsible for more complex functions” (p. 38). If the infant has experienced a good enough early environment, her ability for affective regulation and impulse control will enhance her cognitive capabilities. If, on the other hand, the infant’s environment was impinging, misattuned, and chaotic, she may quickly become emotionally dysregulated, leading to behavioral impulsivity and limited understanding and insight (De Bellis, 2001, 2003, 2005; Perry; Schore, 2003a, Wilkinson, 2010). Therefore, it is essential for a therapist who is working with fostered adolescents to “receive” the teens prior to
attempting to “translate” the adolescents (Astor, 2007). In other words, resonating with and attuning to fostered youth must occur before interpreting their behaviors.

Yet, as in Winnicott’s (1958/1974, 1960/1974b, 1962/1974) ego maturational process, cognitively understanding and verbally communicating one’s affective and psychobiological experiences are a necessary part of growth and, in the case of trauma, healing. One promising method of working with fostered teens that combines emotional and cognitive interventions is mindfulness. Kabat-Zinn (2003) defines mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (p. 145). The nonjudgmental aspect of mindfulness may help decrease feelings of shame and guilt as well as beliefs of self-blame and unlovableness in youth who have been placed in out-of-home care. Additionally, by encouraging consistent attentiveness to feelings and thoughts, dissociative tendencies, and subsequent problems with impulse control, may lessen. One foster child who completed a mindfulness-based expressive therapy group notes that the group “has been a way for me to relax and to…get to know myself a little bit better and its helped me make decisions…based on our behavior” (Coholic et al., 2009, p. 41).

Indeed, the ability to relax—to not be on constant guard for impingements and threats to one’s sense of going-on-being—is a precondition for play. Winnicott (1958/1974) indicates that relaxation allows one to unintegrate, which leaves the individual open to experiencing a personal impulse. This internally-generated, spontaneous gesture then utilizes objects within the environment as a means of facilitating expressions of one’s True Self. According to Winnicott, “A large number of such experiences form the basis for a life that has reality in it instead of futility” (p. 34). Mohamed, a 17-year-old who had lived in a group home as well as with a foster family, writes how he would isolate from his peers while in the group home. However, after Mohamed met a supervisor who was attuned to him, Mohamed
began to feel an “inner tranquility,” which led him to become more open to “talking, playing, and joking around” with his peers (Desetta, 1996, p. 196). Mohamed experienced his own agency and significance, and this, in turn, gave him the desire to become a writer and therapist in the future.

Wilkinson (2010) also focuses on complementary affective and cognitive interventions by discussing her “double helix” approach to working with trauma survivors:

One aspect of therapy deals with the implicit, arising from the right hemisphere [of the brain]; it is predominantly affective, composed of the affective encounter between therapist and patient. The other deals with the explicit, arising from the left hemisphere; it is predominantly cognitive, manifest in interpretation. (p. 85)

Wilkinson argues that this complementary approach may enable neural network integration, which is salient for adolescents with a history of trauma and foster care placements. For instance, children who have been abused and/or neglected were found to have significantly smaller corpus callosum areas (i.e., the brain region connecting the right and left hemispheres) than children without this history (Teicher et al., 2004). With integrative interventions that focus on developing emotional regulation and cognitive/executive functioning, the fostered teen may obtain “a more flexible capacity…to reflect on the past, live fully in the present, and have an active sense of the self in the future” (Siegel, 2003, p. 52).

**Constructing a coherent personal narrative.** A coherent narrative about one’s life may engender a sense of going-on-being, which is a positive psychophysiological product of a good enough holding environment (Winnicott, (1960/1974a). Thus, facilitating the development of an understandable, meaningful personal story, through the therapist’s use of reflections, clarifications, metaphors/analogies, and interpretations, is a relevant intervention
for adolescents in foster care. For instance, attachment-related research highlights how fostered youth would benefit from the ability to make sense of their past—to put themselves in context—so they are better able to understand their present experiences as well as to plan for their future (Siegel, 2003). Attachment studies have found that some adults, who may have endured childhood abuse and neglect, moved from early insecure attachment statuses to a later earned-secure attachment status (e.g., Egeland, Jacobvitz, & Sroufe, 1988; Phelps, Belsky, & Crnic, 1998; Roisman, Padrón, Sroufe, & Egeland, 2002). A key component to obtaining earned-secure attachment was autobiographical coherence—the capacity to talk about one’s life in a consistent, integrated, and affectively connected manner (Roisman et al., 2002). Narrative stability may allow fostered adolescents to bring some order and comprehension to early lives marked by uncertainty and chaos. Indeed, the story itself could become the holding environment—a secure base from which the adolescent can explore and interact with the larger world (Bowlby, 1990).

Relationship-building and group treatment. Moreover, instilling the capacity for relating to objects in fostered youth provides these adolescents with a relational route by which to heal their experience of traumatic loss, abuse, and neglect. Winnicott (1967/2001b, 1970/2001) discusses how potential space supplies the area, and symbols (i.e., objects) afford the medium, through which persons meaningfully interact with others as well as with the culture. Herman (1992/1997) further asserts that interpersonal reconnection is a salient aspect of recovering from trauma. Herman likens survivors during this reconnection stage to adolescents who “band together in tight friendships in order to risk exploring a wider world” (p. 205). Therefore, group treatment can also offer healing intervention with adolescents in foster care. For instance, Baez (2003) observed that adolescent girls in a residential setting found emotionally supportive allies in group treatment. Najavits, Gallop, and Weiss (2006) noted significantly improved outcomes for adolescent girls who attended a group focused on
decreasing comorbid posttraumatic stress and substance abuse symptoms. Brendtro, Brokenleg, and Van Bockern (1992) argue that building synergistic, cooperative, and goal-directed relationships among peers is one method by which to utilize adolescent peer persuasion for positive outcomes. Additionally, Levine and Kline (2007) indicate that play groups (e.g., theater- or dance-based groups) not only build neuronal connections, they also meet the need of the child/adolescent to belong.

The issue of belonging is likely significant for adolescents who experienced abuse and neglect and were then placed in out-of-home care. One fostered teen describes a feeling of belonging as follows: “I knew in me as I was getting older that I wasn’t my mum’s proper child, but… the way my mum looks at me, I am her son” (Luke & Coyne, 2008, p. 407). According to a 16-year-old girl who was placed with her foster family when she was eight years old, “I don’t really look at [my foster parents] as anything different than a mum and dad really. They treat me the same as their normal family, take me on holiday, go shopping” (Schofield & Beek, 2009, p. 264). In an April 8th, 2010, interview conducted by Neal Conan on National Public Radio, Jeremy Long, a former foster youth, reports on the salubrious effects of having one foster placement. Jeremy says,

> It’s actually been extremely beneficial, just for the fact that I didn’t have to get used to numerous different families, which is very hard on the emotional state of a lot of foster youth. And, to this day, [my foster mother and I are] still in connection…she’s still my mom.

