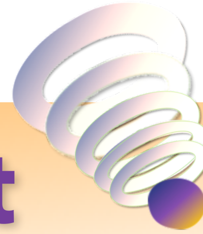
intersect

CCNY Clinical Psychology

The Point



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ABOUT THIS NEWSLETTER

The realities of Fall 2020 delayed our publication. This double issue presents studies emerging from the child-oriented services at The Psychological Center as well as ongoing studies related to the COVID-19 experiences and psychological sequelae among a CUNY students.

Part 1: Learning From Our Child Patients

Many of the questions and concerns arising amidst our tumultuous current moment are focused on children, the ways to ensure their fruitful development, and how their progress may interact with future uncertainties. The work conducted at The Psychological Center offers a glimpse into the complex interplay of familial, societal, and psychological factors that influence childhood mental health.

The Child Health and Psychotherapy (CHAP) program is, on one hand, a comprehensive programmatic evaluation of the psychotherapy services provided to youth at the Psychological Center. More importantly, however, it is a comprehensive and empirical dimension of the child psychological services offered at The Clinic. The intake process for youth begins with a questionnaire filled out by a primary caregiver that includes developmental history, child and family demographics, caregiver attachment and mentalization measures, symptom checklists, and open ended questions regarding the child's presenting problem and goals for treatment. Second, objective psychological assessment measures (i.e. the Rorschach Inkblot Method (RIM) and the Thematic Apperception Test (TAT), conducted by therapists, are administered to the child. These assessments seek to understand, among other things, the object relations, affect maturity, and defense mechanisms of the child, dimensions rarely measured objectively during the intake process for child psychotherapy.

Third, the intake therapist has several one-on-one sessions with the caregiver(s) and with the child. Fourth, the therapist administers the Parent Development Interview to a primary caregiver. It is our belief, that when examined together, these data provide a nuanced understanding of the child and family system.

Data continue to be collected from caregivers, the child patients, and their respective therapist every 6 months for the duration of the treatment. It is our hope that these data complement the therapists clinical observations and inform their conceptualization of the child and family system. In addition, these data are used by The Clinic to understand successes and pitfalls of our treatments, possible explanations for various treatment trajectories, all while simultaneously delving further into the childhood origins of our own psychological processes.

The ways in which caregivers understand their children and encourage modes of self-reflection can directly affect their children's personalities and developments of self-concept. The ability to view ourselves as multilayered individuals with ever changing minds is borne out of the interactions we have with our caregivers.

In one analysis, program evaluations conducted at the Clinic examined the dimensionality of the language that caregivers use when describing their reasons for seeking treatment for their children. Caregivers may describe behavioral attributes, such as their child's repeated sucking on toys at school (unidimensional). They may describe these behaviors while concurrently referencing their child's underlying emotions, such as expressing that the behavior occurs in the context of separation anxiety (two-dimensional). Lastly, caregivers may think about the influence of the presenting problem as defined by behavior and affect on the child's self-concept (three-dimensional). In this vein, caregiver reported presenting problems were coded as 1-, 2- or 3-dimensional. The combination of linking behavior to affective experiences, as well as to understandings of treatment as fostering an improved sense of self, highlight a capacity for multi-dimensional views of children and their roles within treatment.

Additionally, research documented the relationship between the dimensionality of thinking in the caregiver and childhood psychological wellbeing. Specifically, children of caregivers who portrayed their child's behavioral difficulties as rooted in an emotional experience (i.e. multidimensional), experienced less depression than those youth whose caregivers see the child's behavior only (i.e. unidimensional).

These findings echo extensive writing on the role that caregiver mentalization capacities play in their children's psychological functioning. While our work does not seek to equate coding of presenting problems and treatment goals with the extensive coding of caregiver interviews for reflective functioning, these data do suggest that the quality of caregivers' descriptions of their child's difficulties are meaningful and may relate to their child's psychological well-being.

Related, we explored the relationship between caregiver attachment and child depressive symptoms. The study findings indicated a relationship between caregiver attachment styles that involve avoiding close, dependent, trusting, and emotional relationships, and greater levels of depressive symptoms in the child. This finding supports previous analyses that highlight the role that caregiver attachment plays in child psychopathology.

These are just two examples of questions assessed via CHAP data that explore the indisputable link between caregiver and youth mental health. Together these data are compelling evidence for the importance of engaging the full family system in child psychotherapy treatments, and the ways in which inquiries into caregivers and children are enhanced when understood in interaction.

