THERAPEUTIC WORK FOR CHILDREN WITH COMPLEX TRAUMA

A Three-Track Psychodynamic Approach

Nicole Vliegen, Eileen Tang, Nick Midgley, Patrick Luyten and Peter Fonagy

ROUTLEDGE

‘This is a text that child therapists have long needed. It brings together understandings which have historically been too separate, of the effects of complex trauma on children, alongside psychodynamic, attachment and developmental science, integrated into a deep but user-friendly and effective way of working not only with the child but also with the significant adults and systems around them. Clinicians, from the most experienced to newer therapists, will breathe a sigh of relief that this is available’.

Dr Graham Music, *Consultant psychotherapist, Tavistock Clinic, Author of* Nurturing Children *(2019) and* Nurturing Natures *(2016)*

‘The present volume is much needed as communities around the world face more strife and conflict and complex trauma in children is increasingly common. The authors offer a concise and invaluable integration of clinical theory with insights into how therapists create a safe space to facilitate children’s recovery and growth. In language accessible for students as well as parents, the authors provide a vivid portrait behind the scenes of experienced therapists working with great skill with traumatized children and their families’.

Linda Mayes, *Arnold Gesell Professor Child Psychiatry, Pediatrics, and Psychiatry, Yale Child Study Center, Yale School of Medicine*

‘Child psychotherapists working in the psychodynamic tradition have always worked with children and families struggling with the effects of complex trauma. Yet there has been a lack of an integration of longstanding psychoanalytic clinical experience with contemporary ways of working with trauma emerging from other fields, including neuroscience, developmental psychology and mentalization-based work. Nicole Vliegen and her colleagues have produced an approachable and inspiring practice guide, which will be useful for any child psychotherapist working with traumatised fostered and adopted children. Especially useful is the three-track treatment approach: direct therapy with the child has to be combined with active work with the parents/carers and the wider network for the work to have a lasting impact’.

Maria Papadima, PhD, *Editor of the* Journal of Child Psychotherapy; *Senior Child and Adolescent Psychotherapist in the NHS Service for Adolescents and Families in Enfield (SAFE)*

Therapeutic Work for Children with Complex Trauma

Therapeutic Work for Children with Complex Trauma offers a contemporary three-track psychodynamic treatment model to mental health professionals working with traumatised children and their caregivers.

The book provides a contemporary and comprehensive approach to working with traumatised children by integrating knowledge and skills from traditional psychodynamic child psychotherapy and more contemporary trauma-informed and mentalization-based frameworks. It advocates three tracks of work, involving direct work with the child, work with the child's primary caregivers and work with the network. The book is divided into two parts: Part I of the book covers the theoretical background and Part II discusses the core components and phases of the trauma-informed and mentalization-based treatment approach. The authors bring out the specific dynamics of the psychotherapeutic work through four composite cases woven through the book.

Written in accessible language this treatment guide is primarily aimed at psychodynamically trained psychotherapists, mental health professionals and professional caregivers working with traumatised children.

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

Designed cover image: © Street artwork by Achilleas Michaelides (Paparazzi Art Studio, Karaoli & Dimitriou, Larnaka, Cyprus). Photograph taken by Lieve Van Lier

First published 2023
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

ISBN: 978-0-367-49177-2 (hbk)
ISBN: 978-0-367-49175-8 (pbk)
ISBN: 978-1-003-04491-8 (ebk)

DOI: 10.4324/9781003044918

Typeset in Times New Roman
by Apex CoVantage, LLC

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Acknowledgements

Writing a book like this is always the result of exchange, collaboration, thinking and writing together. Many children, parents, network partners and colleagues have contributed each in their own way to this book. We first and foremost wish to acknowledge the many children and adoptive parents and foster carers we have been fortunate to work with and from whom we have learnt so much. It is because they allowed us to be part of their life and to share in their sorrows and longings, their confusion as well as their growth, that we have been able to develop our psychotherapeutic approach to children who have experienced complex trauma and their carers. In this book, we have called them 'Jemal', 'Lisa', 'Mei-Lan' and 'Youri', each representing the many children referred to PraxisP, the practice centre of the Faculty of Psychology and Educational Sciences at KU Leuven, Belgium. Furthermore, we are indebted to the many teachers, foster care workers, residential care workers and psychiatrists with whom we have worked collaboratively and from whom we have learnt so much in the process of our joint efforts to support and foster psychological growth in often severely traumatised children.

In line with the mentalizing approach that is central in this book, the clinical work we do with children, their parents and other adult carers is per definition a 'joint venture'. Therefore, we are extremely grateful to the psychodynamic team at PraxisP for the many years of working and thinking together, which has enabled us to improve the mental health care we provide to these vulnerable children and their carers. Eva Bervoets, Annabel Bogaerts, Orfee Callebert, Ilse De Clippeleer, Simon Fiore, Stefanie Hesemans, Karolien Hobin, Astrid Lauwereins, Saskia Malcorps, Patrick Meurs, Let Moustie, Lise Robeyns, Hilde Seys, Lisa Vanbeckbergen, Ann Van de Vel, Camille Van Havere, Lieve Van Lier, Yannic Verhaest, Sus Weytens – thank you, all, for your mentalizing presence and contributions!

