CHAPTER 1

Introduction

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> After 4 months of therapy, 6-year-old Miranda came into my office with a Ping-Pong paddle in her hand, announcing, "Here, this is for you!" "Oh, what is it?" I asked, and she said, "It's a paddle." When I then inquired what the paddle was for, she said, "For you to hit me," in a matter-of-fact way. "Why would I want to hit you?" I responded with shock, and she quite earnestly replied, "You like me, don't you?"

This vignette illustrates one of the most insidious lessons of child abuse: People who love you hurt you. The unfortunate reality is that children who are abused and maltreated can develop expectations of the world as unsafe and grow to believe that interpersonal relationships carry inherent dangers that will surface predictably. As Lieberman and van Horn (2008) so poignantly explain, "The child's normative tendency to seek protection from the parent is violated by the stark realization that the parent is the source of danger. The child is torn between approach and avoidance, between seeking out comfort and fighting off danger"(p. 23).

Little 6-year-old Miranda had already learned at her young age to expect some kind of injury at the very point that she felt nurtured. For her, love or affection went hand in hand with physical injury. Once she was assured of someone's positive regard for her, her entire body began to cue her that something bad would happen. Miranda, however, was a

very resilient and smart young girl, a girl who worked hard to establish some kind of predictability in her world: As she began to sense anticipatory anxiety about the inevitable danger she faced at the hands of someone who liked her, she took charge of when and how the injury would happen. Thus she brought me the weapon with which I would hit her and requested that I get it over with so we could proceed with our relationship and she could calm her body. What a sad and amazing behavior for a child who had been beaten by her mother since she was 3 years of age (and likely before) and had learned that once her mother beat her, she would hold her in her arms and rock her, sometimes for hours.

This was not the extent of how Miranda had learned to take care of herself. She also developed a unique ability to scan her mother's face for signs of tension, pinpointing how close her mother was to becoming explosive. Miranda was infinitely talented in finding a way of provoking an incident that would elicit her mother's release of tension (an explosion) and create for her a shortcut to mother's repentant arms and the warmth of the comfort she seemed unable to generate at other times. Unfortunately, Miranda had quickly learned to both expect and elicit negative responses in order to reap the rewards of her mother's fleeting guilt.

I was eager to meet Maria Lourdes, a 4-year-old child who had been abused sexually by a confused, distressed, and young drug-addicted mother who prostituted herself for drug money. It is hard to understand how mothers can reach such depths of pain as to turn to their young children to get their own needs met. From what could be deciphered, the mother was confused about her sexuality, far gone into the world of drugs, and had recently taken her daughter from her father in order to extract more financial help from him to support her habit. She'd only had this child for about 1 full month, but during that time, the child witnessed sexual activity by her mother and her customers, was left alone to fend for herself for days without food, and was witness to her mother's severe beating by an unknown male, likely a drug supplier, angry at not being paid. From what this child was able to communicate verbally to police, her mommy was "gone now," and she repeatedly asked for her father.

When I first met with this child, she appeared healthy and full of curiosity. It appeared that she was very comfortable with her father, who came into the play therapy office with her so that she could see the room that he had described to her prior to coming to therapy.

Once the door was closed and her father had left, Maria Lourdes took off her underwear and sat across from me, spreading her legs so

that I could see her vagina. Few moments in my professional life have left me as stunned as I was with little Maria Lourdes. I had an immediate realization that I had to act. I took her underwear from the floor, handed it to her, and stated firmly and gently, "This is a place where you keep your underwear on and I keep my underwear on!" I repeated this statement only one other time, and the behavior ceased; however, it was a behavior I would never forget. Here again, this child had learned an interaction with her mother that she could neither forget nor understand. As a result, it's likely that she was conditioned to view private situations with adult women as situations that often included some sharing of sexual interactions. Once her father left the room and she was alone with me, she was clearly triggered to recreate an interaction that at this point she both expected and feared. As I later decoded the child's behavior, she was clearly asking "Is this what you want?" and "Will you do these sexual things to me as well?" The experience of being alone with me and hearing me say that we would "play" together in this room obviously moved us into perilous ground. I believe that Maria Lourdes, anxious at being left alone with a woman, was now taking action to decrease her anxiety and make the situation more predictable and more within her control.