Jeremy Long is currently on the board of Bridging the Gap, a United Way initiative that helps foster adolescents successfully transition out of foster care. These foster youth felt as though they belonged in their foster families. They had found a place in which they experienced
attunement and resonance. Prior impingements to and holes in their sense of going-on-being were repaired and filled. They were held and, as a result, they felt consequential.

An important point of entry into this sense of belonging is the foster child’s awareness of her ability to have a constructive impact on her environment. Brendtro et al. (1992) state, “Young people cannot develop a sense of their own value unless they have opportunities to be of value to others” (p. 34). The necessary comingling of agency and interdependence is seen in Winnicott’s theory (1963/1974b) of how an infant develops the capacity for concern:

The infant experiences anxiety, because if he consumes the mother he will lose her, but this anxiety becomes modified by the fact that the baby has a contribution to make to the environment-mother. There is a growing confidence that there will be opportunity for contributing-in, for giving to the environment-mother… (pp. 76-77)

For Winnicott, there is a balance of environmental attunement to the individual and individual responsibility toward the environment that is negotiated throughout life. This negotiation is especially salient in the “management of adolescents” (Winnicott, p. 77).

**Agency and personal responsibility.** Therefore, if, as Brendtro et al. (1992) argue, “relationship is an action, not a feeling” (p. 76), then providing foster youth with occasions to assist others will enable these adolescents to experience positive relationships, as well as agency and responsibility. For example, Meloney, a former foster child and current special education teacher, recommends the use of adults who underwent out-of-home placements as mentors for children presently in the foster care system. These former foster youth, says Meloney, “can use their experiences to ease the way for [youth now in care]” (Brown & Seita, 2009, p. 110). In a similar vein, Gilgun (2002) believes that a sense of belonging can be engendered in foster
youth if these teens are encouraged to participate in community activities that connect them to their cultural/ethnic identities. Another example is the Becoming a Responsible Teen (BART) program, which is focused on increasing adolescents’ awareness of sexual health issues (e.g., condom use, sexually transmitted diseases, etc.). The BART curriculum was successfully utilized with adolescent girls in a residential foster care setting (McGuinness, Mason, Tolbert, & DeFontaine, 2002). A key component of this intervention is “spreading the word” to other teens; thus, these adolescents learned how to “use their knowledge to influence others in a positive way” (McGuinness et al., 2002, p. 95). Additionally, youth currently in foster care would likely benefit from being active members of their own treatment and advocacy teams. For instance, a foster teen who co-constructs treatment goals with her therapist may experience validation and empowerment. The resulting goals may also be more relevant to the adolescent.

The importance of holding a fostered teen accountable to, and within, relationships is seen in the reflection of Rachel, an adolescent in substitute care. Rachel praised her former foster parents because “they knew how to handle me cause like they have been through it as well as I have, so they put a foot down and that’s why I love them so much” (Stanley, 2007, p. 262). Rachel felt as though she belonged because she was expected to contribute in to the family. Rachel’s sense of responsibility facilitated her love for her foster family—the intermingling of agency and interdependence. Eigen (2005), who was challenged to empathize with a patient’s feelings of longing, writes that his own difficulty stemmed from feeling “strong, involved, put together through love of family and work” (p. 172). Eigen had achieved integration, personalization, and the ability to relate to objects—an active, interpersonal process needed for the psychological development and well-being of adolescents in foster care.
Environmental Interventions

While the majority of the previously mentioned interventions focus on directly working with fostered youth, the enduring success of these interventions will likely depend upon the support these treatments, as well as the foster youth, are given by significant others in these teens’ lives. Winnicott (1960/1974a) recognizes that the capacity for a good enough mother to appropriately attune and attend to her infant is aided and scaffolded by the mother’s own environment. Winnicott (1946/1997) also asserts that youth who have been deprived of an attuned home life must be provided with “a strong stable environment with personal care and love, and gradually increasing doses of freedom…[or] personal psychotherapy is not likely to succeed” (p. 118). Bronfenbrenner’s ecological view (1979) on the development of an individual reinforces Winnicott’s belief that individual psychological maturation is dependent upon a nurturing climate. According to Bronfenbrenner, there is a progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives…[and] this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded. (p. 21)

Therefore, treatment strategies for foster youth must include advocating for, and sustaining, the people and institutions that assist fostered adolescents.

Foster Parents/Caregivers and Siblings. As discussed in Chapter Three, foster parents who had a secure attachment status and were able to care for their foster children in an attuned, sensitive manner were significantly more likely to create secure attachments with the youth in their care (Dozier et al., 2001; Ponciano, 2010). To facilitate this sensitivity, the therapist who treats fostered adolescents should either work with the foster family as well, or this therapist can connect the foster parents to programs and groups that will provide
assistance to the caregivers. By increasing the caregivers’ experience of support, they are in a better position to support the adolescents in their care. For instance, Dozier et al. (2009) found that foster parents who underwent group training that increased their affect regulation skills, thus increasing their capacities to respond in an attuned manner to the children in their care, were more likely to have foster children who sought these caregivers out when in need. Members of the foster families in the control group, which was focused instead on enabling foster parents to aid in the cognitive development of the children through linguistic exercises, were significantly more likely to avoid one another in times of stress (Dozier et al., 2009).

McWey (2004) also recommends family therapy with foster families as a means by which to “disrupt [avoidant attachment] patterns of behavior, help families work toward forming healthy bonds, and assist families in achieving safety and stability in their lives” (p. 449). Similarly, Hughes (2004) believes that the inclusion of foster parents in treatment enables foster youth to generalize experiences of attachment and emotional co-regulation with their caregivers within session to the home setting. Further, the therapist has the opportunity to work, in vivo, with the caregivers’ own attachment experiences, thus increasing the foster parents’ “ability to remain present with the child whenever the child is at risk for affective, behavioral, and/or cognitive dysregulation” (Hughes, 2004, p. 275). In this way, the therapist empowers the caregivers to create “healing environments” for their foster adolescents by increasing the caregivers’ capacity to be “playful, loving, accepting, curious, and empathic” with their wards (Becker-Weidman & Hughes, 2008, p. 331).