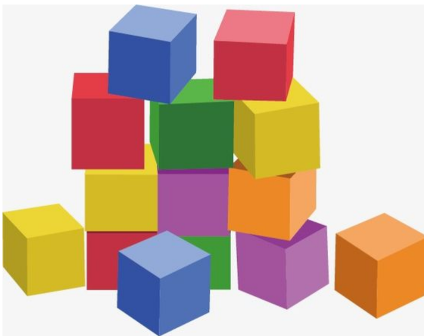
Bifulco, A., Moran, P., Ball, C., & Bernazzani, O. (2002). Adult attachment style. I: Its relationship to clinical depression. Social Psychiatry and Psychiatric Epidemiology, 37(2), 50-59.

Camoirano A. (2017). Mentalizing Makes Parenting Work: A Review about Parental Reflective Functioning and Clinical Interventions to Improve It. *Frontiers in psychology*, *8*, 14. https://doi.org/10.3389/fpsyg.2017.00014

Egleson, A. (2020). *Is Child Depression related to Parental Adult Attachment Style? An Exploration of the Relationship in a Sample of Community Mental Health Clinic Child Patients and their Parents.*

Wright, L. (2019). *Clinical Prisms: Understanding Youth Through a Caregiver's Lens.* [Conference Presentation]. Division 39, New York, NY.

Caregivers and Therapists



The relationships between therapists and caregivers contributes to treatment outcomes for child patients. We sought to document the factors responsible for meaningful change within caregiver-therapist relationships by looking at caregiver and therapist goals for treatment, the quantity and quality of their interactions, as well as caregivers' capacities for self-reflection and awareness.

Findings highlighted the distinct importance of quality in caregiver-therapist interpersonal engagement (more so than the mere quantity of interactions). Specifically, the stronger the quality of engagement, the greater the therapist and caregivers' reported treatment goals began to match over the course of treatment.

Importantly, such a significance, in caregiver-therapist interaction quality, was only found when such caregivers had individually high levels of self-reflection. Therefore, for those caregivers who spoke of their children in more unidimensional ways (i.e. of their behavior or affect, but not the child's behavior *and* affect), it is even more vital for clinicians to engage caregivers in interaction, with the hope that discussing their children in a reflective manner could result in mutual agreement on goals for the child treatment as well as a shared understanding of the therapeutic process.

Effective communication between therapists and child patient's caregivers may affect the views that each hold regarding psychotherapy. Caregivers may be perceived as third-party participants to therapist-child dyads, when in fact their explicit consent is what allows the continuation of treatment and their potential termination can end it. In this way, the caregiver-therapist relationship warrrants greater attention.

Routhier, E. Wright, L. Rudenstine S. (2018). *Exploring Caregiver and Therapist Treatment Goals after Six Months of Child Treatment.*

Children and the Unconscious

Our clinical approach emphasizes the import of understanding both the conscious and unconscious processes of our child patients and their caregivers, as well as the ways that such processes interact. A recent study sought to understand, first, the relationship between internal experiences of others and external symptoms of aggression in children, and second, how this relationship might differ depending on assigned sex at birth. Findings highlighted the ways in which for girls, higher "object relatedness," or greater internalized understandings of others, was associated with less external aggression. However, for boys, this relationship was not significant, and aggression behaviors did not differ based on unconscious processes. One explanation for these results is that assigned childhood sex as well as societal and caregiver gender-based expectations

influence the differing ways in which we teach our children to understand, experience, and display aggression.

We separately investigated the relationship between a caregiver's ability to understand and communicate their own emotions and the ways in which their children deal and react to intense emotional experiences and conflicts (i.e. defenses). Results indicated that children of caregivers who had lower mentalization scores, (i.e. did not express, communicate, or modulate their emotions), mostly employed denial as opposed to more mature and nuanced defenses, such as projection and identification. Overall this finding suggests that children are left with the need to deny their own emotional experiences in the context of caregivers with limited capacity to understand their own emotions.

As is apparent, the aforementioned findings relied on the rigorous use of projective tests, such as the Rorschach Inkblot Method and the Thematic Apperception Test. Such vital tools, with their basis in psychodynamic theory, are pillars of our treatment model. We believe their utilization is crucial to understanding a child's complex internal life, as formed and developed in interaction with ever-changing familial, societal, and cultural environments.