To understand how children can construct these very complex ways of interacting with their abusive caretakers, and later others, it is important to underscore some of the important lessons that Miranda and Maria Lourdes demonstrated too well: Children are most attentive and receptive to their parents' interactions with them. In fact, as their parents exhibit tenderness, anger, or indifference, children are captive students to their very first lessons about the world. The very broad and prolific field of bonding and attachment has been quite definitive on this topic. In fact, Bowlby was the first to define and develop the concept of "internal working models," emphasizing the concept that an "individual developing within himself one or more working models representing principal features of the world about him and of himself as an agent in it . . . such working models determine his expectations and forecasts and provide him with tools for constructing plans of action" (Bowlby, 1989, p. 140). When discussing parental behaviors such as neglect, rejection, threats of not loving a child, and a range of threats to abandon the child, Bowlby further states that these experiences "can lead a child, an adolescent or an adult to live in constant anxiety lest he lose his attachment figure and, as a result, to have a low threshold for manifesting attachment behavior . . . anxious attachment" (Bowlby, 1989, p. 163).

Children can have multiple responses to inconsistent caretaking: Some develop anger toward parents that turns to unexpressed resentment; others withhold expectations in order to avoid disappointment; still others may constantly try to alter their own behaviors in the hopes of finally eliciting the love and affection they crave. Left unresolved, these attachment difficulties, which begin in the context of a parent–child relationship, can become the substantive root of many relational difficulties throughout the child's development (see Shaw, Chapter 2, this volume). In what appear to be random or erratic ways, children with attachment issues may reject those they most want, may elicit negative responses from those they desire to feel cared for, and may be unable to sustain an investment in another in any kind of successful manner. In fact, research suggests that interpersonal trauma "is especially destructive to children's attachment relationships" and that "maltreated children have higher rates of insecure and disorganized attachment and are less able to rely on their caregivers for emotional and behavioral regulation, have relationship problems associated with dysregulations in children's stress hormone systems, and the fact that they cannot turn to their parent for help (because the source of protection is simultaneously the agent of terror) creates what Main and Hesse (1990) call an 'unsolvable dilemma' " (Lieberman & van Horn, 2008, p. 48).

Recent work in the area of neurobiology expands our understanding of attachment to include the physiological changes that take place internally as attachment behaviors are activated and exhibited through emotions, verbal declarations, and behaviors. Badenoch (2008), describing early attachment processes and citing the work of Cozolino (2006), Goleman (2006), and Siegel (1999), states that "our brains are genetically hard-wired for attachment, seeking the interpersonal sustenance needed to structure our brains for personal well-being and healthy relationships" (p. 52). She goes on to state that "the sympathetic nervous system dominates over the parasympathetic during this early period of life, fueling the infant's efforts to reach and connect" (p. 52). Schore (2003) and Sigel (1999) note "that the way our parents approach us shapes the structure of our developing brain" (as cited in Badenoch, 2008, p. 53).

Daniel Siegel's (1999) book *The Developing Mind* catapulted the focus on the relational aspect of the brain to new heights, and others have followed suit. Bruce D. Perry has made a great contribution to our understanding of the value of recognizing brain science and has postulated a structured and sequential approach to therapy called the neurosequential model of therapy (Perry & Szalavitz, 2007). He strongly

emphasizes early attachment relationships and the importance of activating attachment impulses in children who sustain early injuries through interpersonal trauma with attachment figures.

CHILDREN AND TRAUMA: PLAY OR ACT IT OUT

In Chapter 4 I discuss posttraumatic play by children in greater detail. Suffice it to say that children who undergo traumatic injuries at the hands of parents and trusted caretakers often have powerful challenges ahead. The fact is that young children, as recipients of abuse, are ill equipped to process psychological stress on their own. In fact, the younger they are, the more global the impairment can be, given their inability to protect themselves from physical and emotional injuries. So somewhere, somehow, some issues must be repaired in order for the child to meet his or her full potential. Lenore Terr (1991) stated that traumatized children "play it out or act it out," and this observation rings true from my years of clinical work with children. The child who can perceive and identify his or her distress, worries, and problems and who can then seek help, communicate clearly, and find a positive resolution on his or her own, is a rare youngster indeed. More common is the youngster who is emotionally and behaviorally dysregulated or the one who is utilizing play to depict stories replete with pain, catastrophic outcomes, or palpable anxiety and who represents danger and death and pessimism. Thus, our clinical responses have to be ample enough to recognize that children may not approach problems in only one way and that they may elicit the very negative attention that they seek to repel. The child victim of interpersonal trauma is highly compromised in his or her ability to seek and receive help (see Dobson & Perry, Chapter 3, this volume). At the very core of the problem is that child victims of interpersonal complex trauma often long for and fear the very same thing: an intimate and safe relationship with a trusted and caring individual. Clinicians are thus advised to be patient, hopeful, and above all, prepared to engage fully with children who may push them away, or worse, children who find or create obstacles at every turn.

TRAUMAS NEED RESOLUTION

This is an exciting and promising time to be a clinician working with traumatized children. The amount of information that is immediately

available is unprecedented. Emerging data are available to us in record fashion, and practitioners appear persistent, dedicated, and consistent in their efforts to tackle important issues regarding the mental health needs of traumatized children.

