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Basic Principles for Working with Abused and Traumatized Children

The purpose of this book is to emphasize the necessity and applicability of an integrative approach to working with children, especially abused and traumatized ones. This approach recognizes children's linguistic and cognitive limitations and their varied developmental levels, as well as the clinical challenges frequently presented by children's resistance to a therapy process that is often unfamiliar and that they themselves infrequently seek out. In addition, children who are physically or sexually abused (especially the latter) are often genuinely resistant to speaking about their emotional and bodily injuries at all. This is true whether children are abused within or outside their families, but when these injuries occur at the hands of loved and trusted caretakers, the resulting conflicts may completely compromise children's ability and/or willingness to address difficult thoughts and feelings.

My career currently spans 33 years, and during that time I have worked with thousands of abused children (and their families or caretakers), briefly or on a long-term basis. I have grown to value the unique nature of each child, his or her family members, and their recovery process. Because of clients' individuality, I firmly believe that clinicians who remain conversant with multiple theories and approaches will be the most successful at engaging and maintaining children and their families in treatment. Following the description of a comprehensive assessment

(see Chapter Two), I summarize treatment goals (Chapter Three). I then encourage an integration of expressive therapies (art, play, and sand, discussed in Chapter Four) designed to engage nonverbal and acutely resistant children, as well as cognitive-behavioral therapy (CBT) for children who are verbal and can participate in this type of therapy (see Chapter Five). I don't see these approaches as exclusive, single modes of therapy, but as complementary and mutually beneficial. Of course, child therapy presumes that children will be assessed and treated within their family, community, and cultural systems. Chapter Six therefore discusses the essential aspect of working systemically with abused children, for whom relationships and interpersonal exchanges can become complex. Work with this population can also involve some special issues, such as posttraumatic play and the presence of dissociative responses in many abused children; these exceptional clinical challenges are addressed in Chapter Seven. The second part of the book offers four clinical case examples to illustrate the possibilities of integrative work for optimal results.

My work is anchored in several basic theories, as well as specific beliefs that have emerged through the practice of meeting abused children and their families—all of whom receive therapy because of similar events in their lives, and yet all of whom are clearly distinctive. These beliefs inform and guide therapeutic work based on clients' needs at different phases of treatment. These beliefs and subsequent approaches are consistently reevaluated and may be emphasized or utilized to a greater or lesser extent, depending on emerging empirical data, ongoing clinical experience, or the fluctuating needs of a child and family. I am most strongly influenced in this stage of my life by trauma theory; the evidence for how children use their instinctive drives to negotiate trauma (with greater or lesser success); the interface of CBT and expressive therapies; my own and others' observations of the remarkable stabilizing effects of resiliency; the overwhelming evidence for the effects of severe and/or chronic stress on children's neurobiology (as well as emerging data on the possibility of reversing some of these effects); and the relevance of contextual/systemic work. Finally, this work requires consistent acknowledgment and processing of countertransferential responses, and this processing is inherently connected to the development and establishment of responsible self-care practices.

TRAUMA THEORY: THE IMPORTANCE OF ASSESSING TRAUMA'S PRESENCE AND IMPACT

The word (and concept) "trauma" has been consumed by popular vernacular to such an extent that it is now often applied to taking exams, getting

haircuts, making speeches, traveling, shopping in crowded stores, and other typically mundane events. When the word is used as diffusely as in these examples, it appears that the intent of communication is to describe something as stressful, demanding, or uncomfortable. This excessive and imprecise use of the word "trauma" dilutes its true meaning and confuses its intended message.

In the area of child abuse and neglect, the words "abuse" and "trauma" are frequently used interchangeably, as if they were synonymous. Instead, I believe it is necessary to differentiate these words and subsequent concepts (and use them purposefully), because traumatized individuals may have different therapeutic needs from those of individuals who have experienced acute stress but who do not suffer long-term traumatic impact. To begin with, the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR; American Psychiatric Association, 2000) defines a traumatic event as follows:

> . . . an event that involves actual or threatened death or serious injury, or other threat as to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (p. 463)

Van der Kolk (1987) notes that the critical issue in defining trauma and its resolution is the *debilitating loss of control* that individuals, especially young children, experience (in other words, he emphasizes the phenomenological aspect). This loss of control has significant consequences:

> . . . if the distress is overwhelming, or when the caregivers themselves are the source of the distress, children are unable to modulate their arousal. This causes a breakdown in their capacity to process, integrate, and categorize what is happening. At the core of traumatic stress is a breakdown in the capacity to regulate internal states. If the distress does not ease, the relevant sensations, affects, and cognitions cannot be associated—they are dissociated into sensory fragments—and as a result, these children cannot comprehend what is happening or devise and execute appropriate plans of action. (van der Kolk, 2005, p. 403)

The effects of traumatic events can often last over long periods of time, waxing and waning. They may be manifested in the symptomatic behaviors associated with posttraumatic stress disorder (PTSD), even if an individual does not meet full criteria for a formal diagnosis of PTSD. In particular, they may be exacerbated with exposure to additional stressors (triggers that remind traumatized persons of the original events).

Among people exposed to traumatic events, there is great variety in the type and level of traumatic experiences and effects, as well as in trauma's short- and long-term management. Terr (1991), for example, distinguishes between single-event traumas (Type I) and chronic traumas (Type II). There are also obvious differences among traumatic events that are "acts of God," such as hurricanes, earthquakes, or floods; random events such as car accidents; acts of terrorism against groups; politically motivated torture; and interpersonal acts of assault and injury between strangers (random rape), familiar people (date rape), and family members (incest). Some recent literature also uses the differential descriptors "simple" and "complex" for types of PTSD. Such is the concern with distinguishing among types of trauma effects in children that van der Kolk (2005) has recently proposed a new term to capture a conceptual departure from contemporary definitions. "Developmental trauma disorder," van der Kolk posits, includes "multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma; affective and behavioral dysregulation; persistently altered attributions and expectations; and functional impairment" (2005, p. 404). This volume focuses on "developmentally adverse interpersonal trauma" in van der Kolk's sense—specifically, on such trauma as the result of child abuse (especially child sexual abuse). However, it's critical to note that interpersonal acts of child abuse and neglect occur within a larger context that can include additional stressors, such as drug abuse, domestic violence, or environmental stressors (poverty, social oppression, etc.).

Although child sexual abuse is often highlighted in the literature on child abuse and neglect, all forms of child maltreatment have the potential to be traumatic: physical abuse, sexual abuse, neglect or endangerment, and both active and passive forms of emotional abuse. All of these are dangerous to children's development and survival, and children can suffer consequences from them, whether they are intense but brief or long-lasting and persistent. What allows one person to return to normative functioning, while another has a life beset with grave difficulties, is the subject of great speculation and study (and is likely to generate discussion and research for years to come). However, it is clear at this time that traumatized children are a subset of abused children, and that children's responses to abuse are extremely heterogeneous. As O'Donohue, Fanetti, and Elliott (1998) point out, "although we know child sexual abuse can have clinically significant effects for the child, the exact nature of these effects, whether they cluster together in some syndrome, the extent to which problems emerge immediately or are delayed, and factors that mediate or buffer the effects of abuse are largely unknown" (p. 356). Treatment providers are therefore advised to suspend judgment when they are gauging and assessing the impact of trauma. Some trauma spe-

cialists tend to expect a maximum impact in all cases, while others may be more disposed to view traumatic responses as transient and manageable. These expectations and assumptions will influence clinical responses.

Because of the wide variation in their responses, maltreated children must be evaluated carefully, so that their individual (and familial) needs can be identified on a case-by-case basis. For example, one child's history of very severe and chronic abuse may signal greater concerns; however, this child may have personality traits that elicit positive, nurturing responses from important people in his or her environment, and thus the child may have the opportunity to form strong and trusting relationships that can be helpful in the recovery process. Another child with a similar or even a less severe history may elicit negative responses from caretakers and peers, and may therefore have difficulty experiencing intimacy with others; this difficulty may compromise his or her ability to trust others or to achieve emotional connectedness. In other words, some children seem to have internal resources to overcome early hardships, and their prognoses are thus often better than those of children lacking such resources. Abused children may fare differently based on many other factors as well, and I describe several types of such factors below.