We are also immensely indebted to our many collaborators and colleagues at University College London and at the Anna Freud National Centre for Children and Families in the UK, who have contributed so much to our thinking about this work. Similarly, we are immensely grateful that we have been able to participate in a network of like-minded colleagues around the world, whose thinking about psychodynamic and mentalizing approaches to working with children and families has been so inspiring.

Finally, we wish to acknowledge the Fund Dr. Pierre Vereecken for the opportunities it has afforded us to develop our thinking on trauma and its impact on children's development.

NICOLE VLIEGEN AND EILEEN TANG, NICK MIDGLEY,
PATRICK LUYTEN AND PETER FONAGY
SEPTEMBER 2022

Introduction

Meeting the children

Ten-year-old Jemal had a difficult start in life, and although he now lives with two very caring adoptive parents, he shows severe behavioural and educational problems, impacting his functioning and performance at school. His adoptive parents also report eating and sleeping difficulties at home. In an intake session, they tell the therapist that Jemal decided one day that he no longer wanted drawings on the wall in his room, and removed all the stuffed animals from his bed, claiming to be 'too old for such childish stuff'. Mother exclaims in desperation that he also hates her food and barely eats. 'And when he goes to bed, he insists on going by himself without a hug or a kiss, but then he can't sleep, gets really fussy and keeps us up all through the night', Father adds. The first term that comes to Jemal's adoptive parents' mind when the therapist invites them to describe him, is 'hard to reach'.

Lisa's foster carers seek help when she is nine years old. They ask for a psychiatric assessment, being convinced that she meets the criteria to be diagnosed with an 'attachment disorder'. They began to read everything they possibly could on the internet about the disorder, trying to find more information and particularly tips as to what they could do to help Lisa. When they read a post by one parent, saying her son is 'a child whose needs are un-ending', they instantly feel that this describes the way they often feel about their foster daughter perfectly, namely that whatever they do for this 'attachment disordered' child, it never will be enough.

Seven-year-old Mei-Lan often misbehaves inexplicably, in a way that exhausts her adoptive parents. In these moments, she seems to be in a kind of blind rage, kicking and biting, seemingly without any reason causing these outbursts. In other moments, she acts like a needy infant, wanting to be dressed by her adoptive mum, or crying inconsolably

DOI: 10.4324/9781003044918-1

when Mum is not there. Although her adoptive parents believe that Mei-Lan is quite an intelligent child, she doesn't do very well at school, and fails to establish and maintain friendships with other children. Her adoptive parents are extremely concerned about her future and increasingly believe that Mei-Lan has some form of autism.

Youri's foster mother seeks help when Youri has just turned eight, because even after being in their family from his first year of life, he doesn't seem to be able to 'settle'. His biological mother died shortly after his birth after years of being addicted to drugs; his father suffers from mental illness and is unable to care for him. Youri's foster mother first hoped that the loving home environment she and her husband provided would be enough, but now she's worried that it's not.

Jemal, Lisa, Mei-Lan and Youri are all children with an history of complex trauma, as typically referred to psychodynamic child psychotherapists. We will tell their stories throughout this treatment guide, in an attempt to help understand the problems these children face and the ways we try to help them and to explore how their foster carers or adoptive parents can deal with the developmental issues their families are struggling with. Their stories are composite cases of real children's and families' stories that have been compiled and adapted so as to protect children's and families' privacy.

The previous brief vignettes illustrate typical problems which traumatised children present with when referred for treatment. Jemal and Mei-Lan are internationally adopted children; Lisa and Youri are children who have been placed in (long-term) foster care. As is evident from the vignettes, children like them form a somewhat heterogeneous group in terms of reasons for referral. The fact that their symptoms and observable behaviour show similarity to other, more commonly known disorders often complicates the clinician's assessment and diagnostic task. However, a common thread through these children's stories is the extreme level of behavioural problems they exhibit and the intense arousal they tend to evoke in the people around them. Their intense, often rapidly shifting and difficult-to-manage behaviour is an energy-guzzler for all those who try to support them – whether family, friends, teachers or other professionals. As a result, their carers typically struggle with feelings of exhaustion as well as with being able to keep thinking about what lies behind the child's 'incomprehensible' behaviour (e.g., intense anxiety), thereby compromising their ability to provide the child with the growth-promoting responses needed to foster developmental recovery. This ability of parents and other caregivers to be curious about the thoughts and feelings that shape our behaviour and to reflect on the often complex mental states behind these children's challenging behaviours has been termed 'mentalizing', and the temporary loss of this capacity under stress or high levels of arousal has been described as 'mentalizing breakdowns' (Bateman & Fonagy, 2019). Such mentalizing breakdowns are

to a large extent inevitable in carers of children presenting with these problems. They also frequently occur in professionals working with these children. One of the main aims of this treatment guide is to present professionals and carers with tools to prevent such mentalizing breakdowns and to restore their capacity to provide a genuinely understanding, caring and mentalizing context for these children.

