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Commentary on

"Multigenerational Ataques de Nervios *in a Dominican American Family: A Form of Intergenerational Transmission of Violent Trauma?"*

Thomas S. Weisner

INTRODUCTION

Schechter and colleagues offer us a sensitive, empathic report of their engagement with Nancy, the mother of Alisa (5 years) and Libby (8 months), from the time of the first encounter in the emergency room to discoveries about their lives and traumatic experiences, through therapy and follow-up.

The case study reports a history of trauma and abuse in Nancy's life, a complex psychiatric history, and a hopefully successful series of interventions, including individual psychotherapy for Libby's older sister, for Nancy, and for Libby and Nancy together for an infant-mother intervention. This included "three videotaped visits: (1) an in-depth interview of Nancy about Libby and Nancy's own history, (2) a parent-child play paradigm one week later, and (3) a videofeedback intervention with Nancy alone two weeks after that." The goal of these interventions included increasing "the likelihood of verbal self-reflection and effective communication, as opposed to unreflected – in this case, medicalized – action [e.g. somatic *ataques*, and PTSD physical symptoms] and consequent disruption of psychological meaning."

The pathway through which Nancy encounters professionals who may be able to help her is via the emergency room (ER), and other medical care situations. Nancy returned to the ER two more times after an initial visit, and some staff began to question the previous diagnosis of epilepsy and medications given to treat epilepsy. Only after staff reported the possibility of medical neglect and physical maltreatment of her children by Nancy did she have the *ataque* that then led to further referrals, including referrals to the infant-mother intervention program. Schechter emphasizes the resilience shown by Nancy in persisting to seek medical help for her suffering,

... even as their culturally informed communication of *ataques* was misunderstood in the North American medical culture – with a few important exceptions. Nancy's persistence resulted in the eventual interruption of intergenerational transmission of violent trauma. This is not to say that the already exacted toll on Libby's formative development of emotion regulation is magically reversible.

Libby and Nancy were fortunate to become connected with Schechter and his research team, but the vast majority of parents and children in circumstances like Nancy's (in Santo Domingo, where Nancy grew up, as well as in the United States or elsewhere) would be very unlikely to find a support service like the one they found in New York. I am sure that Schechter, and all the colleagues and collaborators in the research program designed to interrupt the transmission of violent and traumatic parenting across generations, would agree: Community programs and public health interventions with proven effectiveness will have to be an essential part of any scalable attempt to intervene and disrupt the intergenerational transmission of violent trauma.

More generally, are there changes possible in the *settings* Nancy and Libby are engaged in that could improve their situations, including the violence and traumatic responses that Schechter and his team have identified? The medical settings Nancy went to would be one set of places to start with. What interventions in those settings would put in place ways to identify and better treat patients like Nancy?

The Schechter et al. intervention was psychological and clinic-based. The goals of the interventions are individual psychotherapeutic insights and "interruptions" of Nancy and Libby's responses to and interpretations of trauma and violence. Treatment goals include inducing and affirming insights by Nancy that increase her verbal self-reflection, more positive beliefs about her children and connections with them, and a reappraisal of negative meanings and feelings – hers and those she attributed to Libby and Alisa. No family home visits are reported; nor are other intervention efforts that may have been situated in the family and neighborhood ecology of Nancy and her children. Here again, I am sure that Schechter and his team would agree that a complementary intervention – one that brought a home visitor to work with Nancy and her children in the everyday world in which they are embedded – could likely have enhanced the clinic services described in this case.

There is strong research evidence that such home visit interventions have a greater likelihood of producing positive and sustainable changes in subsequent children's behavior problems, maternal life course, and child

neglect (e.g. Olds et al., 1997; Olds et al., 1998). There is no question about the value of the insights from the video sessions for interrupting transmission of violence by Nancy and others in this study. However, such insights have to be taken up by clients and function in the everyday world parents and children live in. Those new personal insights must continually compete with other insights and ideas and cultural beliefs in the world – and, hopefully, survive in that competition. Home, neighborhood, classroom, and other kinds of setting-focused interventions and changes could not only assist Nancy and Libby, but also (if they can be sustained) help all the other parents and children with trauma who will come after them.