Kagan (1996) argues that foster parents should be considered a part of the foster adolescent’s treatment team in order to increase these caregivers’ sense of efficacy and engagement with the service professionals in the foster teen’s life. One qualitative study of foster parents found that a significant number of caregivers “resented” the foster care agencies because these organizations provided little information about the foster child, which
limited the caregivers’ abilities to assist the children in their care (Daniel, 2011). According to Kagan, “Trust is facilitated when foster parents are recognized as key players within an integrated service…” (p. 215). Consequently, Kagan believes that foster parents should receive ongoing education about the effects of trauma and the child’s experience of foster care, as do the professional treatment providers in the foster child’s life. Winnicott (1950/1997) reinforces Kagan’s assertion by opining that foster parents must be taught about the angry emotions of the child that may be directed at the foster parents because the child is now in a safer environment in which she can express this affect.

To that end, the ARC treatment model, previously mentioned in this chapter, includes interventions that target increasing caregivers’ capacities in the following areas: emotional awareness and regulation of self and the child/adolescent; appropriate reflection of and attunement to the child/adolescent’s behavior and presentation; increased understanding of the effects of trauma and how best to respond to a child/adolescent who has experienced trauma; and the development of family rituals that can provide the child/adolescent with experiences of predictability and consistency that may supplant the child/adolescent’s early chaotic experiences (Kinniburgh et al., 2005). Family rituals that could potentially engender feelings of connection between the adolescents and their foster parents include weekly family dinners as well as engagement in family activities (e.g., playing board games, going for walks, and/or visiting museums and other points of interest to the teen and parent).

By increasing the foster parents’ knowledge and efficacy, these caregivers are more likely to create secure attachments between themselves and the adolescents in their care (Dozier et al., 2009). These stronger attachments may lead to more successful and longer placements, which provides both foster parents and adolescents with a sense of accomplishment as well as relational and geographical stability. One young adult who was a foster adolescent reports, “I couldn’t have come to a better family than my foster family; they
put up with me all the time, despite everything…They’ve been my safe harbor. I’ve always trusted them and still do” (Andersson, 2009, p. 21). Another former foster youth indicated that her foster parents have “always been the people closest to me; they were always the ones I turned to, also when I lived with my [biological] mother” (Andersson, 2009, p. 21). As this last statement shows, even when there is not a permanency of placement, there is, through the attunement between foster caregivers and adolescents, the possibility for the permanency of relationship.

Another avenue by which some foster adolescents receive emotional support and secure attachment is sibling relationships. For instance, in her meta-analysis of 17 studies across several countries (e.g., Canada, England, The Netherlands, Scotland, and the U.S.), Hegar (2005) noted that fostered and adopted children who were placed with siblings achieved similar or more successful placements when compared to children who did not have a sibling placed with them. These findings were reinforced by Washington (2007) who, in a review of 11 studies related to sibling placement in foster care, noted significant psychosocial benefit for foster children placed with their siblings. In another study, which examined the emotional and academic effects of sibling relationships in kinship care placement of 1,415 foster youth, Hegar and Rosenthal (2009) observed that children and youth who were placed with siblings expressed feeling more emotionally supported, closer to their primary caregivers, and increased satisfaction with their placements than the youth who were not placed with siblings. Results from this same study also indicate that the presence of siblings seems to significantly benefit the well-being of foster youth in placements of shorter duration (Hegar & Rosenthal, 2009).

Despite these findings, some researchers caution that the quality of the sibling relationship determines whether or not placement with siblings is beneficial to foster youth. Primarily positive interactions between siblings may serve as a resilience factor for children
and adolescents placed in substitute care. However, sibling relationships characterized by negativity may lead to greater conflict within the foster family, increased risk for conduct disordered behaviors on the part of the placed youth, and unsuccessful placements (Linares, 2006; Linares, Li, Shrout, Brody, & Pettit, 2007). Wunika, a former foster youth, writes about the ambivalence she experienced being separated from her brother when she was 13 years old (Desetta, 1996). Wunika initially expressed relief when she and her much younger brother were placed in foster care together because she was no longer in the position of having to care for him like a mother. She “hated” having to take care of him, and now Wunika could focus on herself and engage in age-appropriate activities. Yet, when they were abruptly separated, and her brother was subsequently adopted, Wunika had no further contact with her brother. She did not even have the opportunity to say good-bye, and there was no time for the sibling relationship to evolve. According to Wunika, “I may have pushed him away when he wanted me, but that doesn’t mean I don’t love him. The system…took away the only family I had. Now I don’t have anyone to love” (Desetta, 1996, pp. 32-33).

It seems that maintaining the connection of siblings, even if they are not placed together, may provide foster youth with opportunities to learn how to negotiate, and be in long-term relationships. A foster youth’s connection to her sibling may be this teen’s most enduring relationship. If this affiliation is defined by negativity, then family and/or filial therapy may help the siblings, as well as the foster family in general, to interact in more adaptive, prosocial ways. Linares (2006) found that foster parents who did not relate to placed youth in a warm manner that was supportive of the sibling relationship contributed to filial conflict. Therefore, family therapy and additional parenting support may enable caregivers to respond in an attuned manner to their foster adolescents, thus decreasing discord between siblings. Moreover, if siblings are separated, then child and adolescent social services, foster families, and community organizations should work together to preserve the
links between siblings. For instance, Camp To Belong, founded in 1995, is an international, non-profit organization that reunites separately placed siblings at summer camp. One camper reports, “[My brother and I] ate together, played together, and fought together. I had a very good time” (http://camptobelong.org/campfire-stories/camp-stories-from-the-kids/). This child learned an especially valuable lesson for a foster youth—arguments can be a part of relationships without severing the connection. This camper also, maybe implicitly, learned that there are adults who care enough to honor and preserve the child’s connections.

Community. As their non-fostered peers, foster adolescents come into contact with a variety of community-based organizations, such as school, church, and youth activities centers/leagues (e.g., the YMCA). However, foster youth, because of their placement status, also regularly interact with institutions with which many other adolescents have little or no contact. These include child protective services and probation, among others. It is not uncommon for foster adolescents to experience as many shifts in social workers as they do in foster placements. In their qualitative study of youths in the child welfare system, Strolin-Goltzman, Kollar, and Trinkle (2010), the majority of participants reported experiencing multiple changes of caseworkers, which often led to placement transitions as well. According to one of the teens interviewed, the switching of caseworkers “was challenging…because once you get used to one person, then you have to change over and over, they are creating an unsafe and unstable environment for us, especially when there is already no stability and permanency in our lives” (Strolin-Goltzman et al., 2010, p. 50). Wunika, who lost her sibling to separate foster placements and adoption, credits a continual fluctuation of social workers with her inability to see her brother (Desetta, 1996). Wunika reports, “I’ve been in foster care for eight years and I think I’ve had six social workers, five law guardians, and counting” (Desetta, 1996, p. 32). Debraha, a former foster youth, states, “Adjusting to new people, new rules, new surroundings, new everything, promotes
adjustment problems, ultimately leading to other behavioral and emotional problems” (Brown & Seita, 2009, p. 96).

