USING TRAUMA-FOCUSED Therapy Stories

INTERVENTIONS FOR THERAPISTS, CHILDREN, AND THEIR CAREGIVERS

Pat Pernicano

ROUTLEDGE

USING TRAUMA-FOCUSED THERAPY STORIES

Using Trauma-Focused Therapy Stories is a groundbreaking treatment resource for trauma-informed therapists who work with abused and neglected children ages nine years and older, as well as their caregivers. The therapy stories are perfect accompaniments to evidence-based treatment approaches and provide the foundation for psychoeducation and intervention with the older elementary-aged child or early pre-teen. Therapists will also benefit from the inclusion of thorough guides for children and caregivers, which illustrate trauma and developmental concepts in easy-to-understand terms. The psychoeducational material in the guides, written at a third- to fourth-grade reading level, may be used within any trauma-informed therapy model in the therapy office or sent home for follow-up. Each therapy story illustrates trauma concepts, guides trauma narrative and cognitive restructuring work, and illuminates caregiver blind spots; the caregiver stories target issues that often become barriers to family trauma recovery. No therapist who works with young trauma survivors will want to be without this book, and school-based professionals, social workers, psychologists, and others committed to working with traumatized children will find the book chock-full of game-changing ideas for their practice.

Pat Pernicano, PsyD, is currently a psychologist with Personal Counseling Services and served as the director of clinical services at Providence House for Children between 2007 and 2013. She is associate professor on the clinical faculty at Spalding University, where she has taught in the PsyD program since 1996.

USING TRAUMA-FOCUSED THERAPY STORIES

Interventions for Therapists, Children, and Their Caregivers

Pat Pernicano

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PREFACE: USING TRAUMA-FOCUSED THERAPY STORIES

This book is intended as a treatment resource for social workers, psychologists, expressive therapists, and counselors who work with abused or neglected children ages nine years and older, as well as their caregivers. It is particularly difficult to communicate trauma concepts to children and their caregivers, yet it is important that they understand how abuse and neglect impact attachment, behavior, cognition, moods, and relationships. Children in older elementary through young teen age-groups have, to this point, been neglected with regard to treatment resources; they are, however, avid readers in their areas of interest (dinosaurs or historical fiction, the Harry Potter collection, or the books within *A Series of Unfortunate Events*), creative organizers (scrapbooks and journals), faithful viewers of Discovery Zone and Animal Planet, and receptive to new ideas. Many abused children in these age-groups are eager to *learn about* the impact of abuse and how to heal that impact.

There are many excellent clinical and academic resources that address interpersonal neurobiology, attachment, post-traumatic stress, and the impact of trauma (Badenach, 2008, 2011; Bremner, 2002, 2003, 2006, 2012; Briere, 2012; Briere & Jordan, 2009; Briere & Langtree, 2008; Briere & Scott, 2006; Cozolino, 2006, 2010; Perry, 2009; Perry & Hambrick, 2008; Perry & Pollard, 1998; Perry & Szalavitz, 2006; Schore, 2001; Siegel, 1999, 2010; and Siegel & Hartzell, 2003). There are also first-rate trauma-informed treatment approaches for working with children and families (Blaustein and Kinniburgh, 2010; Cohen, Mannarino, & Deblinger, 2006, 2012; Crittenden, 2008, 2013; Drewes, 2009; Gil & Briere, 2006; Greenwald, 2005; Lieberman & Van Horn, 2008; Malchiodi, 2008; Pernicano, 2010a and 2010b; Saltzman & Goldin, 2008; and Tinker & Wilson, 1999). The author makes the assumption that the reader already has core knowledge and skills in these areas, as this book is not meant to educate about trauma but rather to translate trauma concepts for clinical use with children and caregivers.

The book also is not intended as a stand-alone treatment model or "cookbook" for trauma intervention. The material is meant to be integrated and used adjunctively with available treatment approaches such as: Child–Parent Psychotherapy (CPP); Trauma-focused Cognitive Behavioral Therapy (TF-CBT) (Cohen et al. 2006, 2012); Attachment, Self-regulation, and Competence (ARC) (Blaustein & Kinniburgh, 2010); Mindfulness-based Stress Reduction (MBSR) for school-age children (Saltzman & Goldin, 2008), and child-focused Eye Movement Desensitization and Reprocessing (EMDR; Tinker & Wilson, 1999) among others.

Part I, *Therapist Guide for Use of Trauma-Related Therapy Stories*, includes a brief overview of the impact of child trauma on development and functioning, as well as information about how to develop and use trauma-related stories with children and caregivers. The author provides case examples to illustrate the development and use of such stories in addition to explaining how to move from stories to intervention. The case study used in the first chapter—in which therapy stories were central to the change process—is included with permission of the mother.

Parts II, III, and IV are sections of therapy stories: Child, Adolescent, and Caregiver. The stories allow easy identification with characters and themes, illustrate trauma concepts, guide trauma narrative and

cognitive restructuring work, reduce avoidance or denial, illuminate caregiver blind spots, and lead logically into one or more treatment interventions.

Parts II and III, the Child and Adolescent stories, address issues and symptoms that arise following trauma as well as the coping skills needed to reduce symptoms and build efficacy. A section of stories for caregivers in Part IV targets *adult issues* central in cases where caregiver behavior or the presence of cross-generational trauma (abuse, neglect, or witnessing domestic violence) impedes child or family progress.

The decision was made to include a set of adult stories in the book because caregivers' own prior trauma experiences may interfere with the capacity for attunement, the development of positive attachment and parenting strategies with children, and result in barriers to healthy adult functioning. Many caregivers with early trauma self-medicate through the use of drugs and/or alcohol and select partners who can rekindle childhood experiences of rejection or abandonment. Adult treatment, including attachment work, needs to take place with caregivers in order to ensure safety and successful reunification: this is particularly the case with those who were themselves abused or neglected as children, who witnessed domestic violence, who had substance-abusing parents, or who have been adult victims of intimate partner violence.