Several evidence-based approaches now guide and shape our responses. The Child Study Group of the National Center for Child Traumatic Stress (NCCTS) has reached a consensus about specific areas for mental health treatment, further increasing our chances of assisting our child clients to resolve their trauma-based problems, restore their developmental trajectory, and develop positive outlooks for the future.

It has been incredibly helpful to the emerging field of trauma studies to have several groups in positions of national leadership. Great strides have been made with the organizational efforts, direction, and focused attention of the National Child Traumatic Stress Network (NCTSN), the International Society for the Study of Traumatic Stress Studies (ISTSS), and the formidable group of professionals of Division 56 of the American Psychological Association. Substantive efforts have been made to increase the refinement of diagnostic categories related to trauma and children (van der Kolk, 2005; van der Kolk & Courtois, 2005) as well as increase the quality of mental health services provided to abused and traumatized children across the nation. Many research studies have yielded valuable data, and we are now in the best possible position to continue to augment the efforts already undertaken.

At the same time, as the research studies, treatment models, and mental health options and possibilities continue to emerge, clinicians will likely always be well served by expanding and building upon any single theory and approach. Common sense dictates that children benefit the most from multimodal approaches that can provide the flexibility to help them with their unique developmental, gender-related, and cultural needs, as well as those with cognitive and linguistic differences. I believe it is imperative that we continue to embrace the information produced by countless professionals on the front line of service provision and to inform ourselves of the many evidence-based programs that show great potential for helping our child clients—for example, trauma-focused cognitive-behavioral therapy (Cohen, Mannarino, & Deblinger, 2006); child–parent psychotherapy (van Horn & Lieberman, 2008), cognitive-behavioral interventions for traumatized students (Kataoka et al., 2003), parent–child interaction therapy (Eyberg, 1988), and child–parent relationship therapy (Landreth & Bratton, 2006), to name a few. In addition, several treatment models have surfaced in the last decade that contribute greatly to our state-of-the-art knowledge

about service delivery to this population; see, for example, the Chadwick Center's pathways assessment-based trauma model (*www.chadwickcenter.org*), Lanktree's integrative treatment of complex trauma and self-trauma (*clanktree@memorialcare.org*), Perry's neurosequential model of therapeutics (*www.childtraumaacademy.org*), and Cincinnati Children's Medical Center's integrated model for treatment of early abuse (*www.cincinnatichildrens.org*; call 513-558-9007 to receive the manual).

The goal of this book is to suggest that some children might be receptive to a play therapy context in which they can design and implement their own treatment direction and strategy. As the title suggests, this is a book about interpersonal complex trauma and one way that children can implement a reparative strategy. Needless to say, not all young children have the capacity or drive to engage in this play. It is something that clinicians may sometimes underestimate, overlook, or distract children away from, and definitely something that deserves to be explored, encouraged, and perhaps at times tolerated by those who are not trained in child or play therapy and who may feel more comfortable taking a more active, directive, or predictable route.

My impression has always been that the conclusions that children arrive at on their own are probably equal to, or surpass, the conclusions that are provided to them by their therapists. Sometimes our insistence to provide children with ready conclusions is met with compliance and agreement, yet such a response does not mean that these children have made internal shifts in their understanding or that they can translate that understanding into positive change. I believe that the healing process is very personal and has a multitude of idiosyncratic factors unique to each person. Thus reparation, by definition, is multifaceted and best sought via multiple paths leading to the same agreed-upon outcome.

SUMMARY

Children who suffer traumatic abuse or neglect at the hands of trusted attachment figures must negotiate multiple needs in the course of their treatment. Because they cannot protect themselves from the substantial harm of interpersonal trauma, children are left to defend themselves in varied and creative ways. Traumatized children access amazingly defensive strategies that serve them well in the short run but may cause long-term difficulties and challenges. Other chapters talk more in depth about the impact of interpersonal trauma on the developing child (see Dobson & Perry, Chapter 3, this volume).

Healing from interpersonal trauma is a complex and idiosyncratic process that needs to stay open and flexible in order to accommodate intrinsically unique abilities related to developmental, cognitive, linguistic, gender, and cultural factors that can influence children's abilities to self-repair successfully. Although there is a consensus about the areas of treatment that must be explored when working with traumatized children, there continues to be animated discussion about the relative merits of integrating evidence-based approaches (Ford & Cloitre, 2009) with other clinically sound therapies that rely on craft knowledge, best-practice guidelines, promising tests, and a vast, informative literature. Several authors suggest that multimodal approaches might maximize our chances of reaching young children, who are, after all, limited in their ability to describe their ailments and seek assistance on their own.

This book honors children's reparative processes by emphatically valuing their own healing strategies. Clinical interventions that allow children opportunities to find their own way toward healing may prove to be extremely helpful and child-friendly.

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