Which children is this treatment guide (not) about?

It is important to note that we do not consider every foster or adopted child at risk for severe or even mild developmental problems. Research suggests that about a third of foster and adopted children follow typical developmental trajectories; a further third develop mild mental health problems at a certain time during their development, for which relatively brief treatment may suffice to get these children back on track; however, the other third of foster and adopted children have been shown to be at increased risk for multiple complex and pervasive developmental impairments (Barroso et al., 2017; Juffer et al., 2011; Palacios & Brodzinsky, 2010; Palacios et al., 2014; Vasileva & Petermann, 2018).

In this regard, research has also consistently shown that foster care or adoption may result in a substantial developmental catch-up in the majority of children with a history of early adversity (Fisher, 2015; Palacios & Brodzinsky, 2010; Welsh et al., 2007). Fostering and adoption, in this respect, are profound therapeutic interventions in their own right. However, this catch-up does not appear to be complete across all developmental domains, and neither do all children show the same extent of catch-up (Fisher, 2015; Palacios & Brodzinsky, 2010; Welsh et al., 2007). A substantial minority of looked after and adopted children suffer from developmental vulnerabilities that may well have longer-term impact on their health and well-being. For these children, the stable and loving environment of their new foster or adoptive family does not seem to suffice to buffer the deleterious effects of adversities suffered earlier in their life.

Evidently and unfortunately, complex trauma is not unique or exclusive to children in foster or adoptive placements; however, this is the group of children that clinicians often encounter in clinical practice. In Flanders (the Dutch-speaking part of Belgium), adoption mainly concerns international adoption, in accordance with the 1993 Convention on Protection of Children and Co-operation in respect of Intercountry Adoption. The group of domestically adopted children is very limited in Flanders (about 5% of all adoptees), as domestic adoption is only rarely part of a child protection measure. Rather, foster care is typically seen as indicated when biological parents are considered to be (temporarily) unable to take care of their children. However, unlike in other countries such as the UK, it is not common for children to be adopted from long-term foster care. In Flanders, foster care only exceptionally moves on to adoption, for instance, for orphaned children. Foster care may comprise different measures, ranging from foster care in crisis situations to longer-term foster care. The present treatment approach has been developed for the following children: (internationally) adopted children and children in long-term

foster care who have a history of severe relational difficulties in their early years but who presently live in a stable family environment.

Adopted children and children in long-term foster care have in common that they have suffered at least one experience of major loss, as they cannot grow up in their family of origin. More often, these children have had to face multiple losses of caregivers as well as of familiar surroundings – and all aspects of 'culture' that belong to it. Moreover, by the nature of having been in need of a foster or an adoptive family, they went through less or more other early adverse experiences. Jemal and Mei-Lan, for example, were foundlings, abandoned between birth and about one year of age, and they spent some time in an orphanage prior to being adopted. Mei-Lan was adopted from an orphanage in China at the age of eight months. Jemal was adopted from Ethiopia at the age of three, after having lived in two different orphanages. Lisa and Youri were placed in foster care by child protective services. Lisa suffered severe abuse and neglect from her biological parents. Youri was taken into care after his drug-addicted mother died of an overdose and his mentally ill father was unable to take care of him. As stated by Steele and Steele (2015, p. 429), there is something uniquely damaging to the human character in spending the first years of life in an environment devoid of typical parental care. As such, from the earliest beginnings, children like Jemal, Lisa, Mei-Lan and Youri have had to face 'the greatest threat in life, that of being deserted and left alone' (Bettelheim, 1976, p. 145).

Attachment failures and exposure to other adverse experiences in early childhood have unfortunately been all too common to many of these children's life histories (Ensink et al., 2019). Prior to being placed in a foster or an adoptive family, some children have grown up with caregivers with severe social and/or psychiatric problems and have gone through experiences of neglect, rejection, role reversal and physical or psychological abuse at the hands of their primary caregivers. Most of these children subsequently spent some time in residential or foster care, some of which was of questionable quality. Whether at the hands of the biological parents or family members or in low quality institutional or foster care, many of these children have experienced 'simultaneous or sequential occurrences of child maltreatment – including emotional abuse and neglect, sexual abuse, physical abuse, and witnessing domestic violence – that are chronic and begin in early childhood' (Cook et al., 2003, p. 5). All this constitutes 'complex trauma'. In such circumstances, the early caregiving system, the very social environment that is supposed to be the primary source of safety and stability in a young child's life, has been a source of stress, danger and traumatic events. 'The earliest and possibly most damaging psychological trauma is the loss of a secure base' (van der Kolk, 1987, p. 32). This is why a subgroup of adopted as well as fostered children suffer from difficulties that can be summarised as constituting complex trauma. Undoubtedly, there are also differences between internationally adopted children and children in long-term foster care – we have attempted to discuss these differences in this book when these have relevant implications for the therapeutic work conducted.