In order to further illustrate the need for comprehensive assessments of children with histories of abuse or neglect, it is useful to think of the abuse or neglect itself (i.e., the stressor) as having the potential of causing great harm. Individuals may negotiate the stressor differently—and outcomes may differ greatly—depending on their perceptions of the event, coping strategies, available resources (both internal and external), and

TABLE 1.1. Individual Characteristics That May Influence Whether the Traumatic Impact of a Stressor (Abuse or Neglect) Is High or Low

High traumatic impact	Low traumatic impact
Inability to cope is persistent	Coping develops and grows
Coping strategies are lacking or unsuccessful	Coping strategies succeed
Internal resources are unavailable	Internal resources are available
External resources are unavailable	External resources are available
Expressive ability is lacking	Expression is achieved
Symptoms persist	Symptoms decrease
Helplessness persists	Hopefulness increases
Personal control is lacking	Personal control is restored
Existential crisis cannot be resolved	Existential crisis can be resolved
Trauma cannot be resolved or is negatively resolved	Trauma can be resolved

other characteristics affecting their overall management of the experience (see Table 1.1). These characteristics in turn are greatly affected by age; cognitive abilities; prior stressors and previously established coping strategies; temperamental differences; and qualitative differences in motivation, attitude, and resiliency. Changes in brain chemistry and in the ability to manage and restore brain functioning are also critical mediators of how long-lasting or intense potential trauma impact can be.

As noted above, several different categories of factors have been shown to be associated with low or high traumatic impact. In addition to child-related variables (type of trauma, level and duration of trauma, child's age, previous level of functioning, caretaking support, past trauma history), these include trauma-related variables (type, level, and duration of trauma exposure, exposure to traumatic exposure, number and extent of secondary adversities and stressors); caregiver-related variables (past and current psychopathology, trauma history); caregiver–child relationship variables (relationship quality, perception of child); and contextual variables (socioeconomic status, current life stress, family supports) (Bosquet, 2004, p. 302).

Whatever children's circumstances may be, their ability to negotiate trauma naturally should never be underestimated. It is important to note that no two children are alike, that perceptions of the same traumatic event may be quite different, and that the ability to cope cannot be easily predicted. There are at least two primary drives that can emerge during stressful events; I discuss these next.

TRAUMA NEGOTIATION: CHILDREN'S INSTINCTIVE DRIVES

Children seem to negotiate their emotional injuries by utilizing two basic drives that can guide their behaviors. The first drive is to master what is painful or confusing, restoring a sense of control and mastery; the second drive is to avoid painful emotions, thereby eluding attempts to engage in therapeutic work.

When young children are driven by a desire to master their stressors, their primary approach is to tackle their difficulties head-on. These children make efforts to seek understanding about their situations, and they seek out opportunities to overcome feelings of confusion, helplessness, or despair. "Mastery is, most of all, a physical experience: the feeling of being in charge, calm, and able to engage in focused efforts to accomplish goals" (van der Kolk, 2005, p. 408). Thus, when spurred on by a mastery drive, children may engage in dialogues about their concerns or may utilize play activities to symbolize what is most important to them.

For example, a young boy who had been physically and sexually as-

saulted came into my office, found a scary monster doll, and used the monster to attack a child doll viciously. The boy then found a superhero doll twice the size of the scary monster doll, and used the superhero to scare and chase away the monster. This boy, who was resistant to speaking about his frightening experience, thus exposed himself symbolically to what he feared (in the form of the scary monster), attacked the child doll in play (identification with his own vulnerability and helplessness), and then found the superhero (police, parent, and/or wizard figure) to chase away the danger. In doing so, he began to acknowledge his sense of vulnerability and fear, and at the same time drew upon resources (the possibility of protection) to help him combat the stressor. His ability to do this in symbolic play afforded him control over the sequence of behavior and the outcome, which inevitably allowed him to feel more immediately empowered. Of course, play behavior such as this is best followed up by coaching with parents and caretakers, so that efforts are made in a child's environment to allow or provide continued experiences with mastery and control.

The second instinctual drive in children who experience abuse is to avoid or suppress what is painful. Children can do this in a variety of ways: They can refuse to think about or talk about the abuse; they can avoid all stimuli reminiscent of the abuse; they can withdraw from interactions with others; and they can refuse to use play materials that remind them of people or things connected with the abuse. Such children may have developed "frozen" reactions that need to be stimulated.

