

# **Finding Words For The Unspeakable: Repairing The Effects Of Trauma On Young Children And Their Parents**

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# What Does Speaking the Unspeakable Mean?

- Creating a safe space to address painful events that are **consciously remembered** and **acknowledged as real** by the child, caregiver, and others
- Exploring possible causal connections between the painful event and presenting symptoms
- Being attuned to the child's and parent's rhythm as they explore these links

# Giving Meaning To Behavior

- Developmental framework
  - Lens of normative themes and competencies*
  - Lens of normative anxieties*
- Child's individual characteristics
- Environmental framework
  - Cultural childrearing values and practices*
  - Family relationships, attachment quality*
  - Adversity/trauma vs. Protective resources*

# Developmental Competencies

- Somatic and emotional regulation  
*Recovering from dysregulation*
- Secure attachments  
*Repairing mismatches*
- Trusting social relationships  
*Negotiating conflict*
- Exploration and learning  
*Managing frustration and fear*

*In the context of cultural childrearing values*

# Developmental Anxieties

- Fear of loss: Separation anxiety  
*(Onset: 6-8 months; Peak: 18 months)*
- Fear of losing love and approval  
*(Onset: 12 months; Peak: 24 months)*
- Fear of body damage  
*(Onset: 12 months)*
- Fear of internal badness: Social rejection anxiety  
*(Onset: 24 months; Peak: 36-48 months)*

# Normative Parental Functions

- Protection from danger
- Caregiving
- Socialization

Each of these functions is vulnerable to stress/ trauma  
Cultural differences in values, expectations, practices

*Support the parent in supporting the child*

# When Trauma Is A Factor

- Trauma is pervasive but usually overlooked in child and adult assessment and diagnosis
- Clinical “don’t ask, don’t tell” is **not** best practice but remains the norm and is rationalized as waiting until “child is ready”
- Trauma-focused treatment is not treatment “as usual”
- Speaking the unspeakable builds reality testing, coping skills, and executive function

# What Is Trauma?



# Key Features of Trauma

A traumatic event is defined by

- Exposure to actual or threatened death, serious injury, or sexual violence (DSM 5)
- Unpredictability, Horror, Helplessness that overwhelm the capacity to cope (Freud)
- Perception of what is traumatic is shaped by competencies/resources

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The National Child  
Traumatic Stress Network

# Trauma In Evolutionary Context

- *“Thinking Fast and Slow”*

(Kahneman, 2011)

Two modes of thinking when we look at a stimulus:

**System I** operates automatically and quickly, with little or no effort and no sense of voluntary control: Limbic system, automatic shortcuts

**System II** allocates attention to effortful mental activities, with subjective experiences of agency, choice, and concentration: Painstaking processing: Prefrontal cortex

# Trauma As Fast, Indelible Learning

- Threatening images are processed much faster, even outside consciousness: An angry face “pops out” of a crowd of happy faces, but the reverse is not true
- We give priority to bad news, even in symbolic form: “war, crime” attract faster attention than happy words (“love, peace”)
- Trauma reminders trigger physiological and emotional reactions: “You shall remember this to survive next time it happens”
- Trauma lives on in the body: Automatic reactions

# Risk As A Continuum From Stress To Trauma

Normative,  
Developmentally  
Appropriate Stress

Emotionally  
Costly Stress

Traumatic Stress



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# Frequent Traumatic Stressors In Childhood

- Exposure to violence
  - Child Abuse
  - Domestic Violence
  - Community Violence
- Accidents
  - Car crashes
  - Near drownings
  - Dog bites
  - Burns

# Prevalence of Trauma Exposure: Help Seeking Sample (Participants)

- Children aged 3-6
- Predominantly ethnic minority (31.8% Black, 43.5% Hispanic/Latino), low income, urban
- Families seeking mental health, developmental screening services
  - Social, emotional, and behavioral problems (42.9%)
  - Parent support and education (23.4%)
  - Developmental issues and concerns (14.3%)
  - Exposure to violence and abuse (13%)

(Crusto et al., 2010)

# Prevalence of Trauma Exposure: Help Seeking Sample (Findings: Trauma Exposure)

- **On average, children experienced 4.9 traumatic and stressful life events**
- **Over 48% experienced 5+ traumatic and stressful life events**
- **39% had symptoms of Posttraumatic Stress Disorder**