These children are the focus of this treatment guide: children who have been unfortunate to have accrued cumulative adverse experiences in the context of their primary attachment relationships, which overwhelmed their coping capacities.

Their subsequent development, often on different domains simultaneously, is paying the price to date. In other words, this book is about children who have experienced and are struggling to recover from complex trauma. Their problems are often persistent and unlikely to respond swiftly to treatment. Therefore, these children and their families may benefit from specialised psychosocial interventions targeting their particular difficulties. Brief treatments, although these may be helpful in the short run or may lower the threshold to seek more extensive treatment, are typically insufficient and may even be harmful (e.g., because they may lead to parents feeling disappointed in mental health professionals because they are unable to help their child or because their child quickly relapses after a brief course of treatment).

For reasons of readability, we will sometimes refer to children who have experienced complex trauma as 'children suffering from/with complex trauma' or 'traumatised children'. Similarly, we will use the term 'parent' and 'caregiver' interchangeably when it is clear that it refers to the child's primary caregiver, i.e., in the Flemish context, adoptive parents and foster carers. When it is important to differentiate between biological parents on the one hand and adoptive parents or foster carers on the other hand or between adoptive parents and foster carers, we have attempted to do so.

Whom is this treatment guide for?

The present treatment guide is primarily intended for child psychotherapists with a psychodynamic training who encounter children who have experienced complex trauma and their families in their clinical practice. This guide integrates 'traditional' psychodynamic, more contemporary mentalization-based approaches and developmental psychopathology approaches to the understanding of the impact of trauma on child development, including the burgeoning research on the neuroscience of trauma. As such, this treatment guide can also be of interest to other mental health professionals who do not necessarily have a background in (psychodynamic) psychotherapy but who are interested in this approach because of their work with this group of children, such as clinical psychologists, child psychiatrists and family therapists, special needs education teachers, social work professionals or foster care workers. In this regard, we have attempted to explain and frame relevant psychodynamic concepts in concise and accessible language.

This principle-based, rather than protocol-based, treatment guide aims to provide a contemporary psychodynamic approach to the understanding and the treatment of foster and adopted children with a history of complex trauma and the parents and other adult carers living and working with these children. A psychodynamic approach, perhaps different from some other kinds of psychotherapeutic approaches, lends itself less to be captured in purely behavioural terms (what a therapist *does*). Rather, it is, in our opinion, a thought process, an active way of being present with and thinking about the child or the carer, which subsequently needs to translate into specific interventions (what a therapist *thinks and* how this informs therapeutic *action*). In line with this, this treatment guide aims to provide the reader insight into

this thinking process of the psychodynamic psychotherapist in working with traumatised children and their carers, by providing structure, delineating guiding principles and outlining interventions and specific techniques that therapists can apply flexibly based on clinical judgement. To this end, clinical vignettes with accompanying commentaries have been integrated throughout the book in order to illustrate theoretical concepts as well as specific treatment interventions and techniques. Following Lemma et al.'s (2011) apt statement that 'knowledge of therapeutic strategies and techniques does not guarantee that a therapist will be competent' (p. 23), we contend that the therapist's competence in considering the timing and the choice of interventions as well as in flexibly applying these interventions is regarded as a prerequisite of good practice (Fonagy & Luyten, 2019). Flexible use of theoretical understanding and therapeutic interventions is considered a key meta competence in effectively delivering psychodynamic psychotherapy (Lemma et al., 2011), and this applies to an even greater extent to the work with this particular group of children and their carers. Therefore, individual and group supervision are important components of training in the proposed treatment approach.

Yet, it is important to note that successful implementation and delivery of the treatment approach outlined in this volume not only involves training and individual and group supervision but also requires support at the team and organisational levels. Studies have amply shown that the implementation of psychosocial treatments in routine clinical care should not only focus on the individual therapist level but also on the team and organisational levels. This is particularly the case with regard to the implementation of more complex, longer-term treatments such as the present treatment approach. For instance, lack of support and lack of implementation planning at the organisational level have been shown to be associated with resistance to change in mental health professionals, communication problems and lack of an adequate supervisory structure at the team level and a lack of competence and adherence to the treatment model at the therapist level, as well as with higher dropout rates and critical incidents in patients during the treatment, resulting in the treatment effects being more than halved (Bales et al., 2017; Hutsebaut et al., 2012). Hence, implementation of the current treatment approach is only likely to be successful when the conditions necessary for the successful implementation of this approach at the level of therapists, teams and the organisation or service in which it is implemented are met. This also implies that we do not support training and implementation of the current treatment approach in clinical settings where these conditions are not met or cannot be guaranteed for at least five years. We are currently conducting a pilot feasibility study to further investigate these assumptions and a larger pragmatic clinical trial is planned.