Many young abused children simply state, "When I think about that [the abuse], it makes me feel bad, so I don't think [or talk] about it." This makes perfect sense to me: If there is pain associated with specific thoughts, avoidance of those thoughts (and feelings) is self-protective. However, problems can arise if children develop rigid patterns of avoidance. In these cases, suppression is occurring without any processing of difficult or painful emotions or thoughts. Although suppression (consciously choosing to store such emotions or thoughts in memory) can provide immediate relief for children who have been hurt, it requires sustained efforts to maintain, and will not allow children the understanding and mastery they require to achieve closure, focus on the present, and restore normative functioning. When older children tell me that they don't want to think about the abuse, or want to forget it, I emphasize my agreement with that goal and advise them that the best way to put painful memories in the past is first to acknowledge and understand them. I caution them that trying to avoid painful memories by pushing them away can create a "pressure cooker" effect that allows these memories (and their associated thoughts, feelings, and sensations) to remain powerful. Specifically, memories that are suppressed without any processing can

later "explode" unexpectedly like a pressure cooker without its regulator, renewing children's feelings of helplessness and vulnerability (in response to the timing and intensity of the unwanted memories).

It is best to avoid pressuring children into talking about abuse when they don't feel ready to do so. If they feel externally pressured, their responses will either be measured and superficial (intended to appease) or angry and resistant (intended to keep others at a distance, and perhaps increasing their wishes for avoidance). When children seem to shut down or actively resist any discussion or processing of painful memories, they will literally be unable to integrate ideas that can be of true help, but may be able to memorize or repeat statements without true meaning or understanding. I believe that children deserve an opportunity to achieve mastery at their own therapeutic pace. Although it is important not to collude with full denial and avoidance, it is equally important to allow children ample room to unfold their stories (verbally or nonverbally) at their own speed and through various types of communication (behavior, play, or verbal and nonverbal language).

Children may utilize other methods besides overt avoidance to suppress the memory of a traumatic event. My very best friend and her two children were in a serious car accident several years ago. The older child was thrown from the car and sustained severe physical injury, while the younger child escaped the accident with barely a scratch. I remember talking with the younger child soon afterward, and he repeated "the story" of the accident in a detailed, energized, rapid way. He did this for weeks on end. However, his affect decreased when he told the story, and he appeared unconnected to the factual events—as if he was telling a story from a film he had watched, or as if it had happened to someone else, not himself or his family. It took a very long while for this child to integrate the experience. That is, he slowly developed the capacity to recall the event when he wanted; to organize the sequence and develop a narration; to feel his feelings at the time he was describing events; to express his emotions as well as his actions; and, finally, not to be overwhelmed by what he felt while thinking about or verbalizing events of the accident. His rapid, repetitive, energized, literal descriptions (which lasted for almost 3 weeks after the accident) was a different way of avoiding what had overwhelmed him, as well as an obstacle to his integration and acceptance of the accident. During this period, his memories of the accident remained disorganized and compartmentalized (i.e., feelings were separate from visual details), in order to protect him from feelings of helplessness and survival guilt.

Yet another example of avoidance was provided by 10-year-old Hayden, who had been sexually abused by a trusted male adult (a youth

minister) and had never found it possible to tell anyone. At the same time, due to his age and stage of development, he would spend countless days and nights thinking about the abuse. He blamed himself for not fighting back, for not running away, for not telling his parents, for getting erections when he was fondled, and for touching himself in the dark of his room. He began repeating the abusive behavior with his 4-year-old brother, Jaime. He would plan times to isolate Jaime; he would masturbate him; he would stick his finger in his anus; and he would tell Jaime not to tell, "or else." Jaime told his mother after the second occurrence. Hayden then denied doing it, hit his brother in front of his mother, and had a "meltdown," retreating into his room for hours behind a locked door.