The psychoeducational material in Parts V and VI, the Child and Caregiver Guides to Trauma, written at a third- to fourth-grade reading level, reviews trauma concepts and parallels the story themes. The word "caregiver" refers to any caring adult involved in the life of an abused child, so the materials may be used in a variety of settings, including treatment, school, and child welfare. The caregiver section may be used with parents, teachers, caseworkers, foster parents, or kinship placements.

The Child and Caregiver Guides introduce readers to Bruce Perry's Neurosequential Model of Therapeutics (Perry, 2009; Perry & Hambrick, 2008; Perry & Pollard, 1998) and the state-dependent functioning materials used in the Child Trauma Academy Video Training Series (Perry, 2004). The guides and appendices describe the ways in which traumatic stress impacts child development at different ages and stages and how adult responses to child victims can exacerbate symptoms or help children develop better self-control.

The stories are intended to be read with the child and caregiver to allow interaction, and the simple questions following the stories allow the child to apply the material to his or her own life. The Child's Guide to Trauma includes workbook-type activities to help young clients think about and process home life and traumatic experiences in step-by-step ways that will not be overwhelming and which will allow them to be active participants in their treatment. The material in the Caregiver's Guide to Trauma allows a caregiver to better understand the child in the context of the his or her past experiences and educates the caregiver about the ways in which caregiver behavior can exacerbate symptoms or support recovery.

Those working with abused and neglected children realize that many of their young clients do not meet diagnostic criteria for post-traumatic stress, yet these children present with a constellation of attachment-related life problems and traumatic stress-related symptoms that are deeply tied to prior life experiences (Briere, 2012). John Briere pointed out during a 2012 workshop that when working with victims of complex trauma, it is hard to know "which exactly of the 14 prior abuse episodes" most triggers stress and impacts current functioning. Bruce Perry (2009) points out that an abused child's brain continues to exist in a state of fear unless something changes via treatment and interpersonal relationships. It is hard for a child to "behave," have good relationships, and live a normal life while existing in a state of fear. It is important that adults living with such children recognize the signs of complex trauma and intervene to help children recover from past abuse and neglect.

As mentioned earlier, this book is not intended as a "stand-alone" protocol; rather, the stories and psychoeducational material can be easily incorporated into other evidence-based models of treatment. They should, however, be read and worked through with the child and parent and the work continued at home to solidify and expand upon the work of the session.

The best and heartiest stew has many savory ingredients, and the finished product is tastier than any of its individual components. It should be no surprise, then, that the flavor of an already delicious casserole can sometimes be enhanced, made richer and more satisfying by adding a new ingredient. It behooves us to

incorporate new ingredients in trauma intervention, especially ones that impact the child's relationships with caregivers; ultimately it is relationships that result in neurobiological integration of emotion and cognition and improve the capacity for self-regulation.

Note: The author acknowledges that perpetrators can be men, women, or older children. For simplicity's sake, the author has chosen to use the word *he* throughout this book as an inclusive term. Readers are encouraged to substitute whatever word suits the nature of their work with children and families.

The stories and psychoeducational guides for use with children or caregivers in treatment are available to download as eResources here: www.routledgementalhealth.com/9780415726924

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This book has been a work in progress, and the concepts and content have emerged and evolved over time. I am especially grateful to Anna Moore, Routledge editor, who understood the importance of publishing practical material for use with traumatized children ages nine to 13 and their caregivers. Thanks to the assistance of Patricia Zline at Jason Aronson, my previously published stories have been included in this publication. Dr. Bruce Perry, whose theory and research contribute widely to trauma-informed practice internationally, was kind and gracious in providing articles and material from the Video Training Series at the Child Trauma Academy and in offering guidance about concept fidelity.

I thank the children and families who over the years taught me about trauma and gave me opportunities to help mend their lives. Their lives and treatment experiences are woven into the therapy stories in this book, and their stories will help other children and families participate more fully in their own care.

There are many graduate students and colleagues who encouraged me to develop a trauma-informed workbook and assisted me in those efforts. Special thanks to Ashley Casto for her valuable editing and feedback on the manuscript. Thanks also to my colleague Dr. Meg Hornsby, who piloted some of the state-dependent learning material. Dr. Allyson Bradow took the time to read the stories with her seven-year old-daughter, who one evening asked, “Instead of watching my program, can we read another story?” The material was clearly child-friendly!

A special thank you to my psychologist husband Kevin, for encouraging my writing and contributing to the final edit. Without his support and co-regulation I would not be capable of doing this work. My son Sam brags that his mom is a “famous author.” I am certainly not famous but I am grateful to be an author and to have the privilege of sharing my work with others.

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PART I

THERAPIST GUIDE FOR USE OF TRAUMA-RELATED THERAPY STORIES

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CHAPTER 1

OVERVIEW: IMPACT OF TRAUMA ON CHILD DEVELOPMENT AND CAREGIVING BEHAVIOR

1.1 Complex Trauma—A Case Example

A twenty-something mother of four had been referred by the local child welfare department to participate in a six-to-12-month family-in-residence program where families receive campus housing, case management, transportation, linkage to community resources, and treatment services. The program offers parent education, parent–child interaction skills training, trauma-informed play therapy, family and individual therapies for trauma recovery, a women's relationship recovery group, and a dual diagnosis group.

The mother moved into the program with her two boys, one a preschooler and the other in elementary school, and child welfare officials wanted her and her children to be self-sufficient within six to nine months. The mother's own sexual abuse had begun at age four at the hands of her older brother and lasted eight years. When she was nine, her first *boyfriend* (client's term), age 16, began molesting her although she did not initially understand that this had been a form of abuse. Her three marriages had been unstable, her partners emotionally and physically abusive to her and her children.

