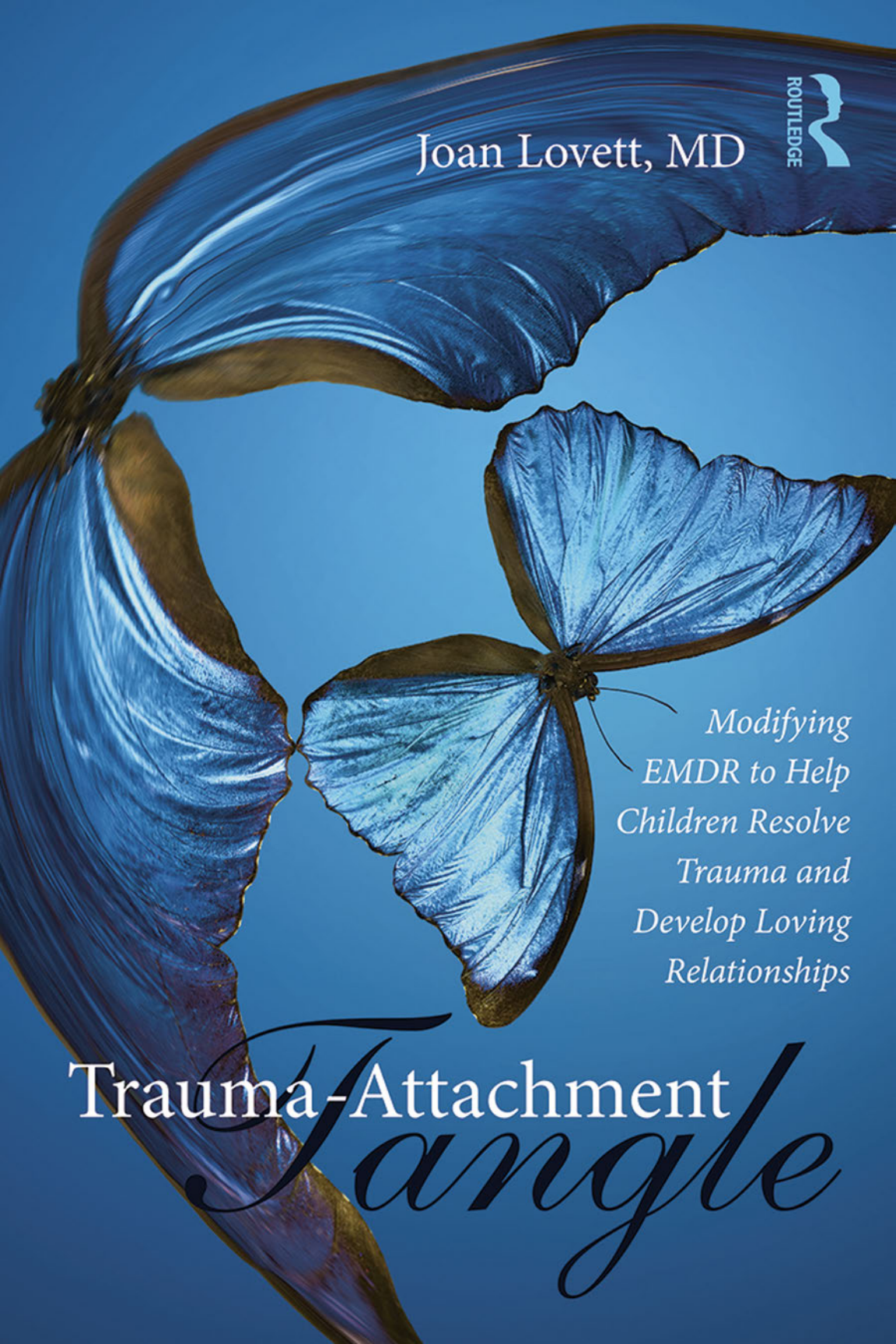
Joan Lovett, MD
ROUTLEDGE
Modifying EMDR to Help Children Resolve Trauma and Develop Loving Relationships
Trauma-Attachment Tangle

"This lovely, sensitive account of how young children with seemingly intractable behavioral problems can find peace and a place in the world is a treasure for parents and clinicians alike. Dr. Lovett uses case vignettes not only to describe what she does but also to explain her thought processes and the science behind her interventions. Clinicians interested in her approach will find the latter part of the book especially helpful, with detailed instructions on how they can incorporate into their own practice the techniques Dr. Lovett uses so adroitly. Parents will treasure her message of hope and find many valuable gems they can use to enhance their daily efforts to express their love and caring for even the most difficult children."