Agency and organization professionals who specifically work with foster adolescents must be given the opportunity to form long-term relationships with these youth. Lower social worker caseloads, greater organizational support, appropriate and effective training, fewer intra-agency transfers, and agency cultures that view the professional-foster youth relationship as a significant attachment will likely engender lower organizational turnover rate, enhanced professional commitment to the foster adolescent, and improved adolescent well-being (The Annie E. Casey Foundation, 2003; Kufeldt, McGilligan, Klein, & Rideout, 2006; Schwartz, 2008; Strolin-Goltzman, 2008; Strolin-Goltzman et al., 2010; Winnicott, 1950/1997). According to a study conducted by Ahrens et al. (2011), many of the young adult participants reported meeting significant, helpful, and enduring mentors “through their involvement with the child welfare system, such as a caseworker, parole officer, or supervisor in a job-training program” (pp. 1015-1016). Additionally, for foster youth involved with several organizations (i.e., child protective services, probation, etc.), coordinated working relationships among the professional and foster caregivers must be established to ensure a sense of stability and continuity in the foster adolescent’s life (Chamberlain, Saldana, Brown, & Leve, 2010; Kagan, 1996). Furthermore, an integrative system, characterized by streamlined communication, may allow all of the caregivers to have a comprehensive understanding of the youth and her history. This knowledge will enable the team to respond in proactive ways that will induce better teen functioning across several domains including physical and mental health, peer interactions, and academic performance (Chamberlain et al., 2010; Kagan, 1996; Kufeldt et al., 2006).

As foster adolescents usually spend as much time at school as adolescents who have not experienced substitute care, school programs that enhance academic functioning and
instill a feeling of belonging are also salient components to promoting the psychosocial health of fostered youth. As discussed in Chapter Three, foster youth undergo academic struggles for a multitude of reasons, such as transitory school placements, lost school records, truancy, and the presence of learning and executive functioning disabilities (e.g., Courtney et al., 2010; Kagan, 1996; McDonald et al., 1996; Zetlin et al., 2010). The school performance of foster adolescents would benefit from school programs and/or therapists/social workers who will ensure that these teens are appropriately assessed and can receive needed academic accommodations (Rosenfeld & Richman, 2003; Zetlin, Weinberg, & Kimm, 2003). Possible accommodations include one-on-one tutoring, smaller classroom sizes, Individual Education Plans, and weekly communication between teachers and foster parents regarding the needs and progress of students.

Moreover, after school programs and extracurricular activities provide the teen with additional academic support, as well as opportunities to socialize with peers (Rosenfeld & Richman, 2003). Vorrath and Brendtro (1985) note that adolescent peers can successfully work together to create a positive culture based on care for one another. Persson, Kerr, and Stattin (2007) observe that teens who participated in adult-supervised, skill-building, and regularly-scheduled activities were less likely to engage in delinquent behaviors than adolescents who engaged in unstructured activities (e.g., hanging out). These same authors note that adolescents were more likely to participate in structured activities if they experienced positive relationships with their parents (Persson et al., 2007). This finding is important for foster youth, as it suggests that secure foster teen-caregiver attachments are more predictive of decreased delinquent behavior than just the adolescent’s engagement in extracurricular activities (Farineau & McWey, 2011). Therefore, therapists who work to enhance support and communication among teachers, mentors, coaches, and foster parents
may enable both the school and the caregivers to jointly facilitate foster adolescents’ competency and efficacy in academic and social domains.

Political/Societal. Foster adolescents, and their relationships to caregivers, peers, schools, and community providers, are embedded within the larger context of state and federal policies, regulations, and funding. Brown and Seita (2009) point out that “the government invokes the doctrine of parens patriae when it acts on behalf of a child…the state takes over the parental role” (p. 161). Therefore, if the state and/or federal government assert their authority to act in the best interests of the foster adolescent, then laws and mandates that promote the adaptive psychosocial development of the teen are necessary. Psychotherapists who work with foster youth would reinforce their treatment of these teens and their caregivers by advocating for adequate federal funding and state- and countrywide-interventions that would facilitate access to “food, clothing, human love and understanding…schooling…and ideas leading to rich play and constructive work” (Winnicott, 1947/1997). Psychologists can do so by implementing research to determine the effectiveness of various foster care interventions. In this way scientific evidence for the financial and legal support of appropriate treatments can be obtained (Chamberlain et al., 2010; Kagan, 1996). The Annie E. Casey Foundation (2009) recommends the utilization of “innovation, evaluation, and widespread implementation of policies and practices supported by strong evidence” as a means by which to overhaul the U.S. child welfare system (p. 4).

Therapists who treat foster youth can also intervene on a larger scale by helping these teens to advocate for themselves. One former foster youth argues for the importance of encouraging “foster care alumni to assume leadership roles in child welfare agencies” in order for the development of appropriate programs (Brown & Seita, 2009, p. 24). A therapist can connect a foster youth to organizations that utilize the voices and stories of these teens to facilitate beneficial foster care agendas. For instance, Breindtro et al. (1992) discuss Youth in
Care Canada, which aided the Canadian government in creating relevant interventions for youth at risk. “Represent! The Voice of Youth in Care” is a magazine published by Youth Communication, a media group that obtains and disseminates the stories of foster youth for the purpose of providing practical help to foster teens and caregivers as well as intervention ideas to policymakers (http://www.youthcomm.org/Publications/FCYU.htm). The psychosocial functioning of foster adolescents would likely be further improved if therapists linked foster carers to networks that help the caregivers support their charges. One example is the National Foster Parent Association (NFPA) whose mission is to “support foster parents in achieving safety, permanence, and well-being for the children in their care” (http://www.nfpainc.org/index.asp).