Interestingly, this mother had never had difficulty maintaining employment, but she left her children in the care of unstable friends for days at a time. Early in the program, she had difficulty multitasking and became easily overwhelmed, confused, and depressed. When her sons hit her or yelled at her, staff observed that she became scared and tearful. She reported that it *felt* as if she was being abused *all over again*.

Psychological testing showed cognitive deficits and other psychological problems: poor abstract reasoning, slow processing speed, impaired working memory, features of dependent personality, and symptoms of trauma and depression. The treatment team set therapy goals that took her limitations into account and referred her for a psychiatric evaluation, at which point she began taking antidepressant medication.

As her children began to disclose prior physical and sexual abuse at the hands of her partners, she experienced nightmares and flashbacks about her own abuse. Her own mother had been sexually abused as a child and had not understood how to protect her daughter.

With regard to the children, there were many emotional, interpersonal, and cognitive developmental delays to address. Their mother's parenting skills included yelling, ignoring serious safety risks, and putting the children in their rooms for long periods of time. All four of the children in this family were *hyperactive and emotionally dysregulated*. Expressive language and communication deficits were present. We learned through communication with the school that the children did not own a toothbrush or know how to brush their teeth; the mother believed that teeth develop cavities if brushed too much. One of the older children had been shown pornography by an older family member and had become sexually reactive with his brothers prior to entering the program, so a safety plan had to be implemented around bathing and privacy.

The mother showed visible favoritism for the younger child, since the older boy looked like and reminded her of his abusive father. The younger child had failed to thrive in his first year of life. When he joined his mother to live on campus, he would not sit and eat at the table and instead wanted to be fed. He had delayed speech, would not walk on his own, and hit his mother during angry outbursts that lasted between 20 and

30 minutes. He had nightmares and was terrified of being in the bathtub. His older brother had soiling accidents and poor eye contact. His intense *rage meltdowns* lasted up to 30 minutes, and his play was regressed and compulsive.

Child Services was often more concerned with the cleanliness of this mother's home than with the bonding that was taking place with her children, and they wanted a *quick fix*. One social worker said to the mother, "You need to forget about all this therapy stuff and focus on taking care of your home and your finances," and at one point was going to recommend termination of parental rights rather than give the family three additional months in the program to complete trauma work. The treatment providers and the case judge understood the need to address the family's complex issues, however, and so the mother was granted the extra time to continue her family's slow and gradual healing progress.

It should be mentioned that this well-intentioned mother attended every session, did her psychotherapy homework, and called staff for advice when she did not know what to do. She participated in parenting classes and learned how to make informed choices and use consistent discipline through repeated feedback. She practiced problem-solving skills and rules for dating relationships that helped her override her lack of common sense. In time, she became more nurturing, emotionally regulated, and attuned to her children. She also became very *attached* to the campus therapy staff and used those attachments to *grow up*.

In retrospect, a turning point for this client was a set of therapy stories that touched her emotionally and helped her understand and talk about her childhood trauma experiences. The reader might be curious about how a woman with somewhat low cognitive functioning became interested in reading therapy stories. Early in placement, a story was used in the women's group, and she asked me if I had "any more." She borrowed a book of trauma-related therapy stories, read each one, wrote answers to the story questions in her journal (without prompting), and dropped in weekly to talk about how the characters reminded her of her life. She took time to think about and process what was in the stories. About eight months later, when she was coping much better, she said to me, "You know you always reminded me of my grandmother. She was the one person in my childhood that made me feel safe. Thank you for being there for me." I did not realize until then the ways in which our discussions had contributed to the development of a positive adult attachment.

The therapy stories were well matched to someone with cognitive and emotional deficits. Reading them grounded the client and helped her understand, week by week, how her childhood trauma had inflicted damage and how she might *take charge* of her life and function better as an adult. She became aware of and better able to manage her behavior and emotions in the face of trauma cues; she also developed a strong attachment to her children.

This client *changed from within*, at least in part because of stories that brought back memories, allowed her to process her abuse, allowed her to *feel and behave more like an adult* around her children, and helped her develop a significant attachment with persons who cared about and believed in her. She came to believe that she could give her children a better life.

For her children, it was a story about *Lucky the Junkyard Dog* that gave them words to talk about their past abuse. They identified with Lucky's fear and discussed why he was still scared long after his abuse. The older boy did a *Mad List* (Pernicano, 2009) with his therapist and he began to engage in trauma-focused play therapy. He delighted in a bathroom intervention where he could poop and pee (like a dog) in the toilet and flush the waste down on his perpetrator's head in the sewer.

It took over a year, but her youngest son is now doing well and sets good boundaries for privacy, seeks out his mother when he is distressed, has normal weight and eating habits, is making friends at preschool, has age-appropriate verbal skills, and openly displays affection. His older brother eliminated soiling, plays well with his younger brother, is attached to his mother, and is able to talk about his trauma. At the present time the mother is employed, lives back in the community, and parents her children in a *good enough* fashion. Child welfare is in the process of closing her family's case.

This case illustrates the complex needs encountered in families that experience cross-generational and repeated trauma: interpersonal, emotional, cognitive, and environmental. With these types of families,

change is needed at multiple systemic levels and must be matched to the cognitive, emotional, and developmental functioning of the children and their caregivers. Fortunately, treatment providers are now better able to access information and training in evidence-based practice, both online and through comprehensive training programs. Providers are referred to the National Child Traumatic Stress Network (www.nctsn.org/), the SAMHSA evidence based repository (www.nrepp.samhsa.gov), and the Child Trauma Academy (www.childtrauma.org) for resources.