***—Glen R. Elliott**, PhD, MD, Chief Psychiatrist, Children's Health Council; Clinical Professor (Affiliated) in Child and Adolescent Psychiatry, Department of Psychiatry and Behavioral Sciences, Stanford School of Medicine*

"Dr. Joan Lovett has written a remarkable book that will appeal to parents, teachers, mental health clinicians, daycare workers, doctors, and nurses—basically, anyone who interacts with children. Readers will be guided to understand children's behaviors and how to resolve inappropriate behavior though the heartwarming and comprehensive case stories, which describe an array of challenges, including attachment issues, early medical traumas and hospitalization, vicarious traumatization, loss of a parent, extreme neglect, and developmental delays. With sensitivity and skillful artistry, Dr. Lovett models how to help children feel safe and form positive and loving relationships through the use of EMDR therapy, engaging games, healing narratives, and other practical, easily implemented tools."

***—Robbie Dunton**, MS, MA, EMDR Institute Coordinator*

"This is a fascinating book on the integration of play therapy, narratives, and EMDR to heal children who have suffered complex traumatization very early in their development. It focuses on rebuilding trust, resolving trauma, and repairing attachment. Lovett works from an empathic and sensitive understanding of the child's world and the child's perspective. Rich in wonderful clinical case material, this gifted therapist gives detailed insights into her thinking and offers a variety of very helpful creative clinical tools and strategies and how to use these to guide parents and children. It is a must-read for all clinicians working in this complex field."

***—Joanne Morris-Smith**, CPsychol, AFBPsS, EMDR Europe Accredited Child and Adolescent Trainer; Co-author of* EMDR for the Next Generation: Healing Children and Families

"Joan Lovett's *Trauma-Attachment Tangle* is an invaluable book for anyone working with young children and their parents. Her portrayal of children struggling with the burden of traumatic experiences illuminates how early disruptions to a child's sense of safety can make daily life almost unbearably difficult for the child and his parents. The book emphasizes strategies for treatment of PTSD, including EMDR, but Dr. Lovett's approach can be adapted for any child who has had an interruption to developing a sense of safety and security during the early months and years of life."

***—Meg Zweiback**, RN, CPNP, MPH,*
Pediatric Nurse Practitioner and Family Consultant

"Readers of *Trauma-Attachment Tangle* have a unique opportunity to virtually join Dr. Joan Lovett in her office—to follow her thought processes and witness her artistry as she unravels and intervenes with the perplexing problems of complicated child cases. The book includes creative games and strategies for enhancing parent-child relationships and guidelines for writing narratives that provide healing and hope. It's an inspirational read for both clinicians and parents who have struggled with the challenges presented by severely traumatized children."

***—Debra Wesselmann**, MS, LIMHP, Co-founder of*
The Attachment and Trauma Center of Nebraska;
Co-author of Integrative Team Treatment for Attachment
Trauma in Children: Family Therapy and EMDR

"Dr. Joan Lovett's latest book is an engrossing and extremely useful book for developmental pediatricians, therapists, and general pediatricians who are at the front gate. For a general pediatrician who treats patients with complex medical problems, adopted families, and children with other attachment-attunement issues, this book provides detailed accounts of children's behaviors, parents' responses, and Dr. Lovett's approach to improving their physical and psychological well-being. She also presents solid evidence-based information on EMDR to support her treatment of these extremely difficult-to-treat children. *Trauma-Attachment Tangle* will help us to be better clinicians for our patients who have suffered trauma and attachment issues."

***—Elizabeth Salsburg**, MD, FAAP, Kiwi Pediatrics*
Medical Group, Chairperson of Department of Pediatrics
Alta Bates Summit Medical Center

TRAUMA-ATTACHMENT TANGLE

Trauma-Attachment Tangle offers informative and inspiring clinical stories of children who have complex trauma and attachment issues from experiences such as adoption, hospitalization, or the death of a parent. Some of these children display puzzling or extreme symptoms such as prolonged tantrums, self-hatred, attacking their parents, or being fearful of common things like lights, solid foods, or clothing. Dr. Lovett presents strategies for unraveling the traumatic origins of children's symptoms and gives a variety of tools for treating complex trauma and for promoting attunement and attachment.