The parents discussed the situation, noted Hayden's recent moodiness and self-isolation, and decided to bring him to therapy for an assessment. Hayden held to his story that his brother was lying, and that what Jaime had said was "gross!" Noting his resistance, I gave him time and space. Eventually, when Hayden made a self-portrait, he included weapons "because bad guys are everywhere." This led to his disclosure about a bad guy named Scott who used to be in his church group. Hayden was unable to tolerate the anxiety and confusion generated by Scott's abusive behavior in the context of a special relationship and a religious setting. He felt that he himself was doing something wrong, and he suppressed his thoughts and feelings as well as he could. However, unable to process these stressful thoughts and feelings, and lacking the ability to protect himself or rely on his external supports (his parents), Hayden began to act out what he could not withstand. Hayden had not consciously chosen to repeat the abusive behavior with his brother, and much later into treatment, he had an extraordinary flash of insight: "I was trying to tell somebody what was going on when I hurt Jaime." He added, "I didn't mean to hurt him or make him feel bad." Later still, he made a heartfelt apology to Jaime, spontaneously thanking him for telling their parents about his abuse. Hayden's situation demonstrates several psychological constructs: suppression, repetition compulsion, and communication through behavior or acting out what cannot be spoken. Difficult thoughts and emotions can therefore be consciously suppressed by older children; however, since those thoughts and emotions have not been understood or worked through, they tend to come forward behaviorally, seeking expression through actions rather than words.

The two drives and defenses of mastery and avoidance can appear separately or together, and can often appear alternately during or between therapy sessions. There are also several variables that can influence which drive becomes a more or less significant mode of functioning. Be-

cause children may enter therapy with a primary drive (toward mastery or avoidance), I find it necessary to accommodate my approach to them, rather than the other way around. So in answer to the question "What kind of child therapist are you?" or "What kind of child therapy works best with this population?" my response is that I adjust my approach to each child client. In some ways, this is much more challenging than approaching all children in a similar fashion or assuming that specific client responses will be either absent or present.

THE INTERFACE OF EXPRESSIVE AND COGNITIVE-BEHAVIORAL THERAPIES

Expressive Therapies

The assumption underlying verbal therapy is often stated as "Talking to someone makes you feel better." I've always found this statement somewhat presumptuous, because talking about problems can sometimes make clients feel worse, more confused, more restless—in essence, more agitated. Talking can also make a problem seem more real, more compelling, and more serious than before, precisely because it is put into words and spoken to another. In addition, there are some troublesome cross-cultural issues about "speaking." Most importantly, people from certain cultures can feel more uncomfortable once they reveal a secret concern (especially regarding family members). After disclosure, they may feel disloyal for mentioning the problem, or they may have to negotiate how to understand the listener's reactions to what is said. A more general concern is that at times, people of all cultures may experience a sense of loss and control when they reveal secrets or discuss private worries and concerns. They may feel tricked, overexposed, resentful, and frightened, as if they've lost control of something indescribable. They may also experience a sense of generic loss or grief once their private thoughts are shared with others.

Of course, talking can also be a great relief, particularly if clients believe that the world will crumble around them if they verbalize something and discover that they are still standing after making their secrets known. Some children feel empowered by speaking, begin to modulate their vocal tones and pitches, and seem to experience a sense of liberation through speaking; at times, they may raise their voices and endow them with more emotion.

At its most basic, verbal communication is the externalization of a problem in words. The ability to use verbal communication is predicated on chronological age, brain development, linguistic abilities, and encour-

agement either to speak or to "hold your tongue." Cultural differences in parenting may contribute to children's utilization of a primary communication style; that is, parents may either encourage or discourage speaking about personal subjects. Children's temperament and personality traits also determine their primary communication styles. I recently worked with a young child who was encouraged (almost pressured) to speak more both at home and at school, and yet she resisted this primary mode of communication, opting instead for expressive and nonverbal communication. This might change, depending on age, confidence, and future experiences.

Expressive communication is much broader than language; it is the infant's primary mode of contact with the world. Infants and toddlers communicate much sooner than language is available to them. Sign language is ample and valuable. Verbal language is a much more complex form of communication, since it assumes that the speaker and the listener are attributing the same meanings to words, and that the listener is catching all the contradictory nuances or assertions provided by nonverbal communication, tone and pitch, and idiosyncratic use of language.

As a child and family therapist, I learned early on that I needed to enlarge my repertoire of communication and ways of making contact if I was going to be able to work with young children. Expressive therapies allow for broad or narrow, simple or complex, conscious or unconscious, processed or unprocessed externalizations—giving us a glimpse of what's on a child's mind on any given hour of any given day.