1.2 Diagnostic Clarification

Traumatized children, especially those with complex trauma, present for treatment with any number of symptoms: somatic complaints, disruptive behavior, attention problems, stubborn defiance, odd thinking, mood swings, poor eye contact, rage outbursts, obsessive compulsive habits, attachment difficulties, rule violations, oppositional behavior, delayed language, or poor social reciprocity. Clinicians need to be aware of the ways in which trauma impacts child development, functioning, and behavior and assess carefully in areas often not shared spontaneously by caregivers.

Recently, a ten-year-old boy and his mother sought treatment for his *school and anger problems*. He had been diagnosed with attention deficit hyperactivity disorder (ADHD) by the school based on an ADHD screening measure, and they were recommending medication. He was restless and inattentive in class and, over a two-year period, displayed interpersonal conflict. He had difficulty keeping friends, did not concentrate on his work, and needed a lot of attention and validation from the teacher. His parents were seeking a second opinion.

During assessment that included parent interview and social-emotional personality testing, it became clear that the child's significant anxiety was interfering with his focus and attention. He ruminated about school incidents in detail, used "victim" language, and shared concerns about his friends (and him) getting hurt by bullies. He often felt the need to step in and protect them. During the interview with the boy and his mother, the therapist asked if things were happening at home (like arguments) that might be upsetting him and setting the stage for his anger outbursts. The mother acknowledged that the dad had "a *very* bad temper" and was quite intimidating, to the point of verbal abuse (and prior partner violence). The child said that he worried a lot about his parents' fighting and kept thinking something worse might happen. This boy met all the criteria for ADHD, but his symptoms were better explained by a diagnosis of anxiety triggered by verbal abuse that was occurring in the home.

Diagnoses of disruptive behavior disorder (DBD), ADHD, oppositional defiant disorder (ODD), psychosis, bipolar disorder, obsessive compulsive disorder (OCD), or pervasive developmental disorder not otherwise specified (PDD-NOS) may not be *wrong* given the presenting symptoms (see Appendix D), but evidence-based treatments for these diagnostic conditions alone will not address root family problems of attachment and trauma. The neurobiological dysregulation of abused and neglected children results from the cumulative impact of a lifetime of highly stressful life events.

Traumatized children need to develop and maintain relationships with nurturing, consistently responsive adults within stable, predictable environments, whether in a group home, residential placement, foster, kinship, or biological home. The importance of attachment through the lifespan has never been questioned, but with growing knowledge about interpersonal neurobiology we now better understand what goes on when parent–child relationships break down and how to remediate those difficulties. We also understand the harm that comes when children are forced to endure multiple placements and repeatedly lose attachment figures.

In Patricia Crittenden's *Dynamic Maturation Model of Attachment* (2013), attachment patterns are understood as adaptive, protective strategies used by children to reduce arousal/stress and cope with different types of caregiving. Infants are dependent on the caregiver, and their attachment strategies are

meant to ensure survival in response to caregiver expectations and behaviors. By preschool years, relationship co-regulation should be present, whereby the child is able to seek care (when the attachment behavioral system is activated by stress), engage in mastery-related activities, and self-regulate when the parent is absent.

With consistent, congruent, sensitive care that is responsive to the child's individual needs and personality, the child develops true, integrated cognitive and affective information about the self and caregiver. When the caregiver is punitive, non-validating, inconsistent, non-congruent, or demanding, the child "twists" him/herself to match the parent's needs or view of reality and develops a *false self* (Crittendon, 2013). In doing this (to survive, increase consistency, protest the lack of congruence, gain approval, or seek attention), the child's view of self and others becomes distorted.

Caregivers' own mental health symptoms, prior abuse, attachment deficits, mistaken beliefs, lack of developmental understanding, and relationship problems make it difficult for them to develop *secure attachments*. Mental health systems are sadly lacking in appropriate trauma-informed treatment for the neglectful or abusive caregiver. Therapists working with traumatized children should ensure that caregivers have adequate cognitive coping skills, can engage in effective attachment strategies, and manage their own distress.

It is unwise and even risky to work with a traumatized child without active caregiver involvement. Attachment strategies develop within a cultural and family context and are sustained by the pattern of interactions within the family. The child's behavior serves an adaptive purpose to maintain safety and security within a family context; therefore, a change in the child's functioning can stress the parent–child dyad and alter family dynamics. If professionals take away an adaptive yet unhealthy parent–child strategy without offering something in return, they risk negatively disrupting the family system and bringing harm to the child.

For example, an 11-year-old boy had been exposed to multiple episodes of abuse at the hands of his older sister, largely due to his mother's blind spots and non-protective behavior. He was serious-natured, provided compulsive caregiving toward his mother, performed very well in school, and dealt with his own distress through rigid coping strategies. The therapist's first inclination was to move him more into a *child role* and teach his mother to be more protective. Yet early on during sessions, his mother smiled oddly and her eyes had a glazed look either of medication or dissociation. She laughed inappropriately and did not make good eye contact.

The client loved drawing and creating therapy stories (most of which were about someone being ugly or defective) and we ended most sessions with this activity. About six sessions into treatment, at the end of a family session, the client mentioned a test at school where he had missed three questions.

He then pulled out the dry erase board, smiled and said, "Don't forget this!"

He wanted to go first, so he drew his picture and told a story about a boy that entered a science competition.

> He had a big birthmark on his face, spiked hair and looked funny. He did not think they would let him enter the science competition because he looked different from everyone else. They let him enter, and he ended up being one of three finalists. In the final round, the boy looked out into the audience. His mother was not there. He started worrying about her and got distracted. He missed three questions because he could not focus, so he did not win. Later he tried to tell his mother what happened but she just smiled.

As he finished the story, he looked at the therapist with a solemn look on his face and said, "That's like me." His mother sat across from him with a smile on her face, tears in her eyes.