Joan Lovett, MD, is a behavioral pediatrician practicing in the San Francisco Bay Area. She is a Fellow of the American Academy of Pediatrics and an EMDRIA Approved Consultant. She has given presentations and trainings about treating childhood trauma in the US, Canada, Central America, Europe, and Asia. Dr. Lovett is also the author of *Small Wonders: Healing Childhood Trauma with EMDR*.

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TRAUMA-ATTACHMENT TANGLE

Modifying EMDR to Help Children Resolve Trauma and Develop Loving Relationships

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For John

I love your kindness, generosity, and fun-loving spirit!

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ACKNOWLEDGMENTS

It has been a privilege to know the families described in *Trauma-Attachment Tangle*. I have been inspired by their courage and determination, and I appreciate their willingness to share their stories in the hope that others will benefit.

I appreciate Francine Shapiro, PhD, originator of EMDR, whose therapeutic contribution has relieved suffering around the globe. Without her work, mine would not have been possible.

My colleague and friend Deb Wesselmann, MS, LIMHP, informed me that I was doing attachment work when we both gave presentations at the Menninger Clinic in 2000. Since that time we have collaborated to develop ways to work effectively with children and families struggling with trauma and attachment issues, and we have given numerous presentations together. Many of the ideas in this book originated from her work and our collaboration. Her generosity, humor, knowledge, and commitment to helping children have inspired me.

I am thankful for the assistance of Sheryl Fullerton, my literary agent, who has had faith in this endeavor and who connected me with Routledge, a member of the Taylor and Francis Group. George Zimmar, Routledge publisher, has made the publication of this book possible. Naomi Lucks helped in the preparation of the book proposal.

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INTRODUCTION

Trauma-Attachment Tangle represents the culmination of my decades of work helping children and their parents overcome traumatic experiences. Over and over, I have seen that resolving children's trauma helped them trust that they are lovable, good, and worthy of care and protection. This confidence allows them to blossom emotionally and socially and to enjoy loving relationships with their parents and others, sometimes for the first time. I have observed that attachment issues stem from traumatic experiences. Untangling the trauma-attachment knot through trauma resolution, attachment enhancement, and even "detachment therapy" (detaching the parent from the child's memory of a painful event) has been a deeply satisfying part of my work as a behavioral pediatrician.

When trauma goes untreated, it often emerges later in life, sometimes in unexpected ways, as it did with Tom and Kelly, young parents who were beside themselves with fatigue, frustration, and worry. "I'm terribly afraid to let my baby cry at all," said Kelly. Kelly kept her five-month-old son Andrew with her every moment because she didn't want him to ever be alone. She felt she needed to watch him all the time—even at night—to be able to respond to his every whimper before it became a cry. Because of this, Kelly hadn't gotten much sleep since her baby was born. Baby Andrew had slept fitfully, stretched out in the middle of his parents' double bed, with Tom and Kelly clinging to opposite sides of the bed.

While it is normal for a mother to want to soothe her crying baby, Kelly's reaction was extreme. Whenever she heard Andrew cry, she became sweaty and flushed with fear, her heart pounding furiously. The more fearful she was when she responded to her baby, the more upset the baby became. Tom and his mother had been urging Kelly to put the baby in his own room at night so they could all sleep better. She had refused their advice for five months because she panicked at the thought of her baby wailing alone in another room.

Kelly's extreme fear in response to her baby's crying was a red flag for me: I suspected that trauma was fueling her anxiety. The frequency, amplitude, and inappropriateness of Kelly's anxiety alerted me that her

response might stem from an earlier traumatic experience. I was concerned that Andrew was picking up his mother's anxiety, further exacerbating the situation.

I asked Kelly to picture her baby's crying, to pay attention to her emotional response, and to tell me of any earlier memories that seemed connected. After hesitating for a few moments, Kelly said thoughtfully, "Yes, I do have a memory that sometimes flashes through my mind when I hear Andrew cry. When I was a little girl I shared a bedroom with my sister. One night an intruder came into our room through a window, and he tried to molest my sister. She screamed at the top of her lungs. When I heard her cry out, I froze. I felt helpless. The intruder left in a hurry, but I still feel scared when I think of my sister's blood-curdling cries."