Finally, as the neurobiological research into brain maturation and trauma underlines (e.g., Cozolino, 2006; Perry, 2006, 2008, 2009; Schore, 2003a, 2003b), therapists need to advocate for legislation and funding that targets prevention, not just treatment. For example, one study looked at the utilization of interventions (i.e., infant-parent psychotherapy and psychoeducational parenting intervention) with biological mothers of one-year-old infants who were identified by child protective services as having maltreated their children (Cicchetti, Rogosch, & Toth, 2006). The majority of the infants were initially assessed as having a disorganized attachment status. At follow-up one year later, both treatment groups had facilitated significantly more secure attachments between mother and child than the two demographically-matched community sample groups, which did not receive either of the interventions. As many neurobiological researchers assert, secure attachment in infants, which is fostered by attuned interactions between parent and child, engenders adaptive brain maturation (e.g., Cozolino, 2006; Schore, 2003a, 2003b; Wilkinson, 2010).

Cicchetti et al. (2006) also point out the strain caused to parent-child relationships by financial limitations. To combat the risk factor of poverty and a low socioeconomic status,
Kagan (1996) states that “poor parents of all ages and society as a whole benefit...[from affordable] childcare, job training, job placement, health insurance, and help...to escape from generations of abuse and neglect” (p. 220). Although current economic trends are heading in a different direction, legislation, policies, and funding directed toward prevention strategies may serve as a buffer against the deleterious impact of poverty and debt. As a result of these types of policies, fewer adolescents may end up in foster care, thus alleviating the negative biopsychosocial effects for these teens, as well as the financial, social, medical, and criminal burdens to the general society.

Summary

This chapter reviewed treatment strategies for working with foster adolescents based on the object relational-developmental framework constructed by this author. An ecological model of individual development delineated several, ever-widening points of intervention. These points include individual and group psychotherapy with the teen, support and psychoeducation for the caregiver, family therapy with the caregiver and foster siblings, coordination of care among professional and community-based organizations (e.g., child protective services, probation, schools, etc.), and advocacy of state and federal policies and funding that target prevention and/or the development of adequate and effective responses to the effects of trauma and foster care placement on youth. The goal of all of these interventions is to enable the foster teen to experience growth-facilitating stability, consistency, and connection to significant, attuned caregivers. With a newfound sense of felt security, a teen who has undergone traumatic loss, neglect, abuse, and foster care placement may begin to develop the affect regulation, cognitive functioning, and impulse control—elements of the capacity to be alone—needed to play, create, and work. The final chapter will discuss recommendations for future research and the effects of current adolescent culture...
(e.g., technology, social media, and teen use of leisure time) on the development and maintenance of the capacity to be alone.
Chapter 6

Discussion

Throughout this dissertation, I have utilized current literature on attachment (e.g., Bowlby, 1990; Cole & Deater-Deckard, 2009; McElhaney et al., 2009; Morris, Silk, Steinberg, Myers, & Robinson, 2007; Shumaker, Deutsch, & Brenninkmeyer, 2009; Zimmermann et al., 2009), trauma (e.g., Cicchetti & Rogosch, 2002; De Bellis, 2001, 2003, 2005; Perry, 2006, 2008, 2009; Schore, 2003a), and adolescent biopsychosocial development (e.g., Brendtro, Brokenleg, & Van Bockern, 1992; Larson & Verma, 1999; Males, 2002, 2003, 2010; Spear, 2000, 2007, 2009; Steinberg, 2005, 2008, 2010) to illuminate the potential for integrating Winnicott’s (1958/1974) theory of the capacity to be alone with more recent ideas regarding normative and non-normative adolescent development. This approach has been necessary in order to determine the relevance of Winnicott’s construct for adolescents now living in the U.S., whether or not they have been in foster care. According to Chao and Otsuki-Clutter (2011), the identification of contextual and sociocultural features, such as race, ethnicity, and socioeconomic status, is a salient component of theory building. The following sections highlight promising avenues and mechanisms for future research as a means to refine, elaborate, and make culturally congruent the proposed object relational-developmental framework.

Current U.S. Adolescent Culture and the Capacity to Be Alone

If, as Denzin and Lincoln (2003) claim, “the central task of theory is to make sense out of a local situation” (p. 25), then this author believes that research is necessary to determine how current adolescent culture affects the development of the capacity to be alone in youth in general. Winnicott, an Englishman, wrote his paper on this subject in 1958. Winnicott’s theory evolved out of his observations of children, adolescents, and caregivers in
his era. There have been significant cultural changes since the time in which Winnicott practiced. In his discourse on cultural experience, Winnicott (1967/2001b) says,

…I am thinking of the inherited tradition. I am thinking of something that is in the common pool of humanity, into which individuals and groups of people may contribute, and from which we may all draw if we have somewhere to put what we find. (p. 99, author’s emphasis)

With the capacity to be alone, Winnicott has created a theoretical tradition related to human psychosocial maturation. What, if anything, can the current culture contribute to this tradition? What are today’s values and expectations in terms of how children and teens utilize their alone/leisure time? Does this generation of youth use the technological objects (e.g., the Internet and social media) in their environment to facilitate play and expressions of their True Selves? Or, do these new media impinge on development in unanticipated ways?

There has been recent psychosocial interest in how U.S. children and adolescents spend their time, including delineating the factors that contribute to choosing activities as well as inquiring about the social-emotional effects of time use. While conducting a 1997 survey of a sub-sample of families that were part of the 30-year longitudinal Panel Study of Income Dynamics (PSID), Hofferth and Sandberg (2001) observed that children under 13 years old spent 29 percent of their time in free play, 24 percent in television viewing, and 18 percent in structured activities. In their meta-analysis of child and adolescent use of time across various cultures (e.g., the U.S., Korea, Japan, Italy, India, etc.), Larson and Verma (1999) found that American adolescents have more discretionary time to engage in non-structured (e.g., talking with friends) and structured (e.g., sports, clubs) activities than their adolescent counterparts in Korea and Japan, who appear more focused on schoolwork. Zick (2010), who compared time diary data from 1977 to 1978 and 2003 to 2005, notes a significant teen “exodus from the labor market…and a substantial increase in their leisure
time” (e.g., participating in sports, computer use and television viewing, and hanging out with friends, etc.) over the 25-year period reviewed (p. 590).

Some researchers express concern about pressure being placed on children and adolescents to over-book this “free time”. Elkind (2001) discusses the “hurried child;” that is, a child and adolescent who experiences significant stress due to having an over-scheduled life (e.g., engaging in several extracurricular activities and carrying a full academic course load). According to Elkind, adolescents, primarily from families of middle-class socioeconomic status, are “enmeshed in ‘achievement overload’…[and] have to keep date books because their time is so tightly scheduled” (p. 151). Doherty and Carlson (2002) similarly warn against “time famine.” These authors claim that “the frantic pace of American family life” leaves little time “for spontaneous fun and enjoyment, for talking over the day’s events and experiences, for unhurried meals…” (Doherty & Carlson, p. xiii). From these perspectives, there is little room for the today’s adolescent to relax, unintegrate, and be open to occurrences of her spontaneous gesture (Winnicott, 1958/1974). Such “overbooking” of American adolescents would appear to have significant implications for their capacity to be alone.