Dunn, H. Goldman, R. Rudenstine, S. (2020). *Examining the Relationship Between Parent Mentalizing and Child Defenses.*

Fredman, A.Rudenstine, S. (2020). *Children's Intrapsychic Processes and Externalizing Behaviors as a Function of Sex.*

Our Patients and Our Current Moment

The Clinic has operated remotely in a consistent manner since April 2020. As the therapy room moved into families' and therapists' respective homes, new hurdles and new opportunities arose. For example, while difficulties with audio or video sometimes made it challenging for children and therapists to communicate, therapists have been able to see their child patients in their home environments, offering a rich new context for therapeutic treatment. Despite our patients' and therapists' heroic successes in overcoming the challenges imposed by a remote Clinic, anticipated vaccine distributions provide necessary hope for resuming in person treatment in the future.

Yet, with this hope remains the intense stress of the current moment. Many families are still seeking therapy for their children—as is apparent in daily headlines, and the current pandemic has exacerbated preexisting difficulties while simultaneously forming newfound stressors for families and children. From unpredictable school closures, to dangerous working conditions for essential workers, to racist violence, the stress, specifically for children and families of color with fewer resources, is immense.

As we move further into 2021, we seek to both affirm our mission as a community mental health clinic, constantly inquiring as to how best we may serve the communities from which our patients come, as well as to assert our commitment to an approach infused with cultural humility, in consistently reflecting on the socio-economic and cultural context of our work. When we look at the data from our child patients and their families, we find data rich in natural contradictions. No two children, no two caregivers, no two families, and no two therapists are the same. We aim to understand the stories that our patients bring, both clinically and through research, to better comprehend interactions between nuanced human individuality and the wider economic and societal inequities that surround us and that our current world has vastly amplified.

So What's a Child Scholar-Practitioner Anyway?

By: Steve Tuber

Our Clinical Program has long chosen the title of "scholar-practitioner" to define itself but it has rarely tried to explain, in plain language, what that actually means. This is especially true when it comes to articulating the underlying zeitgeist of the child training aspect of our Program. I'd like to attempt to do so in this brief essay through a depiction of the necessity of play: play in our childhood, play in our adolescent and adult life and play as it leads to playfulness, one of the most underrated positive elements of human existence.

The importance of play cannot be overstated. Playing with reality allows us to understand it. Playing at reality allows us to modify it. Playing against reality allows us to minimize reality's grimness. Playing for the sake of playing enlivens us. It allows us to practice reality until we get it "right" yet simultaneously permits us to escape it. The capacity to play allows us to enjoy aloneness and privacy at the same time as it fosters social awareness and interchange. It provides the arena for a theory of mind to develop and for empathy to incubate. Its very nature is as a blend of primary and secondary process and it thus allows even young children to distinguish between the two. The immersion into fantasy paradoxically enhances our capacity to problem solve in the real world. We simply can't do without play.

And yet the great bulk of children who we assess and treat in our Psychological Center have not been able to use play to sustain and be nurtured by the sense of playfulness that comes from repeated, benevolent experiences as a "player". Thus, the very being of playing is both a goal and a process to understand as we treat our patients. We employ projective testing to assess the psychic structure of our child patients, giving us a window through which we can see how their sense of self and other and their use of affect and defenses all intertwine to establish a dynamic diagnosis and prognosis that we hope to be of help to our patients. We employ the PDI to get at the parent's capacities for playfulness, of which their ability to mentalize, to show empathy and hence to create a treatment alliance with the child's therapist all derive. We engender school visits to capture the child's phenomenological experience of learning, we ask the child, therapist and parent at regular intervals to speak to how the treatment is progressing. Our supervision of the child's treatment is typically focused on the content and process of their play and how the therapist can enhance the child's play so that she comes to see play as their primary ally in making sense out of the world between and around them. We assess to treat and treat while we further assess.

These multiple and multi-dimensional assessments of child, parent and therapist are all in the service of simultaneously bolstering the child in his family while exploring facets of experience across patients that aid or disrupt their development so that more children can be helped over time. "The play is (thus) the thing" that expands the field's scholarly efforts to understand how and why child treatment is effective while actualizing our student's capacities to practice what we preach. Child treatment at City is thus the embodiment of the scholar-practitioner approach to our training model while at the same time hopefully makes all of us better able to appreciate and maximize our own playfulness in an often dark and play-less world.