## Witnessing violence

- Domestic violence - heard or seen family assaulting each other: 42%
- Community violence – physical assault between nonfamily members: 27%

## Separation from important people

- Been separated from a caregiver: 41%
- Death of someone close: 15%
- Severe injury or illness of someone close 15%
- Someone close to child attempted suicide: 6%

## Direct abuse and/or neglect

- Physical aggression - been physically assaulted or beaten: 18%
- Been without food, water, shelter: 11%
- Forced to see or do something sexual: 6%

Crusto et al., 2010

# Trauma As Paradigm Of Ghosts In The Nursery

- Shattering of developmental expectation of protection from the attachment figure
- The protector becomes the source of danger
- “Unresolvable fear”: Nowhere to turn for help
- Contradictory feelings toward each parent

(Pynoos, 1993; Main & Hesse, 1990; Lieberman & Van Horn, 1998)

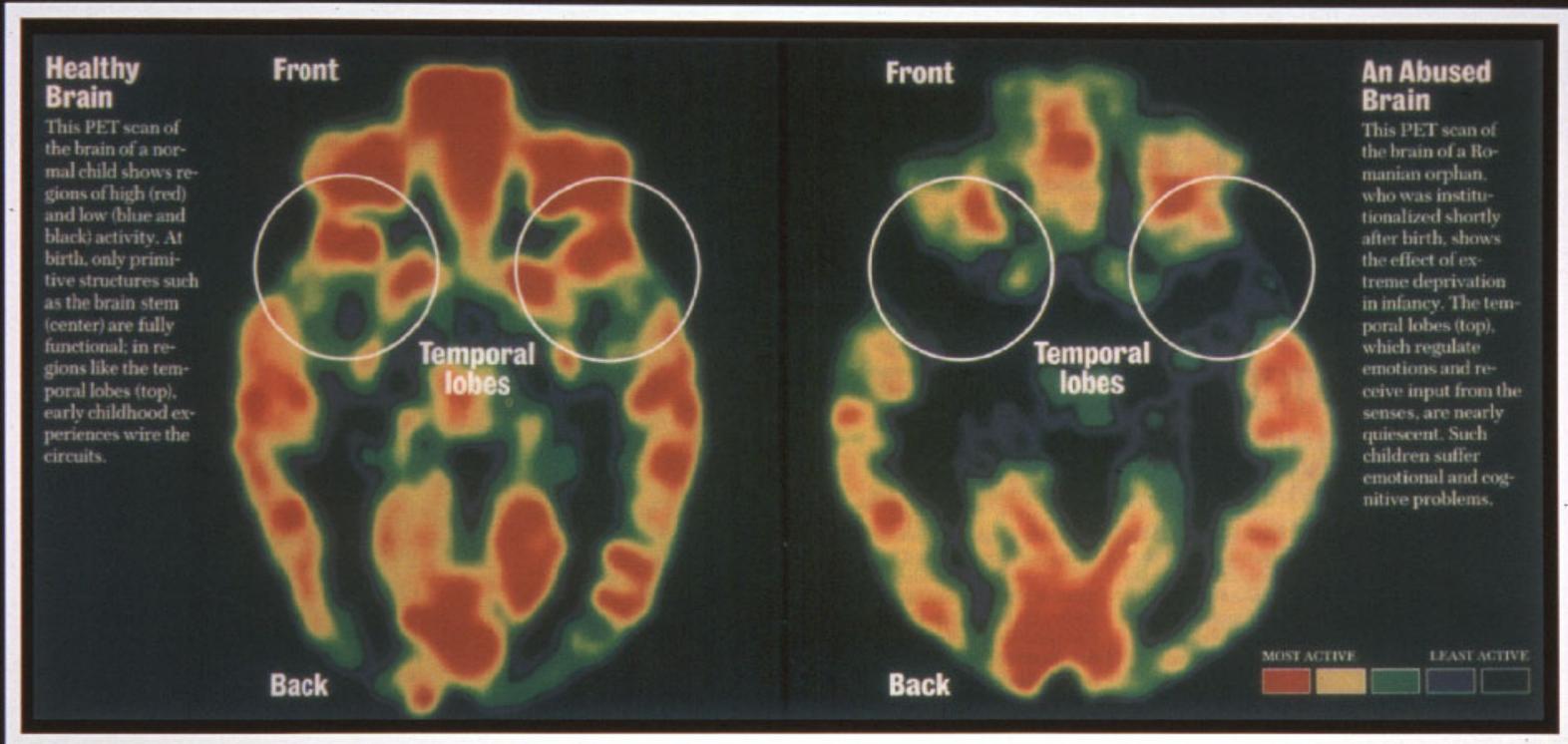
# Changes In Parent-Child Relationship After Trauma