The Schechter infant–mother treatment program focused on Nancy's personal experience and trauma, and the treatment was for her as an individual, and for the mother-infant dyad as well. The mother-infant attachment relationship and ways to reframe Nancy and Libby's interactions and beliefs were the key. However, a social-relational, ecocultural approach to understanding working models of close relationships provide a complementary model for the study of such relationships over time and in cultural context (LeVine & Norman, 2001; Lewis & Takahashi, 2005). Patterned expectations for close relationships vary across age, class, purposes, contexts, and local cultural communities' goals for those relationships (Weisner, 2005). Children are involved in sibling attachments, peer friendships, the worlds of preschool and school, fantasy- and story-based relationships from media, then romantic partners, then weaker but nonetheless very important acquaintance networks and work affiliations over time. Each of these relationships and roles has its own varied cultural norms and expectations, and its own functions and emotional scripts. There are multiple contexts and opportunities for flexibility in relationship models and settings available for intervention, in addition to the mother-infant dyad, important as that dyad is.

Nancy is a working poor single mother, as well as a victim of trauma, abuse, and family tragedies. There are tested and effective interventions that can assist her in managing her daily routine, finding a job, providing health care, and finding appropriate child care for Libby and Alisa (Duncan, Huston, & Weisner, 2007; Yoshikawa, Weisner, & Lowe, 2006). Such work-based supports for parents can assist working poor parents with troubled children (Bernheimer, Weisner, & Lowe, 2003). Nancy would most likely benefit from assistance and intervention in helping her sustain a daily routine of family life that had meaning for her and for her children. There are ways to ask parents about this ongoing project of sustaining their family routines of life, as well as ways to assess that project (Weisner, Matheson, Coots, & Bernheimer, 2005; Weisner, 2008). More sustainable

family routines have characteristics in common: They fit with available resources, have lower levels of conflict and disagreement among family members, provide meaningful activities that fit with parental goals, and are reasonably predictable and consistent over time (Weisner, 2002). A family-level setting intervention that assisted parents in their project of creating these kinds of family activities and routines would in turn support individual and dyadic therapeutic interventions such as those Schechter et al. have developed.

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SECTION FOUR

SOCIAL AND CULTURAL CONTEXTS OF CHILDHOOD DEVELOPMENT: NORMATIVE SETTINGS, PRACTICES, AND CONSEQUENCES

Carol M. Worthman

The material in this section leads to encounters with the old anthropological problem of how to evaluate culturally normative conditions and practices. Concerning pathways in human development, how many roads lead to Rome? What makes a practice "good" or "right" for a child? Hence, Glover responds to Briggs's case study about Inuit use of teasing and shaming for early child socialization by asking "whether the type of upbringing described will really help young Inuit children adapt successfully to their future life." Similarly, Kirmayer notes the "urgency to understand cultural variations in parenting practices and healthy developmental trajectories."

But how do we define "success" and "healthy"? Such questions spring to mind when we are confronted with normative practices of other cultures that jar against our own. We start to wonder about what childcare practices really do, as opposed to what culturally received views suggest they do, although we may not be so quick to ask the same critical question about our own society. Through its engagement with other cultures, anthropology has cultivated unsettling epistemological moments to cast into relief preconceptions about the "natural order" of things and permit us to see our and others' worlds in a new light.

Now with globalization and media, all of us are anthropologists. Encounters with unfamiliar cultural logics and meanings may catch us up at any moment, with unexpected and enduring effects. Thus, the Anderson-Fye case study: An apparently well-adjusted teen with culturally unexceptionable parenting in Belize sees American women on *Oprah* discussing domestic violence and sexual abuse, and the experience catalyzes a thoroughgoing reframing of her life experiences as a moral outrage of "I have

Formative Experiences

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