Other researchers, however, question if these children and adolescents actually feel overwhelmed by their immersion in activities. Hofferth, Kinney, and Dunn (2009) state, “Although there is substantial research on the positive aspects of activity participation, there is almost no empirical evidence for the stress and strain part of the hurried-child hypothesis” (p. 185). Positive aspects of structured youth activity engagement include increased self-esteem and self-knowledge, greater personal and interpersonal integration into the community, better emotional regulation and task-related skills, higher cognitive achievement, and fewer occurrences of risky and conduct-disordered behaviors (Hansen, Larson, & Dworkin, 2003; Hofferth & Sandberg, 2001; Urban, Lewin-Bizan, & Lerner, 2010). In terms
of the proposed stress that “hurried” youth experience, Hofferth et al. (2009) found that voluntary engagement of children in structured activities promoted psychosocial functioning, especially due to the effects of parents’ monitoring activity on their children’s well-being. Moreover, these authors observed a correlation between maladaptive psychosocial functioning and limited participation in structured activities (Hofferth et al., 2009).

Along with parental interest and supervision, the element of choosing the activities in which one would like to engage may serve as a protective factor against developing stress-related symptoms. Urban et al. (2010) note that teens who were able to identify goals, and then select and collaborate with individuals and groups that would enable them to reach their goals, significantly benefited from engagement in structured activities. One important avenue for future research would be the evaluation of the impact that these profound changes in the use of structured and unstructured time have had on the capacity of adolescents to be alone. Further research would also necessitate the evaluation of variations in the use of “alone time” between adolescents in foster care and the population at large.

One area that has seen a significant rise in youth engagement is Internet use (Dunn et al., 2003; Larson & Verma, 1999; McMillan & Morrison, 2006; Zick, 2010). The Internet is a vehicle by which adolescents do not have to experience any alone time due to the multiple methods it has for connection (e.g., e-mail, instant messaging, social networking Websites, interactive game Websites, blogs, etc.). Several studies underline the value that youth place on the Internet for initiating and maintaining connections to others, including family, friends, romantic partners, and acquaintances (e.g., Bargh, McKenna, & Fitzsimons, 2002; Buote, Wood, & Pratt, 2009; Livingston, 2008; McKenna, Green, & Gleason, 2002; McMillan & Morrison; Seepersad, 2004; Subrahmanyam, Garcia, Harsono, Li, & Lipana, 2009; Subrahmanyam & Greenfield, 2008). According to one young adult, “People log onto the Internet precisely because it is interactive. They want to participate in something” (McMillan
& Morrison, p. 79). Jenny, a 14-year-old interviewed about her social networking page, reports, “You look through other people’s profiles and look through their pictures, different pictures of their mates and that…if someone gives me a comment, I’ll comment them back…you get, like, addicted to it” (Livingstone, 2008, p. 403).

Winnicott’s discussion (1969/2001) on the use of the object seems relevant to the current literature on adaptive and maladaptive Internet use. Winnicott posits that an individual’s capacity to “use” an object presupposes the person’s knowledge that others are subjects as well as objects. For Winnicott, object usage is a developmental achievement—a culmination of integration, personalization, and object-relating—that occurs in potential space. Play, creativity, and work are results of object usage. Furthermore, the properties of the object, which can now be seen as a separate thing by the individual, can influence the user as much as the user can manipulate the object. Bi-directional influence is occurring. And, because there is a relationship involved (i.e., a shared reality), abilities for symbolization must be present to facilitate the dialogue. The capacity to be alone (Winnicott, 1958/1974) is constructed on the same building blocks as the capacity for object usage. The two are intertwined as early positive attachment experiences and emotional-, cognitive-, and behavioral-regulation abilities mitigate the anxiety one may experience with the recognition that objects exist that are not one’s creation or completely under one’s control.

From the literature reviewed regarding youth Internet use, aspects of the capacity to be alone—secure attachment status, affect regulation, frustration tolerance, cognitive and impulse control—seem to correspond with how an adolescent perceives and uses the Internet. Seepersad (2004) found that adolescents and young adults with avoidant coping styles used the Internet for entertainment purposes as a way to escape feelings of loneliness. Buote et al. (2009) observed that young adults with an insecure-fearful attachment style (i.e., negative view of self and others) were incautious and imprudent about the personal information that
they would disclose online. In their study of early adolescents, Gross, Juvonen, and Gable (2002) note that teens who are comfortable in face-to-face interactions with peers will use the Internet to further interact with friends. However, teens who experience social anxiety and detachment from others avoid feeling alone by utilizing the Internet to connect with people who are not a part of these adolescents’ everyday lives (Gross et al., 2002). A respondent in the McMillan and Morrison (2006) study differentiates between a purposeful use of the Internet and the ease one may experience by controlling a machine.

Moreover, for some youth, the Internet provides a way in which they can play as well as express spontaneous gestures and elements of their True Selves. According to 14-year-old Elena, “I think layouts should like who you are…I like to have different ones…it’s different likes, different fashion, different feelings on that day” (Livingstone, 2008, p. 399). Blogs, a type of personal online diary, appear to be used by adolescents to reflect on their daily lives as well as to share their thoughts, feelings, and concerns (Subrahmanyam et al., 2009). McKenna et al. (2002) found that young adults were more likely to initially discuss interests, thoughts, and feelings with people they met online, leading to a quicker establishment of intimacy and the further development of the relationship offline. The stability of these relationships was intact at a two-year follow-up (McKenna et al., 2002).

Of course, not all of what young adults share on the Internet is truthful (Bargh et al., 2002; McMillan & Morrison, 2006). However, the Internet may allow some youth who have social anxiety to express aspects of their personality, thus, facilitating their capacity to play. One young adult writes, my brother calls himself “Insane Marcos,” and I believe real life mirrors fiction in his case. He does everything the news media say people do in chat rooms, exaggerating his height and changing his hair color. He is also a rather shy
person in real life, a characteristic he sheds in the anonymity of the Internet and e-mail. (McMillan & Morrison, 2006, p. 78)

As Subrahmanyam and Greenfield (2008) assert, “real-world relationships and adolescent issues influence adolescents’ electronic communication at least as much as electronic communication influences their real-world relationships and developmental outcomes” (p. 140).