In work with children, it is useful to stay within the metaphors or symbols that they generate themselves, without making efforts to move into more reality-based interpretations immediately. For example, I asked an 8-year-old boy to "draw a picture of yourself." He drew a tree, a big rock, and a little squirrel behind the rock (he put the squirrel's tail coming out of the side of the rock and then noted, "The squirrel is behind the rock"). There were many possible ways to approach this child after this drawing. Notice how the following questions or statements might elicit different responses in the child:

"Why is the squirrel hiding behind the rock?" (Demands an answer.)

"That squirrel must be feeling very scared." (Suggests an emotion the child might not feel ready to acknowledge.)

"Oh, I can see by your drawing that you're feeling really uncomfortable and shy about being here." (Tells the child how he feels, which might offer him a reason to contradict, defend, or feel exposed and uncomfortable.)

All of the interpretations guiding these questions and statements would be fair to make, and some clinicians would do so with ease. However, these different interpretations, when shared directly with the child, would move away from the metaphor that the child had provided and abruptly force him to address the clinician's responses. Interpretations may also cause children to withdraw. In the example above, it was likely that the rock was serving as a barrier, which the child probably required at this moment. Commenting directly might make the child feel the need to protect himself even more strongly.

Notice how the following statements or questions would be likely to elicit a different response (it helps if you put yourself in the shoes of the 8-year-old boy who made the drawing):

"What's it like for the squirrel to be behind the rock?"
"How does the squirrel like it that the tree is so nearby?"
"What does the squirrel do with his free time?"
"How long has that rock been in front of the squirrel?"
"When the squirrel peeks out from behind the rock, what does he see?"

Notice that these are not "why" questions, and that they are formulated to express interest in the metaphor created by the child. Although the interpretation of the drawing might be surmised, it would be more fruitful to pursue the expansion of the metaphor to learn more about the child. The worst-case scenario would be losing this child who was available for emotional contact because a clinician felt the need to rush or push ahead without special attention to what the child's metaphors suggested about him.

In work with children, the value of expressive therapies (play, art, and sand therapies in particular) cannot be overemphasized. Although most professionals who work with children have some toys and art materials in their rooms, not all professionals have sought specialized training in order to use expressive therapies to their full potential. The literature on this field has flourished in recent years (see Chapter Four) and is described more completely throughout this book. Simply put, however, expressive therapies allow and encourage opportunities that greatly enhance therapeutic perspectives, especially in work with abused and neglected children. The bottom line is that through expressive therapies (symbols, play, art images, storytelling, dance, music), children can find alternative forms of depicting and regulating their inner worlds. In play therapy (toys, miniatures), children can identify with objects or symbols, project their thoughts and feelings onto those symbols or objects, and then process (or work through) difficult, painful, or conflictual material in

a protected and safe way that respects defensive mechanisms and pacing. Sometimes the working through is on the level of unconscious material, using symbols or metaphors. At other times, the working through is cognitive and rational.

Cognitive-Behavioral Therapy (CBT)

Since the early 1990s, the practice of CBT specifically with sexually abused children has been well studied, and the available research strongly suggests that this approach is efficient and valuable for children who are old enough and have sufficient verbal abilities to make use of it (see Chapter Five). The CBT approach targets potential behavioral problems that can develop as a result of cognitive errors' negative effects on emotions—that is, problems involving both behavioral and affective dysregulation. CBT seems to offer relief and guidance to young children who experience sexual abuse and may be confounded by experiences that overwhelm their abilities to perceive the situation accurately, negotiate their emotions, or access appropriate behavioral responses. Both expressive and CBT approaches can be useful to abused children, and clinicians need to decide which (or what combination) of these to use with children on a case-by-case basis, with specific consideration to their individual needs.

Finally, I reiterate that developing a treatment plan is always a unique challenge and will vary greatly, depending on each child's unique personality, temperament, interests, talents, gender, culture, age, and developmental stage. Deciding how to use the different approaches becomes the "art" of therapy. Each child presents a new "canvas," and the content and process of therapy will take form as the therapeutic relationship builds and mutual understanding deepens.