Finally, it is also important to note that the present treatment approach was originally developed for elementary school-aged children living in Flanders, exhibiting complex trauma symptoms due to a history of early adverse experiences. These ideas were then shared and expanded on in discussions with colleagues from University College London and the Anna Freud Centre in London. Yet, the principles outlined in this treatment guide are also relevant for those working with infants

and pre-school children who exhibit problems related to complex traumatic experiences and can be adapted to work in other cultural contexts. Similarly, mental health professionals working with adolescents will recognise many of the issues discussed in this treatment guide. The therapeutic approach outlined will need to be adapted when working with younger or older children and young people or in other settings or contexts.

Outline of the treatment guide

This book consists of two main parts. In Part I, we outline the theoretical approach that underpins the proposed treatment approach, described in Part II. In Chapter 1, we describe the theoretical background underlying the present treatment approach. In Chapter 2, we aim to provide a contemporary comprehensive framework to understand traumatised children's inner world by outlining the specifics of their developmental impairments. In Chapter 3, we discuss how these children's developmental impairments continuously and pervasively challenge the mentalizing capacities of the parents and other adult carers living and working with these children.

Part II of the book discusses the principles of the contemporary psychodynamic treatment approach for adopted and foster children with complex trauma. In Chapter 4, we outline the three-track conceptualisation of the present treatment model as well as the basic principles, including principles underlying the therapeutic stance. In the following chapters, we describe how the basic principles and attitudes of the treatment approach take shape and are applied in the assessment phase, which we see as a central and integral part of the treatment (Chapter 5), the direct work with the child (Chapter 6), the work with parents/carers (Chapter 7) and the work with the network (Chapter 8). Finally, Chapter 9 covers the ending phase of the treatment.

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Part I

Theoretical background

Psychotherapeutic work with children who have experienced complex trauma requires a flexible theoretical framework that allows therapists to tailor their treatment to the specific needs and vulnerabilities of each child and their environment. In Part I, we outline the theoretical background underpinning the contemporary psychodynamic treatment approach set out in the second part of this book. Specifically, in Chapter 1, we first present a contemporary psychodynamic approach to complex trauma that offers a dynamic and integrative understanding of the profound and pervasive impact of complex traumatic experiences on the child themselves in terms of developmental impairments but also on the adults caring for such children on a daily basis. In the next chapters, we elaborate on these two aspects, as a profound understanding thereof is crucial to informing an effective treatment approach. In Chapter 2, we discuss four domains of child development that are central in understanding the profound disruptions in social-emotional and behavioural development that typically result from complex trauma experiences. In Chapter 3, we outline the particular challenges to parents' and other carers' resources in general – and mentalizing capacities in particular – in caring for traumatised children.

DOI: 10.4324/9781003044918-2

Chapter 1

A contemporary psychodynamic perspective on and approach to complex trauma

In this chapter, we outline the theoretical background underpinning a psychodynamic treatment approach to children with complex trauma. We briefly define complex trauma and discuss what this means in terms of the mental health needs these children and their families present with. We then explain the four basic assumptions underlying psychodynamic treatment approaches to children with complex trauma.

Complex trauma and implicated mental health needs

Complex trauma, also known as attachment trauma (Allen, 2013; Schore, 2009) or developmental trauma disorder (van der Kolk et al., 2009), refers to negative experiences occurring early in life in the context of unsafe and unreliable primary attachment relationships. As such, complex traumatic experiences have a tremendous detrimental impact on the child's subsequent development, often in multiple domains. In this introductory section, we first briefly define complex trauma, relative to other types of trauma. We then discuss its consequences for child development, as well as how it impacts upon the people living and working with children who have experienced complex trauma. Finally, we elaborate on what this means in terms of these families' – often complex – mental health needs.

Complex trauma defined

Trauma in general is defined as an event or a series of events that exceeds an individual's resources and skills to cope with the event itself and the accompanying physical and emotional consequences. By and large, traumatic experiences can be situated on a continuum, ranging from impersonal trauma (e.g., being involved in a car accident resulting in severe injury or losing a sibling or grandparent), to interpersonal trauma committed by people other than one's primary attachment figures (e.g., being bullied by peers or being abused by a sports coach) and complex trauma, committed in the context of the child's early attachment relationships (Luyten & Bateman, in press; see Table 1.1).