Part 2: Investigating The Social Determinants of Psychological Health During COVID-19

The previous volume of The Point highlighted key findings from COVID-19 data collected in April 2020, during peak viral transmission, and while New York City was deemed a global epicenter of the pandemic. As we continued to collect more information regarding demographics, stressors, both directly related to the virus as well as broader financial and social stress, and psychiatric symptom prevalence, we gained greater insight into the psychological experiences of urban populations during this crisis. Together, the findings below begin to offer us a glimpse into the ever-shifting psychological consequences of the pandemic and the foundational role that societal factors play in the development of mental health outcomes.

Financial Assets, Social Support, and Adaptability

Previously published analyses during Spring 2020, documented high rates of depression, anxiety, and stressors. In accordance with well-established phenomena of adaptability, we noticed in July 2020, three months subsequent to the initial data collection, that diagnostic symptom rates significantly decreased, while stressor rates remained relatively stable. This ability to “adapt,” or to exhibit decreased symptoms while enduring ongoing stress, was not present for participants who endorsed **financial or material stressors,** such as difficulty paying rent or recent unemployment, or **social stressors,** such as feeling alone or experiencing relationship problems. For these individuals, depression, anxiety, and post-traumatic stress symptoms persisted at relatively the same levels found in April. We also found that those who met diagnosis in July endorsed a greater number of cumulative, or consecutive stressors, as compared to April. In other words, both the quality of the stressors, the role of material and social stress, as well as the quantity of stressors, played important roles in symptom prevalence. When we further examined which type of assets more strongly predicted diagnostic symptoms, social stressors proved to be the most predictive of subsequent symptom endorsement. This result points to the immeasurable stress occurring within our social worlds, within our feelings of isolation, and the psychological effects of these stressors.

Additionally, our findings highlighted the unique development of post-traumatic stress symptoms (PTSS). The experience of losing a loved one was significantly associated with PTSS to a stronger extent than it was with depression and anxiety. The experience of grieving during COVID-19 contributed to psychological responses that persisted in the presence of population-level adaptability. Such findings highlight the importance of both acknowledging hopeful results of adaptation, and simultaneously emphasizing the role that economic insecurity, social isolation, and grief, play in the presence of ongoing distress and suffering.

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Suicidal Ideation and Life Stressors

Although we found the presence of some adaptability from April to July 2020, endorsed rates of suicidal ideation (SI) persisted from April (21.4%) to July (20.4%). Demographic characteristics, such as educational attainment, marital status, household incomes and savings, as well as stressor levels were found to be important contributors to reporting SI. In looking closely at the relationship between suicidality and specific types of stressors, we found that reports of feeling alone, of experiencing relationship problems, and of financial stress, all significantly predicted suicidal ideation. Diagnostic symptom rates were also significantly higher for participants who reported suicidality.

Taken together, these results point to important risk factors associated with increased SI. Interventions aimed at preventing suicide must account for the current crisis, and for the plethora of social, economic, and psychological stressors that are contributing to a prevalence of SI above what had been documented pre-COVID-19 among a US national sample. Such factors must be centrally identified among populations, in order to protect the at risk populations, and to ensure that adequate care is easily accessible to those who need it most.

Neighborhood Factors and Depression

Given the neighborhood shifts that occurred at the start of the pandemic in New York City, with higher-income populations fleeing their urban homes, while their lower-income neighbors could not afford to flee, we wanted to investigate the role that neighborhood-level variables may play within mental health outcomes, and in depression symptom prevalence specifically. We examined two types of neighborhood factors: neighborhood perceptions, such as green space, street lighting, litter, and neighborhood social cohesion, such as feeling that you can trust your neighbors, sharing values with them, etc.

Results indicated that, in the face of COVID-19 related stressors, which, as previously mentioned, play a significant role in high symptom rates, both neighborhood perceptions and cohesion were significantly protective against depression.

COVID-19 is interacting with systemically racist neighborhood inequities caused by governmental policy and gentrification-induced disruptions in community social ties. Regulations that promote the perseverance of communities and social worlds are both acts of justice and of psychological health promotion.

Collaborate with us

Please send thoughts, ideas, and contributions to mrudenstine@ccny.cuny.edu
For more information visit: www.intersectccny.com

Credits

Sasha Rudenstine, Principal Investigator
Talia Schulder, Writer and Graphic Design
Helen Feldman, Writer
Tecora Williams, Graphic Design of The Point logo

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