OTHER ISSUES INFORMING TREATMENT

Focus on Resiliency

As my earlier comments on the better prognosis for children with positive personality traits and other internal resources indicate, I have been consistently impressed by the role of resiliency (Klimes-Dougan & Kendziora, 2000) and innate human motivators (such as survival instinct) that can protect children from the effects of otherwise powerful stressors. Traumatized individuals are not inevitably doomed to succumb to the stressors in their lives; with varying degrees of therapeutic support (depending on their circumstances and needs), they can manage, endure, overcome, or triumph over these stressors. Rigid therapy agendas or clinical biases, however, can limit or overwhelm child clients. The most realistic clinical

approach is therefore one that includes a structured, purposeful, and comprehensive assessment (discussed in Chapter Two).

The Role of Neurobiology

Recent findings consistently emphasize the need for an understanding of neurobiology in any attempt to determine the impact of severe and/or chronic stressors on young children. Specifically, early stress in the form of childhood maltreatment "produces a cascade of neurobiological events that have the potential to cause enduring changes in brain development" (Teicher et al., 2003, p. 33). More and more data reveal without a doubt that maltreatment in childhood can have enduring negative effects on a child's brain development and functioning (Teicher, 2002). According to Stien and Kendall (2004), "Experiences in childhood influence brain growth through a process called gene transcription, which affects how genes are activated" (p. 6). The specific effects of chronic stress on the brain that have been identified thus far include diminished development of the left hemisphere in general and the left hippocampus in particular; decreased right–left cortical integration; an increased incidence of electroencephalographic (EEG) abnormalities; and diminished size of the corpus callosum. The reduction in the corpus callosum seems most important, because of this structure's critical role in connecting the two hemispheres of the brain (Teichert, 2004).

Teicher et al. (2003), reviewing these stress-induced effects, state:

> We postulate . . . instead that these alterations in neurodevelopment represent an adaptive, alternative developmental pathway. Stress-induced developmental modifications, triggered by the nature of experience during critical, sensitive stages, are designed to allow the individual to adapt to high levels of life-long stress or deprivation that may be signaled by early stressful experience. If an individual is born into a malevolent and stress-filled world, the manifestations of early stressful experience on later development may serve an adaptive purpose, enabling the individual to mobilize intense fight–flight responses or react aggressively to challenge. On the other hand, these alterations are not optimal for survival and reproductive success in a more benign environment. (p. 39)

Van der Kolk emphasizes that "many problems of traumatized children can be understood as efforts to minimize objective threat and to regulate their emotional distress" (2005, p. 403). He goes on to state that when children have been living in unpredictable environments, they "may experience difficulty developing object constancy and inner representations of their own inner world or surroundings. . . . Without internal

maps to guide them, they act instead of plan and show their wishes in their behaviors, rather than discussing what they want" (p. 405).

Since typical brain development occurs in a gradual and progressive manner, abuse in the early years of life can interrupt, alter, or overtax internal resources in many different ways, causing many short- and long-term challenges for children. This important topic, still in preliminary stages of understanding, has been eloquently articulated in an influential text by Daniel Siegel, *The Developing Mind* (1999). Siegel synthesizes concepts and findings from the disciplines of attachment theory, child development, communication, complex systems, emotion, evolution, information processing, memory, narrative, and neurobiology. In doing so, he gives us access to profound interacting variables that allows us a deeper understanding of the potential impact of child abuse on mind, spirit, and body, as well as implications for treatments that might enhance and strengthen the injured person.

However, in spite of what appear to be very gloomy data, current science is becoming more optimistic about the plasticity of the brain and the possibility of some recovery from trauma-induced brain damage. This optimism has stemmed from further thinking about potential reconditioning of brain development—and, in particular, from the beginnings of research on ways to stimulate growth in areas of the brain that might be underdeveloped after exposure to severe stressors. According to Stien and Kendall (2004), "positive experiences (e.g., nurturing from a parent) can activate genes, creating new proteins that can, for example, strengthen healthy neural connections and promote learning" (p. 6).

Brain science can be quite useful in suggesting aspects of treatment with the potential to be helpful in the process of neurobiological restoration. Stien and Kendall (2004), for example, have proposed an "interactive treatment model" based on the principle that environment can change (and rechange) brain circuitry. They state: "On the one hand, how our brain functions determines how we perceive, think, and behave. On the other hand, by changing our thinking and behavior, the organization and functioning of our brain can be retooled" (Stien & Kendall, 2004, p. 12). The interactive treatment model and other implications of brain science for clinical work are explored further in Chapter Three.