Trauma such as Kelly experienced generates a sense of confusion that persists long after the traumatic event is over. As a child, Kelly had felt helpless and terrified when her sister had cried out. As a new mother, Kelly had confused her Andrew's cries with the cries of her sister, who had been attacked years earlier, and responded fearfully, as if her infant were being attacked. While Kelly hadn't consciously connected her baby's cries with the molestation, the thread of terror generated by her sister's cries of distress had entered her subconscious, resurfacing years later to interfere with her relationship with her child.

In response to what Kelly told me, I suggested that Eye Movement Desensitization and Reprocessing (EMDR) therapy could help her resolve the memory of her sister's terrifying scream. EMDR therapy, originated by Francine Shapiro, PhD, in 1989, activates the information processing system that is innate in each of us. It utilizes eye movement or another form of alternating bilateral stimulation (ABS) to desensitize or take the charge off of an old memory and to reprocess the distorted negative beliefs that got stuck at the time of the trauma.[1] Kelly agreed to try EMDR, and during the first session she was able to change the distorted belief about herself from "I'm helpless and in danger when I hear crying" to "I'm safe and can respond calmly when my baby cries."

The next week, Kelly came back to my office smiling and immediately told me, "My baby is sleeping down the hall in his own room now, and we're all sleeping better." One session of EMDR took the distressing charge off the traumatic childhood memory, changed Kelly's belief about herself as a parent, and restored her sense of calm and confidence in taking care of her baby. A parent who believes "I'm safe and can take care of my child calmly" behaves very differently from a parent who is afraid that she and her child are in danger.

I have extensive experience working with children and adults whose daily lives reflect shadows of earlier traumatic events. Kelly's story reminds me that sometimes a small change can make a big difference, and I hope to make that difference in the lives of the children I see. Many of

the children in my practice lived through a traumatic experience that happened before they were mature enough to effectively process what was happening to them, whether they experienced trauma resulting from medical procedures or hospitalization, trauma resulting from ruptured attachment with a caregiver, or other traumatic experiences that interfered with their well-being and primary relationships. Integrating EMDR into the treatment of these children has been highly effective.

In my first book, *Small Wonders: Healing Childhood Trauma with EMDR*, I investigate the mysteries of disturbing childhood behaviors, their origins in single traumatic events, and the effectiveness of EMDR therapy in resolving critical incident trauma. In *Trauma-Attachment Tangle*, I have extended my focus to include issues related primarily to the entanglement between early trauma and subsequent attachment problems.

The clinical stories in *Trauma-Attachment Tangle* demonstrate a variety of successful strategies for helping children and families overcome the effects of complex trauma. The people whose stories are presented come from a range of ethnic, cultural, and financial backgrounds. They are Caucasians, African Americans, Asians, and Latin Americans. They are single-parent and two-parent families. They are wealthy families and families who are financially distressed. All identifying information has been changed to preserve confidentiality.

In the section following the clinical stories, I have described valuable tools specifically designed for treating posttraumatic symptoms in children and for strengthening family and social relationships. These include calming exercises, parenting suggestions, cooperation games, and attachment-enhancing activities. The third section includes instructions for developing healing narratives and sample stories. All of the activities were developed to foster effective communication, cooperation, and intimacy. Additional information about EMDR with children is collected in the Appendix.

I have been deeply moved by the children who have come to me for care and by their parents who have been determined to help them maximize their potential and to have a full life. It has been my privilege to know these families. It is their struggles and stories, and the belief that stories are powerful teaching tools, that motivated me to write *Trauma-Attachment Tangle*. It is my hope that the stories and activities in this book will help others untangle the legacy and effects of early trauma.

Note

1 For those unfamiliar with EMDR, the entry on this therapy in the Glossary provides a summary of relevant terminology that may be useful while reading the vignettes in the following chapters.

Part I

THE CLINICAL STORIES

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1

AMY

Violent Behavior in an Adopted Toddler

It is not unusual for parents of an adopted child to come to me and say, "Is there any hope? We wouldn't really send him back, but the thought has crossed our minds. We have done everything we can, and he just doesn't love us. He hits and kicks and screams and makes our lives miserable."