With some help, he was able to talk about being abused by his sister and that he wanted his parents to take it *seriously*. The therapist talked with him and his mother about a safety plan he could be in charge of, given the family circumstances and his mother's visible limitations.

After his mother went back to the waiting room, the therapist said, “I really like your story. In a few places it did not turn out the way I expected. Would you like to hear how I thought it would go?” He was curious and agreed.

> The boy had spiky green hair and a big birthmark on his face, so he did not think he would be invited to compete in the science competition and he assumed no one would like him. But he was wrong. He entered the contest and they said, “Thank goodness you are not like everyone else. We need someone new and different. All these science contest kids are geeks, nerdy and too serious, and they all look alike. You are *one of a kind*. We need someone who is one of a kind.” The boy competed and in the finals, he looked out and saw his mother was not there. Well, his mother was often not all there, and he had come to know and accept that. He took a deep breath, focused on the questions, and managed to win the contest, not that winning or losing was the most important thing. Later he told his mother he had won. She smiled, and he knew she was really proud of him.

Not surprisingly, he smiled at the therapist’s story.

It is important to assess caregiver expectations with regard to communication, discipline, and parent–child interaction as well as the ways in which family members manage stress. When a child does not live up to unrealistic, pre-conceived caregiver expectations, problems may arise.

Information about caregiver–child interaction may be gathered throughout treatment and interventions tailored to those interactions and family dynamics. A parent who seems disconnected, sits across the room, texts during session, allows the child to wander untended, or ignores a child’s needs may have difficulty tuning in to the needs of a child. Does the parent push, hold, slap, caress, or hug the child? Does the parent readily touch the child to comfort or redirect? Does the parent move abruptly toward the child or demonstrate calm patience? What is the quality and intensity of the parent’s mood in response to the child’s behavior? It is important to note whether caregivers are *on the same page* regarding values, child discipline, and communication; and subtle cues, such as a mother always looking at her partner before speaking, provide useful information. It can take a while to *put the pieces of the family interaction puzzle together*, and the conceptual *roadmap* may change as new information emerges.

1.3 Evidence-Based Practice

There are a variety of evidence-based trauma informed therapy approaches that facilitate cognitive, emotional and behavioral change.

Regardless of a therapist’s theoretical orientation, the PRACTICE *elements* included in Cohen et al.’s Trauma-focused Cognitive Behavior Therapy (TF-CBT) are critical ingredients in trauma recovery: psychoeducation and parenting, relaxation (and stress reduction), affective identification and expression, cognitive coping (to lay the groundwork for later restructuring), trauma narrative development, *in vivo* exposure, conjoint child–caregiver sessions, and enhancing future safety, relationships and self development.

Therapists will also find the Attachment, Self-Regulation, and Competency (ARC) model developed by Blaustein and Kinniburgh well suited for work with traumatized children and caregivers with multiple, prolonged traumatic stress. ARC includes relationship development (resilience through attachment), self regulation, and dimensions of cognitive and emotional competency. It also suggests intervention for the management, identification, modulation, and expression of affect. The competency component of the program, in addition to self-efficacy, addresses executive functioning and individuation. It is a *must-read* for every trauma-informed therapist.

Child–Parent Relationship Therapy (Landreth & Bratton, 2006) strengthens the relationship between the caregiver and abused child. Dialectical Behavior Therapy (DBT) helps abused teens learn to regulate

moods and combat faulty beliefs. Schema Therapy and Acceptance and Commitment Therapy (ACT) assist older teens in developing new coping abilities.

Parent–Child Interaction Therapy (PCIT) (Zisser & Eyberg, 2010), Filial Therapy (VanFleet, 2005) and Child–Parent Psychotherapy (Lieberman & Van Horn, 2005, 2008) are excellent models of evidence-based parent–child training. PCIT is an empirically supported treatment for behaviorally disordered young children with an emphasis on improving the quality of the parent–child relationship while changing patterns of parent–child interaction. In this model, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior. This treatment focuses on two basic play-based interactions: Child-Directed Interaction (CDI) for strengthening the parent–child relationship; and Parent-Directed Interaction (PDI) for specific behavior management techniques. We have found that the Child-Directed Interaction allows the parent to become more sensitive to the child, build positive attachment, and respond more consistently.

EMDR and Mindfulness-based Stress Reduction training are effective treatments with school-aged children for emotion focused right-brain work and neurobiological integration. EMDR is being used clinically with children for both single and complex trauma (Gomez, 2013; Lovett, 2007; Tinker & Wilson, 1999).

Gomez speaks succinctly of how EMDR impacts neural pathways and cites controlled randomized studies with children. EMDR taps into use of memory function and right-brain experiential contributions to trauma. The interventions activate right-brain areas through sensory stimulation (tapping, tones) and then integrate those neural pathways with left-brain functions through verbal processing. The Child Welfare League of America (CWLA) now includes EMDR as one of their approved evidence-based practices for traumatized children.

Mindfulness-based Stress Reduction training for school-age children and a wide variety of mindfulness practices are also recommended interventions with abused children, since they allow the child to improve self efficacy, increase cognitive focus, achieve relaxation, improve distress tolerance, and seek body/mind integration. Some mindfulness resources are listed in the parent resource list in the appendix and these practices offer opportunities for caregivers and children to practice breathing, meditation, and acceptance together at home.

And finally, play therapy techniques have long been used in trauma intervention within both psychodynamic and cognitive behavioral therapies (CBT; Drewes, 2009; Gil & Briere, 2006; Kaduson & Schaffer, 2003; Malchiodi, 2008; Markell & Markell, 2008; McGee & Holmes, 2008; and Pernicano, 2010a and 2010b). Play therapies may be integrated into almost any trauma-informed work, and they can be tailored to the age and developmental functioning of the child.