The Necessity of Contextual/Systemic Work

No child exists in a vacuum. Childhood is a time for identity formation, establishment of interactional patterns, and maturation in many dimensions. Most importantly, it is a time when children grow and develop through exposure to parental nurturing, protection, guidance, and the formation of adaptive mechanisms and expanded coping repertoires.

Children's relationships to adult caretakers, peers, and educators are pivotal to their continued growth. When we work with children, we need to understand the social and family contexts in which they operate, so that we can assist in whatever ways are necessary. I am committed to working in the best interests of children, which means that I am constantly striving to ensure that children are situated in nurturing, empathic, and safe environments. Many of our child clients are moving through a foster care system in which their placements are not always stable. Although the intent of foster care is to provide children with necessary temporary caretaking in a protective home, many children experience years of multiple placements with varying degrees of stability, contentment, or conflict. In addition, many decisions that are made for children may be perceived by them as nonsensical, confusing, or punitive. Children who are removed from their families may not understand the separation easily or well. They may remain worried about their families, and they may experience significant feelings of loss. Their caretakers may or may not have profound understanding and superb skills to work with their foster children; indeed, in some unfortunate cases, caretakers and children may be uniquely mismatched.

When parents are separated from their children, they may or may not receive helpful services, and thus family reunification may be challenging at best. Parents may feel more or less comfortable providing safe and stable care. In some cases, children are re-placed in homes where virtually no changes have occurred and where little progress has been made in building healthier, more functional parenting approaches. Reunification services must be provided with a clear understanding that disruptions in attachment, transitions, losses, environmental changes, and the initiation and termination of caretaking relationships between children and parental figures will inevitably produce stressors for children and their families.

Clinicians must remain involved with the inherent contextual and systemic issues that abused children bring into treatment. This often means that when working with this population, clinicians must broaden their roles beyond the boundaries of traditional mental healthcare (see Chapter Six).

Monitoring Countertransference and Pursuing Proactive Self-Care

Working with abused and traumatized children and their parents can evoke strong countertransferential responses in mental health professionals. These may become apparent through somatic problems (headaches, nightmares); emotional distress (anxiety, fear, hyperarousal, or depression); social problems (withdrawal from normative social experiences,

withdrawal from social contact); difficulties with interpersonal or intimate relationships; sudden inability or unwillingness to continue working (burnout, stressful work relationships); and a host of other concerns (eating disorders, intrusive flashbacks, emotionality): This problem, known as "vicarious traumatization," is now widely understood and discussed (Osofsky, 2004a; Nader, 1994; McCann & Pearlman, 1990). It is considered an important topic for supervision and consultation among mental health professionals in general, and among those clinicians who are routinely exposed to traumatic material in particular.

Clearly, it is critical for clinicians to be constantly alert for the possible presence of countertransference and subsequent effects. When such effects are detected, it is imperative to design action plans designed to prevent long-term negative impact and maximize full involvement with the provision of mental health services. Immediate crisis intervention is required when therapists operate in polar states of hyperarousal or numbness; feel unable to be emotionally present, engaged, objective, and interested in clients' problems; or suffer from personal emotional debilitation. It is therefore necessary to monitor and address personal issues routinely and thoroughly, in order to maximize professional integrity and client safety. In full recognition of the curative powers of play therapy, a colleague and I (Gil & Rubin, 2005) have recently suggested utilizing play therapy techniques to assist clinicians in processing countertransferential responses.

In summary, my message in this chapter (and in this book as a whole) is that working with abused children requires an integrated approach that is flexible and responsive to clients' unique needs. Mental health professionals who pursue this approach must remain conversant with a variety of theories and approaches (both evidence-based and clinically sound), and have the ability to shift perspectives in order to maximize therapy opportunities for their clients. Working with child maltreatment of any type is inimitably challenging, but superbly rewarding. Suspending assumptions, expectations, and firm agendas, as well as monitoring countertransference and maintaining adequate self-care, will result in greater opportunities to be of help to families and children in crisis.