Parents who adopt are motivated to share their love, care, time, money, and other resources for a child in need of a loving home and family. However, few of these parents have been educated about the challenges and demands of raising an adopted child. They have no experience or perspective from which to understand or approach the complexities of adopting a child whose early months were spent with little opportunity for consistent, attuned care or adequate developmental stimulation. The child they adopt comes with a history: a history that may include trauma in the form of neglect or abuse. Without the proper guidance, resources or preparation, the adoptive families may not fully comprehend the effects of the trauma their child experienced or the resulting attachment issues that await them. Fortunately, there is hope and help for children who have experienced early trauma: Issues stemming from traumatic experiences can be resolved with therapeutic treatment and specific parenting strategies designed to enhance attachment between the parents and child.

Amy

Emily and Peter had no idea what to do with their two-year-old daughter, Amy. They had adopted Amy from an orphanage in China when she was 19 months old. Emily explained, "We fell in love with her when we saw her picture. She was just a year old then. She had shiny black hair, a dimple in her cheek, a twinkle in her eye, and that charming smile." Peter added, "I already had a grown son by a previous marriage, and we wanted a daughter. I was in favor of adopting a toddler because I've

already been through the infant stage, and it's intense—all that crying and those night feedings." Peter smiled ruefully, "I thought a girl—and especially a girl who was not an infant—would be easier." What he didn't know was that he and Emily would spend years focusing intensively on Amy's emotional and developmental needs and giving her the nurturing she had missed as an infant.

Their first eight months together as a family were stressful because of Amy's extremely difficult behavior. Amy didn't seem to care about anything—she threw toys, tore up books, tortured the family kittens by twisting their bodies, and attacked her parents and other children with unprovoked biting, hitting, and scratching. When she came close to babies, she tried to jab their eyes with her finger.

Amy also hoarded food by keeping it stuffed in her cheeks, and she sometimes refused to swallow for half an hour. She seemed to have no attention span at all, and she wouldn't listen to a page of a book or play with any toys in an organized way. She just pulled things off the shelves and left them in a jumble on the floor. She slept deeply but appeared to have unhappy dreams and often screamed while asleep.

Peter described the miserable drama he witnessed several times daily: "When Emily or I say 'no,' Amy pitches a world-class fit. I mean she flings herself on the floor and launches this prolonged hissy fit with screaming and kicking and spitting and sobbing. I know that toddlers are oppositional, but I've never seen anything like this—she goes into attack mode and sometimes goes on for an hour." Emily looked defeated: "We've tried everything—time out only makes things worse. We've tried talking to her nicely, but it's like she's having a seizure and doesn't hear us. We've tried rewards and punishments. We have a whole closet full of toys we've taken away. There's nothing she cares about enough to motivate her." Peter added, "I feel really sorry for Emily. I work a lot and travel a lot for work, but she's stuck at home with Amy. Emily's exhausted."

Then there was the other side of Amy. Emily and Peter told me that when Amy wasn't being difficult, she was pleasant, and she was outgoing around strangers. They said that she smiled a lot and even wanted strangers to pick her up. Toddlers don't usually want strangers to pick them up, unless they have had to rely on acting charming in order to get basic care from anyone they could attract. Amy's history of institutionalization and multiple caregivers, her emotional dysregulation, her inability to relate to her parents, her destructive behaviors, and her indiscriminate willingness to go with strangers were red flags for trauma and attachment issues.

While Amy's early history was a mystery, we did know that Amy was found on the steps of a police station in a remote part of China when she was seven months old. She was small for her age but appeared healthy. She was taken to an orphanage, but we don't know anything about her life there. Amy stayed in the orphanage until she was 19 months old.

The 19-month-old toddler Peter and Emily met seemed to understand Mandarin but didn't speak a word. Her motor development was slightly delayed, and she had only seven teeth. (Most babies have more than that when they are a year old.) She was a little clumsy and frequently ran into things. Peter observed, "She looked like a deer in the headlights when the director of the orphanage handed her to us at the hotel where we met."

When Emily and Peter brought Amy home to the US, they had her examined by a pediatrician. Amy was a little behind developmentally, but the pediatrician thought she would catch up quickly. Emily and Peter were sure that love and healthy food were all she needed to thrive.

Emily worked at home and had a Peruvian babysitter take care of Amy. Imagine Amy's shock at being brought to a home in which no one spoke the language she already understood and two totally foreign languages were spoken. In fact, everything was unfamiliar, scary, and overwhelming for Amy—caregivers, language, smells, food, customs, and expectations.