- Impaired affect regulation
- New negative attributions
  - Changes to mental representations
  - Traumatic expectations
- Parent and child may become traumatic reminders for one another

# Do Young Children Remember?

- Implicit versus verbal memory
- After acquiring language, children describe pre-verbal experiences
- Children may misunderstand events that they remember
- Memory is not static

# The Body Remembers



**CDC**  
CENTERS FOR DISEASE CONTROL  
AND PREVENTION

(As cited by Felitti & Anda, 2003; Source CDC)

# Neurobiological Effects Of Early Childhood Trauma

- **Structural Effects**: Larger lateral ventricles; smaller intracranial volume (De Bellis, Keshavan, et al., 1999)
- **Chemical effects**: Dysregulation of stress hormones (De Bellis, Chrousos, et al., 1994; Hart, Gunnar, & Cicchetti, 1996; Kroupina et al., 1997; Tarullo & Gunnar, 2006)
- **Neuropsychological effects**: Higher neurological sensitivity to angry visual and auditory stimuli (Pollak, Cicchetti, Klorman, & Brumaghim, 1997; Shackman, Shackman, & Pollak, 2007)
- **Chromosomal Effects**: Telomere erosion; shorter telomere length (O'Donovan et al., 2011; Shalev et al., 2012)

# Cognitive Effects Of Early Childhood Trauma

- Controlling for genetic factors, 5 year old twins exposed to domestic violence (DV) showed an 8-point loss in IQ
- DV-exposed preschoolers scored significantly lower than non-exposed peers matched on a range of variables
- DV-exposed preschoolers show decreased performance on memory tasks

(Koenen et al., 2003; Ybarra et al., 2007; Jouriles et al., 2008)

# Socioemotional/Behavioral Effects Of Early Childhood Trauma

- Preschoolers exposed to violence have more relationship problems with peers and teachers: negative affect, aggression, inappropriate situational responses
- Preschoolers with trauma history had more oppositional behavior and separation anxiety, internalizing and externalizing problems
- Early physical abuse is more predictive of behavior problems 9 years later than physical abuse after age 5

(Litrownik et al., 2003; Scheeringa et al., 2003; Graham-Berman & Levendosky, 1998; Yates et al., 2003; Appleyard et al., 2005)

# Traumatic Stress In Infants And Young Children

- Re-experiencing trauma (flashbacks, nightmares)
- Numbing (social withdrawal, play constriction)
- Increased arousal (attention problems, hypervigilance)
- New Symptoms
  - Aggression
  - Sexualized behavior
  - New fears
  - Developmental Regression



# Trauma Treatment As Slow, Focused New Learning

If we want children and parents to learn something else . . . .

- We need to help them experience something else
- Over and over, so they can count on reliable change and learn to trust it
- Unlearning the expectation of danger needs to be reality-based, not based on wishful thinking

# Making A Difference

“If nothing changes, nothing changes”

(Graffiti seen in Santa Cruz, CA)

“What will change when a system becomes trauma-informed?”

...Everything.

(Epstein et al., Trauma Transformed, 2014)

# Post-Trauma Growth Happens

- The world is a dangerous place and trauma exposure is an ever-present risk for humans
- Suffering can stimulate a search for meaning that may lead to compassion for others and emotional growth
- Some of the greatest spiritual, artistic, and scientific achievements resulted from this search

# Children Need To Be Understood In The Context Of Their Relationships



# Trauma-Informed Practice

- A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including **children, caregivers, and service providers**.
- Programs and agencies within such a system infuse and sustain **trauma awareness, knowledge, and skills** into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.