1.4 The Four "F" Words: Stages of the Trauma Stress Sequence

Freak out, Freeze, Flight, and Fight (the four "F" words) are terms used by this author in the Child and Caregiver Guides and Appendix B to describe the neurobiological stages of the stress response, in part because they will be easy terms for readers to remember. The stages—and behaviors during each stage—parallel the child's brain functioning under stress and the neurobiological resources being used to deal with threat to the child's well-being (Bremner, 2012; Cozolino, 2006, 2010; Perry, 2004a, 2004b, 2006, 2009; Perry & Hambrick, 2008; Perry & Pollard, 1998; Siegel, 1999). The nature of stress, and its impact on brain development and functioning, have been widely researched in recent years.

When I worked in a residential treatment program for teens and later in a group home/family reunification program with infants, preschoolers, and school-age children, I observed the ways in which staff or caregiver behaviors triggered dysregulation. Child functioning reliably changed in the face of threats, ultimatums, a loud or harsh tone of voice, fast movements toward the child, criticism, lack of consistent attention, and/or visible frustration. Abused and neglected children of all ages were especially sensitive to changes in vocal tone or facial expressions; they also reacted to both verbal and nonverbal signs of stress in the staff.

It was clear that certain staff had a knack for helping children calm down; they softened their voices, ensured proximity, provided nurture, and lessened control. Other staff *unwittingly triggered fear and protective responses* in children—responses that looked a lot like anger or defiance. A fearful, angry, defiant child was usually given a behavioral consequence for his or her perceived actions, yet it was often the caregiver who needed to learn to engage with the child in a less threatening manner.

One staff member, when discussing the defiance of the teens in the group home, said zealously, "We need to show them who is in control/in charge around here!" I replied, "What we need to do is help them gain better control over their own moods and behavior." This person did not realize that traumatized children need to be given as much control as possible in order to reduce their fear and help them feel safe. His power-control strategies often led to physical management with the young people, and he did not understand that his behavior triggered negative caregiver–child interactions.

In searching the web a number of years ago for materials (on trauma-informed treatment) that I might use in teaching and training, I came across the Trauma Academy Web site (www.childtrauma.org). Dr. Bruce Perry and his colleagues have written extensively about what I observed in my clinical practice with traumatized children and their caregivers, i.e. that treatment needs to be "matched to" a child's strengths and limitations, and that the age of onset and duration of abuse (beginning in infancy) have neurobiological ramifications (Perry, 2004, 2006, 2009; Perry & Hambrick, 2008; Perry & Pollard, 1998). The Neurosequential Model of Therapeutics trains professionals to evaluate and "map" a child's neurobiological capacities and identify interventions that utilize skills already mastered by the child (Perry, 2009; Perry & Hambrick, 2008; Perry & Pollard, 1998).

At a play therapy convention several years ago in Louisville, KY, I attended a workshop that incorporated Dr. Perry's training materials on state-dependent functioning (2004a, 2004b). These materials describe how children react neurobiologically (to cope with stress) following trauma, and how caregiver behaviors can either escalate a traumatized child's stress and fear orhelp children calm down and regain control. Perry's materials integrate much of what we have learned over the past 20 years about traumatic stress; a chart in the training materials walks one through the stages of neurobiological coping that occur as a child is increasingly stressed. The Child Trauma Academy training materials are available for purchase at www.childtrauma.org and are strongly recommended for those working with traumatized children and their caregivers. I provide my own example of state-dependent functioning in Appendix B following on from the chart in Perry's training materials and summarize in the Caregiver Guide how caregiver behavior can exacerbate or alleviate fear in a traumatized child.

In my practice, I find it helpful to give copies of Appendix B to caregivers and review the material in session using examples of their recent parent–child interactions, to bring points home. Once a caregiver understands the connection between child functioning and trauma, that person can adapt his or her response to the child. Following is a quick review of the freeze–flight–fight response that can occur in children following trauma.

1.4.1 Freak Out

Since an abused child's brain and nervous system remain in a state of fear even after the mistreatment ends, the child is likely to be vigilant and watchful and less calm than a non-abused child. In essence, children who have undergone this trauma are *on the lookout for the abuse to happen again* and their nervous systems remain at a higher level of arousal (Perry, 1998, 2004a, 2004b, 2006, 2009). These children are easily startled or *triggered* by sensory, interpersonal, or environmental cues that remind them of past abuse. *Vigilant* children also become easily stressed by raised voices, multiple demands, signs of adult criticism or frustration, and perceived failure. As their stress increases, they find it hard to think clearly and are less likely to pay attention or comply with adult directives. When the children are startled, they become highly alert and *freak out* (a state of internal dysregulation).

If a caregiver misunderstands a child's fear-based stress response and becomes more frustrated with him or her, the child is likely to *freeze* or become very emotional. The caregiver can be coached to notice early signs of stress and dysregulation and intervene to prevent the freeze; this can include helping a child *calm down* with mindfulness, relaxation, and guided imagery.

1.4.2 Freeze

Freeze is the second stage of the stress response. Here, the child is in a state of alarm and may be too afraid to move or talk because he or she perceives that something bad is about to happen. During *freeze*, a child might become suddenly very emotional or simply more quiet and watchful, *like a deer in the headlights*. A child in *freeze* may seem inattentive, disobedient, disorganized (doing random things without a clear goal), or paralyzed (still).

The goal is for caregivers of children in *freeze* to help those children relax and regain control. During *freeze*, most children respond to slow movements, light touch, invited contact ("do you want a hug?"), and quiet soothing words. These responses can reduce the child's *fear* and help the child calm down and regulate affect. A loud or threatening voice, a raised hand, or a finger pointing in the child's face will increase fear for a child in freeze (Perry, 2004a, 2004b).