When I finished taking the history during our first appointment together, Peter had one pressing question: "What should we do about her tantrums? They happen so fast that we can't prevent them. She suddenly goes crazy. Sometimes we don't even know what upset her." I explained to Peter and Emily that Amy's prolonged tantrums were not their fault or Amy's fault. I further explained that optimally, during the first year of a baby's life, a special kind of dance takes place between a baby and his or her most intimate caregiver. The attuned caregiver responds to the baby's expressions and helps to regulate the baby's fluctuating states of arousal through touch, voice, facial expressions, and gestures. In response, the baby's autonomic nervous system becomes regulated and organized to respond to a wide range of internal and external stimuli.

During her first 19 months of life, Amy had not had a sustained relationship with one reliable, attuned caregiver. Amy had become chronically stressed and unable to regulate her strong emotions of fear, frustration, or disappointment. Her sympathetic nervous system, primed to respond to threat, was in overdrive.

Amy's parents were relieved to learn that they hadn't caused Amy's tantrums, and now they had an explanation for how early trauma had affected her ability to regulate her moods. Understanding the cause of her behavior was the first step. Now they needed the tools for dealing with her tantrums.

I advised Emily and Peter that a parent should stay in the room with Amy while she had a tantrum to be sure she was safe. They should stay quiet while Amy was angry. I told them about the work of researchers Green and Potegal, who studied children's vocalizations during tantrums and have observed that the vocalizations of screaming and yelling, both angry expressions, are intertwined with whimpering, fussing, and crying, which are expressions of sadness. Green and Potegal found that sad

sounds tended to occur throughout tantrums, with angry spikes of yelling and screaming superimposed.

They observed that children get past the angry part most quickly if the parent is quiet, and that after the anger subsides, what is left is sadness. When the child feels sad, a parent can use that opportunity to comfort the child and strengthen their intimate connection (Green, Whitney, & Potegal, 2011).

The time to approach Amy and begin to comfort her would be when Amy was sad and whimpering. Emily could say, "I'm your mom, and I'm here for you. I won't leave you. When you're ready we can cuddle and I'll rub your back if you want, and you'll feel better." Tantrums do stop eventually, and then there is an opportunity for calming and connection. The end of the tantrum offered an opportunity for Amy to learn that she could count on her parents to comfort her when she felt sad.

Even before I met Amy, I thought about her behaviors from a trauma perspective. What were the experiences that undermined Amy's sense of safety and well-being and gave her false or distorted beliefs about herself or the world? I asked myself: What did Amy learn from her experiences in her first seven months of life? What did she learn in the orphanage? What do her current behaviors tell us about her early experiences?

I knew that Amy had been taken away from familiar caregivers at least twice. Her history made me suspect that she would have trouble trusting Emily and Peter or other caregivers, even if they were very responsive, caring people. Could she trust that she would get food when she was hungry? Given that she was small for her age and hoarding food, I assumed that she could not be certain she would have that basic need met. It made sense that she hoarded food when food was available so that she would have something when she was hungry.

Could she trust that she would have her basic need for attention and attunement met? Given that she was "charming" and indiscriminately went to strangers to be picked up told me that she probably couldn't trust that she would get attention when she needed it, so she had learned to seek it and to be charming to get someone's attention.

Amy had been abandoned by her birth parents and had multiple caregivers in an orphanage. Her early experiences had taught her that attachment leads to pain and disappointment. Trust issues are at the heart of ruptured attachment. Children who have been severely traumatized by early abandonment demonstrate self-loathing. One adopted five-year-old girl told me that she felt "like garbage" because her birth parents didn't want her, and she was "thrown away." Other adopted children have shown me their distress when they played in the dollhouse. I have seen the dollhouse baby stuffed into the oven, flushed down the toilet, and suffocated with pillows or buried under furniture. I don't interpret that play literally but see it as the child's expression of an emotional experience.

I believe that traumatized children "feel bad," and they think that means they *are* bad. Later, they attack animals or babies who remind them of their vulnerable, helpless little selves.

I guessed that if Amy could express her negative beliefs about herself, they might have been: "I can't trust anyone to meet my needs over time, so it's dangerous to connect deeply with anyone. I'm bad because bad things happen to me. I can't tolerate it when things don't go the way I expect or want." My goal was to help Amy and her parents develop a strong positive emotional bond that would feel good to all of them.

Emily began to recognize that her daughter's challenging behaviors indicated an attachment disorder. Emily went online and found the website for attach-china.org and several other sites with information about attachment. She began taking naps with Amy and stopped scolding her so often. Even with those few changes, she noticed a decrease in the frequency of Amy's tantrums.