Since social media is such a salient part of today’s adolescent environment, further research of its effect on foster youth as well as on teens in general may assist in determining the usefulness of the capacity to be alone for understanding and working with adolescents. Further, the specificities of Internet and social media use by adolescents in foster care require significant investigation. In terms of Winnicott’s theories (1963/1997, 1964/1997b) about adolescent development, it would be interesting to assess if the Internet protects the True Self of the adolescent. For instance, is the adolescent able to virtually connect with other teens while physically remaining an isolate (Winnicott, 1963/1997), safe from the undue influence of other adolescents?

**Recommendations for Future Research**

**Qualitative Research.** This dissertation has proposed an object relational-developmental framework based on a critical assessment of the literature related to Winnicott’s (1958/1974) capacity to be alone construct, as well as to normative and non-normative adolescent development. Any proposed theory, however, must be elucidated by, and applied to, the population it claims to represent. I have synthesized several theoretical expositions related to Winnicott’s concept in order to operationalize the capacity to be alone. However, my analysis relied entirely upon previously published theoretical explanations and first-person accounts to illustrate the proposed framework. Therefore, additional
construct-driven research is needed to evaluate the relevance of the capacity to be alone for today’s foster youth. Both qualitative and quantitative studies will help determine the salience of Winnicott’s concept.

Winnicott places substantial emphasis on how an infant’s sense of being develops. He specifically refers to the infant’s “continuity of being” (Winnicott, 1960/1974a, p. 47). For Winnicott (1958/1974), the capacity to be alone is the experience “of being alone, as an infant and small child, in the presence of the mother” (p. 417). If an infant does not experience good enough holding, there will be gaps in her feeling of going-on-being (Winnicott, 1962/1974). The capacity to be alone, then, is predicated on a sensory experience of going-on-being. As such, research grounded in a phenomenological approach may provide a diagnostic tool in assessing foster adolescents’ experiences of this construct.

Phenomenological research views the “individual as a conscious agent, whose experiences, [which are embodied and contextually-related,] must be studied from the ‘first-person’ perspective” (Ashworth, 2003, p. 13). For example, Mitchell and Kuczynski (2010) used a phenomenological research approach to better understand the lived experiences of children and teens undergoing their first transition into foster care. These authors initiated this strategy because they found few studies incorporating personal accounts of this transition. Mitchell and Kuczynski believe that understanding how these youth experience and make sense of the shift to foster care “honors” the participants’ voices and provides intervention-related and policymaking data.

If future research will focus on the lived experiences of particular adolescents from particular backgrounds (e.g., foster youth), then this author recommends an ontological grounding of that research in social constructionism. This philosophy posits that there are multiple meanings generated by interactions between individuals within interpersonal, social, and cultural spheres (Crotty, 1998; Gergen, 1999). According to the constructionist
viewpoint, the researcher and the study participants have specific phenomenological reactions to events, and these phenomenological perceptions would intermingle to create a view of the capacity to be alone construct. As Mertens (1998) points out, the constructionist paradigm emphasizes that research is a product of the mixed values of the researcher and the participants, and the truth that is elucidated results from the fusion of these perspectives. Therefore, by utilizing this approach, study participants become co-researchers.

Further, acting as co-researchers may positively affect the psychosocial development of foster youth. Mason and Hood (2011) report on recent shifts in research strategies with children. They elucidate a theoretical and pragmatic move from research on to research with youth. These authors assert that this alteration in perspective engenders a sense of agency in children and adolescents and minimizes the power differential between examiner and examinee (Mason & Hood, 2011). As a result, a degree of power is imparted on a group that is typically marginalized. Whiting (2000) believes that children and adolescents should be considered marginal members of society because they are prone to victimization due to their lack of power within the family and wider environmental contexts. Adolescents in substitute care, under such a paradigm, should be considered an acutely marginalized group. Therefore, researchers who encourage foster youth to provide critical input into a study’s creation and evolution offer opportunities for these adolescents to “contribute-in”—to experience their ontological significance (Winnicott, 1963/1974b). Research participation, like psychotherapy, can engender a sense of responsibility in these teens, thus generating feelings of belonging (Brendtro et al., 1992; Gilgun, 2002). Further benefits of foster teens sharing their stories include enhanced understanding of their circumstances, emotions and behaviors, empowerment and consciousness-raising, and self-advocacy (Whiting, 2000).

The occasion to describe and delineate their own experiences may aid in healing the neglect, abuse, traumatic loss, and instability in the personal histories of most, if not all,
foster youth. Narrative Psychology is a qualitative research approach that may facilitate psychosocial health in foster adolescents. According to Miller (1996), “the narrative perspective has influenced my understanding of the many ways a ‘problem-saturated’ account of a client’s life limits the potential for healing” (p. 216). Miller is referring to trauma survivors, such as foster youth. Foster adolescents may write themselves into the “tragedy” narrative, and this narrative—characterized by hopelessness and helplessness—may impede their achievement of the capacity to be alone. Through Narrative Psychology, foster youth may have a chance to integrate traumatic events within the framework of a new self-story—a *bildungsroman* that encompasses growth and success as well as loss and disappointments. Additionally, by integrating phenomenological experience with meaning making, Narrative Psychology may promote neural network integration, thus improving affective regulation and cognitive and behavioral functioning (Siegel, 2003; Wilkinson, 2010).

Moreover, qualitative research methods are useful with foster youth due to the attention these approaches give to diversity and cultural concerns. From the constructivist perspective, “researchers must be aware of their own personal theoretical base as well as that of the sponsors and the participants” (Mertens, 1998, p. 50). A phenomenological approach presupposes that investigators are open to learning from the interviewee with the goal of creating interventions that are suited to specific peoples in specific situations and locations. Establishing the generalizability of the capacity to be alone construct to foster teens from a variety of racial and ethnic backgrounds is salient as significant ethnic disproportionality continues to characterize the child welfare system (Cross, 2008; Shaw, Putnam-Hornstein, Magruder, & Needell, 2008). The Annie E. Casey Foundation (2009) reports, Children of color, and especially African American and Native American children, are more likely than white children to be placed in foster care, less
likely to receive the services they need, and more likely to remain in care for a long time, even when the effects of poverty and the type of maltreatment alleged are taken into account. (p. 5)

Qualitative research strategies may determine if the capacity to be alone is a conceit that is effective for understanding how various cultural contexts interact with an individual’s psychosocial maturation. From this knowledge base, culturally sensitive interventions aimed at prevention, permanency planning, and the reduction of racial/ethnic disparity may be produced.