1.4.3 Flight

Flight, the third stage of the stress response, occurs when the child's fear or stress increases to the point that he or she perceives the need to *escape* in body or mind to ensure protection or survival. The midbrain is activated prior to *flight*, and the child's response will be a form of shutting down (during which he or she is not capable of listening or talking) or escape (running or hiding from the perceived danger). A child in *flight* might leave the room or run from the therapist or caregiver due to the increased state of fear. During *flight* the child is unable to think and is emotionally reactive (likely to do or say something without thinking). Dissociation is a serious type of flight that may result from severe or repeated trauma during early childhood, where a child goes somewhere else in his or her mind and tunes out reality.

It is helpful to remain quietly present or offer an attachment object (pet, blanket, stuffed animal, etc.) when a child starts to tune out or appears ready to run. It also helps to reduce noise and distractions and to *disengage* (back off or give the child some space). When the child is in *flight*, a caregiver should not raise his or her voice, lecture, threaten, show increased frustration, show fear, grab the child, or make demands/ultimatums (Perry, 2004a, 2004b). If an adult responds in any of these ways, the child is likely to move into *fight*.

1.4.4 Fight

Fight is the final stage of the stress sequence, and is a state of terror during which the child is concerned only with self-protection and survival. During terror, or *fight*, the child's brain moves to a primitive, lower level functioning (brainstem); he or she cannot think or reason, although a caregiver may interpret this response as willful defiance or intentional aggression. A child's fight may be verbal or physical. Once in a state of *physical fight*, the child may hit, bite, throw things. or kick anyone that comes too close.

Therapists need to teach caregivers the difference between a *meltdown that arises out of fear (self-protection)* and a *tantrum that comes from defiance (oppositional)*. These can look very much the same, but when adults can't tell the difference, children get accused of *acting out on purpose* when in fact they are actually trying to stay safe. Traumatized children do not *behave well* until they feel safe, can self-regulate, and develop the

capacity for cause–effect thinking. If a caregiver grabs, shakes, harshly restrains, or screams at a child in *fight*, it will remind the child of prior abuse and intensify the child's fear. The caregiver should give the child space to calm down and focus on safety and protection. Restraint should not be used with an abused child except as a last resort to maintain or restore safety, since restraint itself can trigger fear.

1.5 Working within the Developmental Context

The Neurosequential Model of Therapeutics (Perry, 2009; Perry & Hambrick, 2008) is beyond the scope of this book, but the model stresses the importance of assessing a child's developmental strengths and limitations, understanding at what ages trauma occurred, and matching interventions to a child's neurobiological and developmental limitations and competencies. Due to the neurobiological impact of trauma (which differs by stage of development), a child may subsequently have functional limitations. A child's play capacity, sensory-motor skills and cognitive/language development need to be carefully evaluated early in treatment, since they establish the scope of developmentally appropriate interventions. For example, expressive or receptive communication difficulties may indicate the need for play or expressive therapies even with older children. The treatment provider also needs to help the caregiver respond appropriately to the child's developmental needs.

Many traumatized children, especially those who have undergone complex trauma, have developmental delays. It used to be thought that children would recover better than adults from the experience of traumatic events since their brains are malleable and still developing. However, neurobiological research suggests that the experience of overly high, debilitating stress (during prenatal development, infancy, or childhood) can result in changes to the developing brain and nervous system that impact attachment, health, and coping, and may last into adulthood if left untreated (Bremner, 2012; Briere, 2012; Cozolino, 2006, 2010; McCollum, 2006; Perry, 2006, 2009; Perry & Hambrick, 2008; Perry & Pollard, 1998). It is unclear whether neurobiological differences are present in individuals prior to their experience of trauma or *caused/exacerbated by* high stress/trauma; this seems a moot point given evidence for prenatal transmission of stress.

1.6 Psychoeducational Needs of Children and Caregivers

It is important to educate children and caregivers about the impact of trauma on child development, including cognitive processing, mood regulation, and parent–child attachment. Caregivers such as teachers, foster and adoptive parents, and kinship care providers need to understand the many types of cues that can trigger fear and arousal in abused children, even those abused or exposed to violence preverbally. Caregivers who believe children were *too young to remember their abuse* will be better able to put a child's behavior in context once they understand that trauma memories and triggers can be sensory (right-brain, non-verbal, limbic) and/or cognitive (verbal, left-brain, hippocampus-mediated).

In doing caregiver–child conjoint work, it is important that the therapist evaluate the caregiver's own trauma and attachment experiences, as memories of these may be triggered by, and impact, the child's therapy process. Avoidance of trauma work by the caregiver can be related to his or her unresolved trauma.

Mental health providers become positive advocates for abused children in school and other settings. They can help caregivers understand the sorts of things that trigger a child's fear and learn to respond in ways that reduce the risk of further trauma. It is not surprising that many children with prior trauma end up suspended from school, incarcerated, or hospitalized when adults misread signals and respond in ways that intensify their fear. Ross Greene's *Explosive Child* (2001) and *Treating Explosive Kids: The Collaborative Problem-Solving Approach* (Greene & Ablon, 2006) describe the problems of "inflexible" children and the ways

caregivers can negotiate with them and collaborate in order to solve daily problems and prevent aggressive outbursts. These strategies can be very helpful with abused children, since many of them move quickly into power struggles or arguments with caregivers and teachers when they feel threatened. Dr. Greene's model teaches listening, reflection, and empathy skills so that adults and children work together to solve problems (see www.ccps.info and www.livesinthebalance.org).