When Amy and her mom came back to see me the following week, I used a modified version of the Marschak Interaction Method (MIM) assessment to learn more about interactions between Amy and Emily. I wanted to observe the quality of Emily's interactions with Amy: how she structured her interactions with Amy, how Emily nurtured her, taught her, challenged her and how Amy responded to her mother (DiPasquale, 2000). Emily and Amy followed the instructions to put lotion on one another's hands, and then they played with dolls, plastic dinosaurs, and stuffed animals. Emily showed her daughter how to help the baby doll be "safe and cozy."

I observed that Emily was good at paying careful attention to Amy, speaking to her in an age-appropriate way, giving her new vocabulary and expanding on Amy's words. She was gentle as she showed Amy how to pet the stuffed dog. When it was time to clean up, Emily asked, "Do you want to clean up? Do you want to put the dinosaurs in the basket?" And when it was time to leave my office, she asked Amy, "Do you want to say goodbye?" Amy's mom repeated these questions many times. Amy ignored her.

When I met with Emily the following week, I complimented Emily on the many ways she was attuned to Amy, and I shared a list of parenting suggestions with her. My plan was to start by encouraging lots of babying activities like rocking, cuddling, feeding, and comforting. I encouraged Emily to cuddle and soothe Amy every day. By starting off the day attuning to Amy and snuggling with her, Emily could help develop her daughter's capacity for connection and help fill Amy's "emotional bank." I encouraged her to notice Amy's interests, follow her lead while engaging her in play, initiate back-and-forth communication, and invite Amy to do activities with her, like singing songs or picking up toys together. Amy had such a chaotic beginning in life, as well as culture shock, that

she needed to begin to see that there are patterns in life that make sense and that she could trust her mom to help her understand the world.

I also thought that teaching Emily to help Amy cooperate would bring some rewards for both Amy and her mother. By asking Amy, "Do you want to clean up? Do you want to put the dinosaurs in the basket?" Emily implied that it was really Amy's choice about whether or not to help and that she would be happy with whatever decision Amy made. Parents may think that they are being friendly by asking "Do you want to . . .?" In fact, they are giving their child a false choice. Given a real choice, most children choose not to do something like clean up a mess or stop watching TV. I instructed Emily to "only ask Amy to do what you want once. If she doesn't comply, gently bring Amy to your side or lap, and tell and show her how 'we clean up like this,' then say 'thank you for following directions' when she does comply."

Young children need explicit instructions and clear directions that accurately tell what the parent wants and expects. Children become confused by requests that are presented as choices. For example, "Do you want to hold my hand when we cross the street?" sounds like a choice, but it's tricky. The parent knows what he or she wants but presents it in a way that sounds like cooperation is optional. "Do you want to hold my right hand or my left hand while we cross the street?" is a more appropriate choice to give a young child.

I also suggested that Emily observe Amy closely and notice when she was beginning to act frustrated or upset. Then Emily could move close to Amy or hug her while she identified what Amy was feeling. She could teach Amy to use words to say how she felt. Then Emily could soothe Amy and tell her exactly what to do. For example, if Amy was becoming upset because she was having trouble trying to take off her shoes, Emily could say, "Oh, I see it's hard getting those shoes off. It looks like you're starting to feel frustrated. Let's see what's making it hard. The laces are tied. You can pull here to open them, like this, or you can say, 'Mom, will you help?' and I will help you." Amy still needed to learn how her parents could be useful to her.

I showed Emily how to set Amy up for success by giving her tasks she was capable of doing, helping her do them if she had trouble, and then acknowledging when she did something the way her mother liked. I wanted her to praise Amy's efforts to follow directions and specific behaviors that she liked rather than generalize "good girl," which implies that she is a bad girl when she doesn't do exactly what her mom wants.

When Amy and her mom came back the next week, Emily said things were going a little better. "It really helped for me to know that Amy's tantrums aren't my fault and that I can help her learn to calm herself. Now that I understand that Amy isn't just trying to defeat me, I can be

calmer. I want to help her learn to regulate her emotions." Being close to Amy, talking with her calmly, empathizing with her feelings, and soothing her all began to calm Amy. Emily discovered that Amy liked back rubs. Emily started telling Amy that she loved her, because she thought it was beginning to be true. There had not been any biting, hitting, or scratching, but Amy was still obstinate and not paying attention.