Finally, qualitative research methods emphasize the dialogic nature of information gathering, and these approaches resonate with Winnicott’s ideas (1953/1986, 1968/2001a, 1968/2001c, 1970/2001) about potential space and play. Studies employing qualitative strategies may utilize a cooperative inquiry approach by which the examiners and examinees, each with their specific knowledge bases, co-construct research agendas, terminology, and recommendations (Mertens, 1998). According to Denzin and Lincoln (2003), “spaces for give-and-take” are created between the researcher and those being investigated—the participant is “active” and more than “the object of the social science gaze” (p. 8). The bi-directional influence of this framework is comparable to potential space—the location in which the individual “engages in a significant interchange with the world, a two-way process in which self-enrichment alternates with the discovery of meaning in the world of seen things” (Winnicott, 1967/2001a, p. 113). This type of inquiry sets the stage for and encourages the spontaneous gestures of foster youth. Like the good enough caregiver-child and psychotherapeutic relationship, the good enough research relationship may facilitate the foster adolescent’s sense of potency, capacities to play and make meaning, and expressions of her True Self (Winnicott, 1960/1965).

Possible lines of qualitative inquiry might include:
1. Do foster adolescents recognize the validity of Winnicott’s construct in terms of their own experiences?

2. What have positive/negative relational experiences been like for the fostered teen?

3. Is there a marked difference in the use of alone time between adolescents in care and adolescents who reside with their biological parents?

4. How do both sets of adolescents describe their experiences of being alone and being with others?

5. How would both sets of adolescents describe current experiences of playing?

6. How do race and ethnicity interact with foster status in terms of obtaining/experiencing the capacity to be alone?

Quantitative Research. Although the utilization of qualitative research methods has been stressed, due to the opportunities they provide for agency, healing, and phenomenological expression to foster youth, quantitative research would also yield salient data. For example, Chamberlain et al. (2010) report that “pressure from a wide range of government and privately funded entities has mounted to incorporate evidence-based practices (EVPs) into publicly funded child welfare, mental health, and juvenile justice systems” (p. 218). The Annie E. Casey Foundation (2009) also recommends state and federal promotion of research on and funding for EVPs to ascertain the needs of, and to delineate appropriate interventions for, foster youth and their caregivers. Since foster youth are considered wards of the state, the majority of their mental and physical health services are funded by the federal and state governments (e.g., Medicaid, MediCal, etc.). Therefore, developing clinically effective EVPs for foster youth may engender greater federal and state fiscal support so all foster adolescents can have access to treatment that will improve their psychosocial functioning.
Quantitative research may also aid in the process of operationalizing the capacity to be alone construct. As explicated in previous chapters, Winnicott’s conceit (1958/1974) is related to attachment, psychosocial development, affect regulation, cognitive and executive functioning, and impulse control. Several instruments are already available to measure these variables. These include the *Parenting Relationship Questionnaire* (Kamphaus & Reynolds, 2006), the *Adolescent Attachment Questionnaire* (West, Rose, Spreng, Sheldon-Keller, & Adam, 1998), the *Behavior Assessment System for Children, 2nd Edition* (Reynolds & Kamphaus, 2004), the *NEPSY-II*, which is a developmental neuropsychological assessment (Korkman, Kirk, & Kemp, 2007), and the *Vineland Adaptive Behavior Scales, 2nd Edition* (Sparrow, Cicchetti, & Balla, 2005), and many others. Put together into a battery, these tests, among others, can determine if a foster teen has experienced the secure attachment, and resulting emotional, cognitive, and behavioral regulation, that are elements of the capacity to be alone. Further, these assessments can also evaluate this adolescent’s treatment progress.

As Mertens (1998) and Denzin and Lincoln (2003) discuss, there was a turn away from quantitative work by social science researchers beginning in the 1960s due to its overemphasis on the viewpoint of the researcher, and its tendency to bestow a false sense of objectivity, especially for diverse and/or marginalized populations. However, these potential problems can be mitigated. First, the quantitative researcher can be explicit about the theory and values guiding the study (Denzin & Lincoln, 2003; Mertens, 1998). Second, there are now more robust quantitative studies that have moved from the clinician’s lab and/or office into the spaces in which subjects live their lives, including schools, homes, and inner city hospitals and community centers (Cohen, 2008).

Potential questions for quantitative investigation include:

1. Is there a relationship between the foster adolescent’s attachment status and her capacity to constructively use alone time?
2. What is the interaction between attachment status and affect regulation in terms of executive functioning?

3. Is the capacity to effectively utilize alone time related to self-esteem in foster youth?

4. Does the provision of a specific intervention that facilitates an earned secure attachment status in foster parents lead to the youth in their care obtaining this attachment status as well?

Quantitative and qualitative assessments are endeavors that encompass both strengths and challenges. In terms of undertaking research with foster youth, one does not have to take an either-or approach. For instance, a researcher can first conduct semi-structured interviews and/or focus groups with foster adolescents in order to determine relevant themes and study variables. Then, the co-created variable can be examined in a quantitative manner to determine their applicability to a greater number of individuals, their transferability from one setting to another, and their helpfulness as treatment markers.

Summary

This chapter examined areas of current adolescent culture, specifically the over-scheduling of teens and adolescent use of the Internet. From the literature reviewed, feelings of overwhelm and stress, as well as maladaptive utilization of the Internet, seems tied to components of the capacity to be alone (e.g., secure relationship status, affect regulation, and cognitive and behavior control). I also discussed recommendations for future research that would aid in the operationalization of the capacity to be alone in order to construct appropriate intervention strategies with foster youth. The value of qualitative research for assisting with the psychosocial healing of foster adolescents, especially through the teens’ use of narratives and their experience of agency, was underlined. Quantitative research was also described, particularly to promote federal and state policies and funding
that could benefit the well-being of foster youth. Additionally, future research focused on the interactions between current adolescent culture(s), both of foster youth and adolescents who are not substitute care, and the capacity to be alone may determine the theoretical, diagnostic, and treatment relevance of the object relational-developmental framework explicated in this dissertation.
References


45-77.


Larose, S., & Bernier, A. (2001), Social support processes: Mediators of attachment state of mind and adjustment in late adolescence. *Attachment & Human Development, 3*(1), 96-120.


Brunner-Routledge.


Appendix A: Object Relational-Developmental Framework

Solid line denotes normative development.
Dotted line indicates non-normative development.