As noted above, many caregivers mislabel child stress/fear responses as willful defiance or "ignoring," and are unaware of the ways in which their behaviors trigger children's protective responses. For example, a young boy whose diagnosis fell on the autism spectrum recently had a temper tantrum when transitioning from his father's to his mother's for the weekend, saying he didn't want to go. Rather than ask why, his parents put hands on him to try to get him in the car. He completely *lost it*, biting, kicking and screaming. When asked by his therapist why he didn't want to go, the child said that his mother's husband *picked on him* and scared him. This was the same man that had abused him four years prior. He denied current abuse, but referred to harsh discipline, a "look" on his stepfather's face, and comments made that raised his anxiety. I explained to the boy's father that his son seemed to be reacting out of fear, not defiance. Therapy was bringing up (triggering) memories of prior abuse, and the child remained in a state of fear around the mother's husband.

Caregivers sometimes judge that children behave in the ways they do *on purpose*. Therapists need to help caregivers understand that some behaviors of abused children have a *purpose (are goal-directed)* but are not necessarily *on purpose*, i.e. done deliberately. The goal of such behaviors is safety and survival—they help the child cope with stress and avoid future abuse. A sudden change in a child's mood or attitude, even *bossiness, backtalk, sudden oppositional stubbornness, or arguing*, can be a child's attempt to regain control or take charge in the face of a stress trigger.

Conversely, *on purpose* behavior is left-brained, rational, and intentional; the child knows what he or she is doing and why. *On purpose* behaviors require planning, foresight, and self-control; many abused children have not developed these skills. They do not plan well, do not think ahead, and tend to react to (rather than act on) their world.

I have heard caregivers say, "He wants his own way," as if having control is a bad thing. Therapists can help caregivers understand that an abused or neglected child felt helpless and out of control during the abuse and now needs to feel more *in charge* or *in control*. If we are to be very honest, we all find satisfaction in autonomy and doing things our own way. Children, especially abused children, need to feel in control of their lives and decisions.

1.7 Developmental Considerations

1.7.1 Trauma Therapy with Caregivers and Infants or Toddlers

Therapists often become involved in court-ordered assessment and intervention in order to increase caregiver sensitivity to infants or toddlers exposed to abuse, neglect, or domestic violence and to educate caregivers about child development.

A number of caregivers have been referred to our program for family reunification when their infants, some of whom were born addicted to drugs or exposed to significant abuse or neglect, are five–12 months of age. These infants may be much too quiet (few vocalizations), non-responsive (little eye contact), fussy, or irritable. A good number of these infants do not start crawling until eight–ten months of age. If they are mobile, they move out of sight of the caregiver with little regard for safety.

A twenty-something mother who had lost parental rights on four older children moved in with an infant and toddler. The baby, who had been in foster care since birth, was engaging and active, seeking proximity to her mother and fussing when left alone.

"She is bad," said the mother. "She never lets me sleep in the morning and doesn't want to stay in the playpen. Why can't she be more like her big sister?"

She considered the toddler a "good girl." The older child stayed to herself, showed little curiosity, did not fuss or cry, and avoided interpersonal contact. She was not yet talking and averted her eyes when approached. She pretended to not hear requests and hardly ever smiled or laughed. She did not show interest in other toddlers or children.

After a few months in the program with intensive in-home therapy activities, the two-year-old began to smile, approached program staff to be picked up, made better eye contact, increased playful behavior, and signaled distress to her mother. She was no longer happy to be left alone, and her mother was not entirely happy at the changes in her formerly "good" baby. In time she came to accept that the changes in her daughter were healthy ones, and she began to see the ways in which her behavior impacted her children.

The age at which trauma occurred, availability of secondary attachment figures, and the quality of attachment in the home subsequent to the trauma in part determine the neurobiological impact of abuse and neglect. With intensive parent–child treatment, an infant can often reach normal developmental milestones within about six months.

Treatment with infants and toddlers focuses on attunement, improving caregiver–child emotional and cognitive attachment strategies, and increasing understanding of child development. Attunement is a synchronized, *brain-to-brain* neurobiological connection between caregiver and child that develops through interpersonal stimulation. This takes place through mutual face-to-face interaction, during which the caregiver *reads and responds* to the baby's arousal and cues. An attuned connection between the caregiver and infant facilitates healthy neurobiological development in the child. Infant mental health providers train caregivers to use touch, vocal inflection, facial expression, and eye contact to connect with the infant and to respond consistently to a child's verbal and non-verbal cues.

1.7.2 Trauma Therapy with Caregivers and Preschool Children

Abused children may engage in mechanical, rote, repetitive play as preschoolers. When this is the case, their play lacks emotional expression and mastery and they do not use or respond to pretend play. When rote play is observed, therapists and caregivers can use sensory-motor activities (music, rhythm, rhyming, and massage) with the child to enhance bilateral brain development and integration. Sensory-motor play is a precursor of language development, and as the child develops language and strong attachment relationships, his or her play behaviors will mature as well.

Play therapy helps children identify and express feelings, solve problems, and talk about their abuse with their caregivers. Caregivers should be pulled into and involved in the child's play therapy. When abused children start to use make-believe play, they often display themes of power-control, victimization, monsters, good/evil, and safety. They may bury "bad guys," fight alligators, or seek help from superheroes. Caregivers may be caught off guard by the level of the child's anger and emotional intensity in play, but therapists can help them understand the difference between fantasy play (which helps resolve trauma) and real aggression. Caregivers can also be encouraged to allow frequent child directed play to give an abused child a sense of autonomy and control.

1.7.3 Trauma Therapy with Caregivers and School-Age Children

Many abused or neglected children, especially those placed in out-of-home care, begin to display disruptive, disorganized, oppositional, or aggressive behavior during elementary school years. Others present with separation anxiety, obsessive compulsive symptoms, or depression. Therapy is usually a mix of structured, activity-focused, cognitive behavioral treatment and creative expressive or play therapy interventions. Children at this age are able to express feelings, answer questions, and process life experiences. During the