For children, the impact of traumatic experiences is mostly intense (at least initially), not only because of the impact on the developing child themselves but also

DOI: 10.4324/9781003044918-3

Table 1.1 Types of trauma and their impact on child development

	Type I trauma **Impersonal** One-off incident by a non-human agent	**Type II trauma** **Interpersonal** Recurrent incidents by a human agent	**Type III trauma** **Attachment figure** Multiple incidents within the caregiving environment
Examples	A tsunami, a car accident, a major loss (of a sibling, a grandparent whom one was close to)	Maltreatment, exploitation, sexual abuse (in child care, school, leisure environment)	Neglect, maltreatment, abuse, unpredictable parental care due to (mental) illness, loss of a primary caregiver
Possible consequences	Overwhelming thoughts and feelings, excessive anxiety, nightmares, trauma triggers	Overwhelming thoughts and feelings, excessive anxiety, nightmares, trauma triggers	Fundamental disruptions in multiple developmental domains
Impact on caregiving environment	Involved in trauma, loss of availability Existing care is source of resilience	Involved in trauma, loss of availability Existing care is source of resilience	Is (or has been) source of fear/threat/danger/stress Lack of 'safe haven'

Source: Adapted from Vliegen et al. (2023)

because in some situations, parents are themselves involved in the traumatic experiences, which may understandably result in a (temporary) loss of their availability and ability to help their child cope. On the other hand, in cases of Type I or Type II trauma, parents can be supported to regain access to their resources or skills, or other important caregivers can step in, to help the child to cope with the trauma and its consequences. This is fundamentally different in case of complex trauma, where a positive and growth-promoting caregiving environment is lacking from early on in life, thus impacting the earliest and deepest layers of development, starting at the neurobiological level.

Accumulating knowledge from neuroscience suggests that particular problematic behavioural patterns originate from trauma-induced, often pervasive, alterations in neurobiological systems and circuits that are implicated in, for instance, arousal and stress regulation (e.g., hypothalamic-pituitary-adrenal axis, i.e., the main human stress response system), emotion regulation and social-cognitive capacities, such as mentalizing (for recent reviews, see e.g., Koss & Gunnar, 2018; McCrory et al., 2017). These alterations have occurred in order to accommodate the adverse circumstances the child has been subjected to. In this regard, Blaustein and Kinniburgh (2010) have aptly described how two salient factors shape behavioural

responses in children affected by complex trauma. First, the chronic presence or threat of danger has resulted in safety-seeking or danger-avoiding behaviours. Second, the absence of sufficient fulfilment of physical, emotional, relational and environmental needs has resulted in these children's frequent reverting back to need-fulfilment strategies. Moreover, these behavioural strategies are prioritised above and thus interfere with other developmental tasks, such as the development of regulatory, neurocognitive, interpersonal and intrapersonal competencies (Blaustein & Kinniburgh, 2010). This implies that 'even the most seemingly pathological of children's behaviours may make sense, when understood in light of the purpose they serve for the child' (Blaustein & Kinniburgh, 2010, p. 25). For instance, a child who has a tantrum when a teacher praises them for their good work may be responding to this apparently benign behaviour with a fighting response, because any act of kindness is experienced as a potential indicator that something dangerous is about to happen. Such a 'fight' reaction may have been highly adaptive to a dangerous and unpredictable environment but now prevents the child from making good use of the benign care being offered. As such, insights from a developmental psychopathology perspective (Cicchetti & Toth, 2009), including neurobiological findings, are highly informative for understanding how complex traumatic experiences have shaped – and continue to shape – both the content and the process a traumatised child brings into everyday life as well as the therapeutic encounter. These neurobiological changes and their accompanying developmental vulnerabilities have been shown to persist into adulthood (Leve et al., 2012; Palacios & Brodzinsky, 2010; Welsh et al., 2007). This, of course, comes at a high cost to the individual child, their family, and society as a whole (Caspi et al., 2016).

The impact of complex traumatic experiences on child development

The quality and stability of a child's relationships in the early years lay the foundation for a wide range of later developmental outcomes that really matter – self-confidence and sound mental health, the motivation to learn, achievement in school and later in life, the ability to control aggressive impulses and resolve conflicts in non-violent ways, knowing the difference between right and wrong, having the capacity to develop and sustain friendships and intimate relationships and ultimately to be a successful parent oneself (National Scientific Council on the Developing Child, 2004). There is little doubt about complex trauma conferring vulnerability to a range of negative developmental outcomes, ranging from physical growth delays to cognitive and behavioural problems to vulnerabilities in the social-emotional realm, typically with impairments in multiple developmental domains co-occurring (Anda et al., 2006; Cicchetti & Banny, 2014; Esposito & Gunnar, 2014; Juffer et al., 2011). Many of these negative outcomes and risks can be understood as arising from core developmental deficits in intrapersonal competencies (i.e., sense of self and self-development), interpersonal competencies (i.e., the capacity to form and engage in relationships with others), regulatory competencies (i.e., the capacity