I noticed that Amy was very sensitive to scary or angry facial expressions on action figures. Amy pointed to a five-inch-high, brutish-looking action figure with a small yellow head and big blue muscles. "It's scary, him scary!" she said. There has been research indicating that children who were maltreated show heightened ability to identify angry faces (Pollack & Sinha, 2002).

Emily corrected Amy by saying, "It's not scary." I modeled a response that validated Amy's feelings and also let Amy know that she's safe: "It looks a little scary, but it's just a toy, and you're safe for real." Later I would encourage Emily to teach Amy more about how to interpret facial expressions and to continue to reassure Amy that she was safe and could count on help when she needed it.

Initially, Amy's "play" consisted of pulling things off shelves. There were no themes. Nothing happened except that piles of toys and random items accumulated. She didn't exhibit any imagination—no pretending to eat or feed stuffed animals, no taking care of a doll. I determined that she needed lots of structure, and she needed to be shown what to do and even how to play.

At my suggestion, Emily began to play that a little stuffed bear was a baby. She pretended that the bear was crying and asked Amy what he needed. "Milk," Amy responded. Emily engaged Amy in giving the bear a bottle, giving him a bath, getting him dressed, and singing to him before his nap. Emily told Amy how the bear was feeling and together they figured out what the bear needed. They took turns holding him and singing to him together.

Then Emily pretended to read a book to the bear and invited Amy to sit on her lap. She was disturbed that Amy had such a short attention span and asked whether we could teach her to learn to pay attention. She showed me how she tried to read to Amy and how difficult it was to get Amy to pay attention. Amy wiggled and tried to pull or tear pages. I suggested that Emily snuggle with Amy and interact with her as she read, pointing to pictures and talking about what she saw. She could hold Amy's hand and identify objects in the illustrations and ask Amy to point to objects she named. She could guide Amy in gently turning pages. I advised her to read to Amy every day like this, extending Amy's listening time by a few minutes a day as tolerated.

By the next time I saw Amy, she was enjoying listening to short books with her mom or dad. She came into my office, pulled out the stuffed

bear, sat it beside her, and pretended to read a book to her "baby." Her mom and I were thrilled to see Amy demonstrate some caregiving activity on her own for the first time. Her gentleness with the little bear told me that she was beginning to feel tenderness and connection.

When it was time to clean up, I noticed that Emily was still asking, "Amy, do you want to help clean up?" Most change of habit does not come quickly or easily. Without being told and shown what to do, Amy didn't want to help, and she didn't know what to do. I encouraged Emily to partner with Amy—show her what to do and then do it with her, making the activities fun.

Each week, there were subtle but definite changes. Emily reported that she and Amy were "happier together." Emily described Amy as "smart, busy, curious, and a good athlete."

Amy did continue to have tantrums whenever she didn't get her way. It began first thing in the morning when she woke up. Nothing seemed right. Amy cried and cried if Emily didn't give her a piggyback ride as soon as she wanted. Amy continued to be "oppositional." When Emily asked Amy not to touch some eggs, Amy picked them up and crushed them in her hands. She continued to be impulsive—and had hit their dog in the face.

Emily asked whether she should give Amy "time out" when she misbehaved. For a child who has experienced attachment trauma, being sent away for time out can trigger the hurt and the enraged feelings of a life-changing rejection. Instead, I recommended that after Amy misbehaved, Emily could help Amy calm down and feel safe, acknowledge how Amy was feeling, and then tell and show Amy what to do instead of the inappropriate behavior.

In order to understand the roots of Amy's behavior, I continued thinking in terms of her early experiences that probably never "felt right" because no one was reliably attuned to her needs. I formulated a list of beliefs that seemed to be triggered when she didn't get her way:

I can't tolerate it if I don't get what I want.
I'm bad.
I'm not lovable.
It's my fault.
I'm going to be alone and terrified.

Whenever I make a list of negative beliefs a child may have, I generate a list of beliefs that will benefit the child's social interactions and foster the child's positive self-image. Here are some of the positive beliefs that would serve Amy well: "I can trust my parents to take care of me and give me what I need (e.g., food). I am safe and can be calm if I don't get what I want right away. I'm good. I'm still good at heart even if I make a mistake or do something wrong. I'm lovable (even if my parent says