Table 1.2 Impact of complex trauma on child development

Domain of development	*Possible clinical symptoms*
Development of stress and affect regulation	Functioning in states of fluctuating or chronic dysregulation Falling prey to fight/flight/freeze states Falling prey to trauma triggers, flashbacks, nightmares Concentration and learning difficulties Sleeping problems Eating problems Irritability and aggressive behaviour (often to achieve a sense of coherence or to protect against anxiety and pain)
Attachment development	Insecure or disorganised attachment patterns, leading to strong destructive templates of relationships (heightening the risk of retraumatisation) Hyperactivating or deactivating attachment strategies or getting caught in an approach-avoidance conflict Profound distrust, making it extremely difficult to establish and maintain healthy relationships
Development of representational and mentalizing skills	Poor capacities to represent (by talking, drawing or playing) what is going on in one's mind Poor capacities to think and feel about an inner world (of self and of others) underlying own and others' behaviour Lacking introspection and self-awareness Lacking empathy
Identity development	Lack of vitality and a sense of self Lacking connection with own longings, interests and talents Negative self-image Inflated positive self-image masking more fundamental insecure and negative self-representation

to recognise and modulate emotional and physiological experience) and neurocognitive competencies (i.e., the capacity to engage executive functions and other cognitive abilities to act meaningfully on the world; Blaustein & Kinniburgh, 2010).

The model on which the present treatment approach is based delineates four domains of development implicated in complex trauma (see Table 1.2). As complex traumatic experiences interfere with the development of stress and affect regulation while these systems are still fully developing, as well as with the development of secure attachment representations, the consequences for emotional and relational functioning are huge. When the early development of regulatory skills and relational capacities is taxed heavily, with the child growing up in an enduring or even a chronic state of dysregulation and attachment insecurity, the related challenges of developing mentalizing capabilities and representing and communicating inner experiences may be compromised, as well as the development of an adaptive sense of self and identity. The theoretical underpinnings of

the impact of complex trauma on these four domains of development will be elaborated on in Chapter 2.

The impact of complex trauma on primary caregivers and the network

Complex trauma is not only a problem of the individual child but deeply affects parents and other adults caring for the child. Due to the immense impact of complex trauma on multiple domains of development and functioning, traumatised children tend to draw their caregivers into reacting in non-thoughtful ways and thus into negative interactions. Their unpredictably fluctuating behaviour and way of relating can tax parents' and other caregivers' intuitive caregiving skills, interrupt spontaneous gestures, challenge 'mentalizing capacities' (see later) and thus strain the relationship with the child. Even well-intentioned new caregivers, such as foster carers or adoptive parents, are likely to be challenged to a much greater extent – and for much more extended periods of time – than those caring for a child who has not experienced complex trauma. Such chronic strain often negatively impacts caregivers' problem-solving capacities, caregiving skills and feelings of acceptance and love towards the child. It may pave the way for a vicious cycle of negative – and even retraumatising – interactions with the child, characterised by a lack of reciprocal trust and an atmosphere of hostility (see Figure 1.1). This

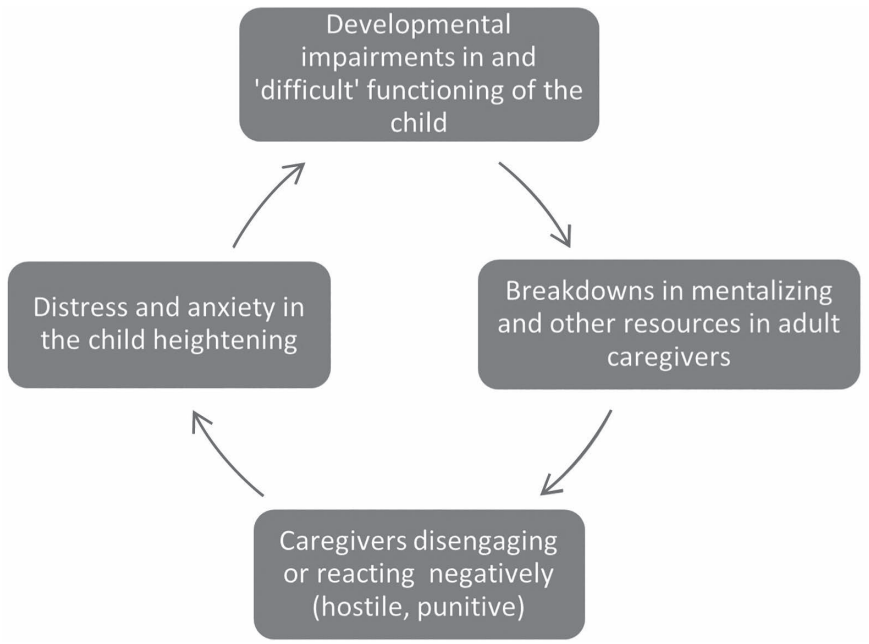

Figure 1.1 The vicious cycle among traumatised children's 'difficult' functioning and their adult carers' mentalizing abilities and well-being.

can lead to an increase of negative interactions and a decrease of shared positive and joyful moments. Caregivers' mentalizing skills may be profoundly challenged, leaving them with a feeling of being stuck in an action-reaction mode (e.g., 'We have to stop this behaviour', 'We cannot tolerate him being so rude') and with no space for thinking, communicating or interacting thoughtfully. The problem with this is that it keeps traumatised children from receiving what they so direly need in order to get back on a more adaptive developmental trajectory: parents and other caregiving adults who are willing and able to remain thoughtful even in the face of complex arousal-provoking situations.

Such difficulties may occur in the context of caring for any child who has experienced complex trauma, even with skilled and reflective caregivers. The risk of getting entangled in negative cycles is even greater for parents struggling with personal vulnerabilities due to unresolved negative or traumatising experiences in their own history. We will elaborate on the theoretical underpinnings of the impact of complex trauma on the child's environment in Chapter 3.

The diverse and complex mental health needs of traumatised children and their families

As discussed earlier, the development of children who have experienced complex trauma is hugely impacted, as are the well-being of and the relationships with important caregiving adults around these children. Moreover, these children's clinical presentation is often diverse and complex, with them being referred with different emotional, social and/or behavioural symptoms and, consequently, running the risk of being diagnosed with one or several 'symptom disorders', such as conduct disorder, attachment disorder, ADHD (Attention Deficit Hyperactivity Disorder), ASD (Autism Spectrum Disorder) and perhaps even (emerging) antisocial or borderline personality disorder. However well-intentioned, these labels seldom succeed in capturing the full picture of these children's developmental impairments – which we have come to understand as a response to complex traumatic experiences. Although the various 'symptom disorder' labels may at times be helpful to make sense of some aspect of the child, our and others' experience is that they do not always explain enough to inform an appropriate treatment approach (DeJong, 2010; Tarren-Sweeney, 2013). The main assessment challenge with these children is that their manifest behavioural problems often obscure the core issues underlying their developmental impairments. At the heart of many of these children's manifest behavioural problems lies an incapacity to regulate arousal and affect, as well as to engage in reciprocal and mutually satisfying relationships with adults and/or peers, which renders everyday life an emotional rollercoaster for the child and their environment. Similarly, their unpredictably fluctuating way of emotional and relational functioning leads to them often being considered as 'hard to reach' in treatment. They often belong to the proportion of children that easily drop out of therapy or are unable to make use of the available treatments (Fonagy et al., 2015).

Basic assumptions of a psychodynamic approach to the treatment of complex trauma

Since Boston and Szur's (1983) publication on psychotherapy with severely deprived children, a vast body of psychodynamic writings on aspects of therapeutic work with these children has emerged (Alvarez, 1992; Alvarez, 2012; Briggs, 2012, 2015; Emanuel, 2002; Hindle & Shulman, 2008; Kenrick et al., 2006; Lanyado, 2004, 2018; Lieberman & Van Horn, 2005; Music, 2019; Nathanson et al., 2022). This treatment guide thus draws on a long tradition of psychodynamic child psychotherapy literature and integrates it with contemporary mentalization-based principles and neuroscientific and other developmentally informed knowledge about the impact of trauma. In the following section, we discuss the four basic assumptions of a psychodynamic approach to the treatment of complex trauma in children (see Table 1.3).

Developmental perspective

Psychodynamic approaches are fundamentally developmental, in that they acknowledge and take into account the formative role of early life experiences and later psychic structures and behaviour (Luyten et al., 2015; Luyten et al., 2008). As such, psychodynamic approaches aim to understand as well as to explain both normal and disrupted development, with a focus on factors explaining developmental disruptions (Luyten et al., 2015). As alluded to in this chapter and elaborated on in Chapter 2, such a developmental psychopathology perspective (Fonagy et al., 2006; Freud, 1973; Lyons-Ruth & Jacobvitz, 2008; Mahler et al., 1975; Midgley, 2011) is of particular relevance in treating children who have experienced complex trauma. A profound understanding of the

Table 1.3 Basic assumptions of psychodynamic work with children with complex trauma

Developmental perspective	A developmental understanding of the impact of complex trauma on the child is central and forms the basis of a model of recovery and growth
Facilitating environment through mentalizing relationships	A context of positive, thoughtful adults, approaching the traumatised child as a subject, whose behaviour is rooted in an inner world of emotions, thoughts and experiences, is core to recovery and growth
Intervening at the level of both process and content	Effective treatment requires flexible and adequate balancing of interventions focused on process as well as on content
Play and playfulness at the heart of recovery	Playful interaction and play are considered the cardinal vehicles to therapeutic progress and change