<http://www.nctsn.org/resources/topics/creating-traumainformed-systems>

# Relationships Are The Vehicle For Trauma Recovery

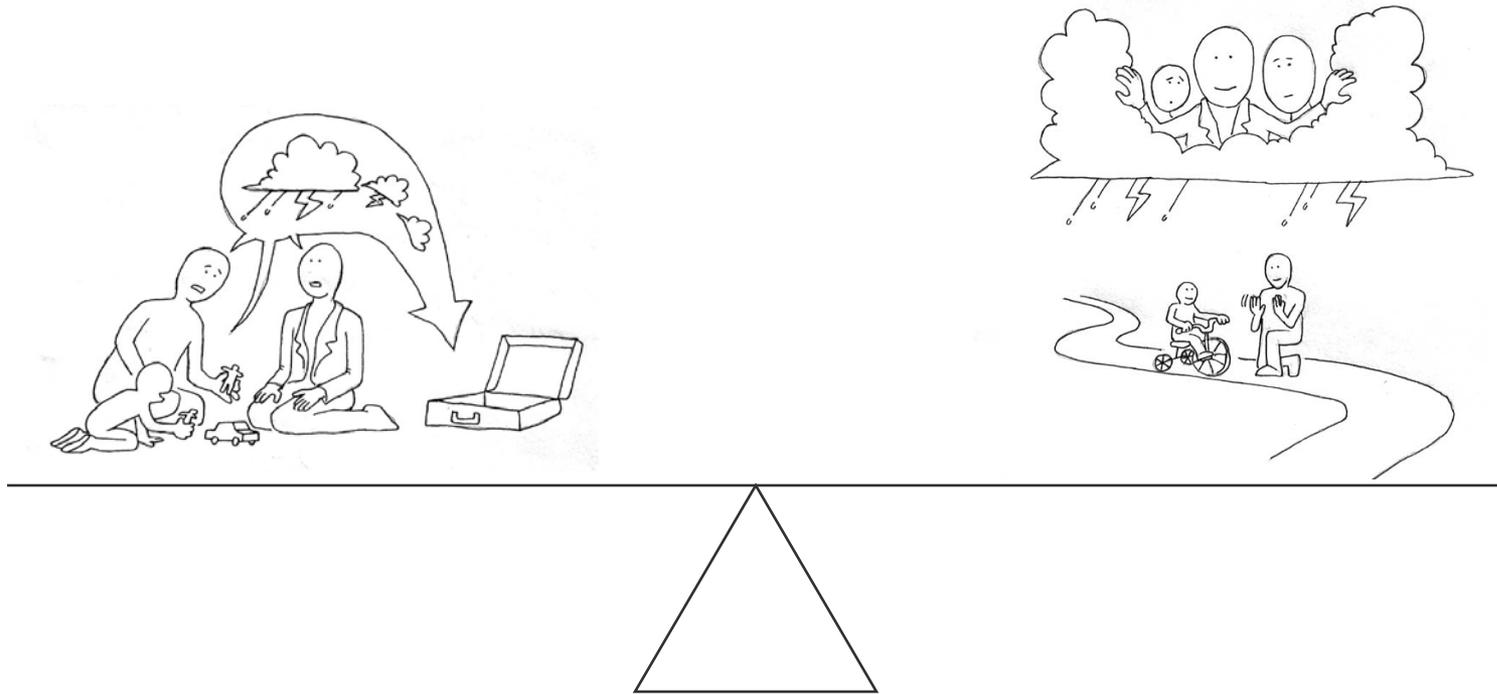
Key trauma-related relationship-based tasks

- Safety
- Individual physiological regulation
- Dyadic affect regulation
- Co-creating manageable meaning for painful events
- Acknowledging the child's memories
- Identifying, accepting, containing difficult feelings
- Offering opportunities for new learning
- Creating pleasurable experiences

# Child-Parent Psychotherapy Trauma-Related Goals

- Safety: Realistic responses to threat
- Promoting developmental competencies
- Giving expression to the “unspeakable”
- Differentiation between reliving and remembering
- Normalization of the traumatic response
- Placing the traumatic experience in perspective

# Balancing Focus on Trauma and Loss With Continuity Of Daily Living And Other Therapeutic Goals



# Pillars Of A Therapeutic Attitude

- Notice feelings in the moment
  - Dare to name the traumatic experience
  - Find connections between experiences
  - Remember the suffering under the rage
  - Seek out the benevolence in the conflict
  - Offer kindness
  - Encourage hope
- (Lieberman, 2010)

# Child-Parent Psychotherapy: Theoretical Integrations

- Developmentally Informed
- Attachment focus
- Trauma-based
- Psychoanalytic theory
- Social Learning processes
- Cognitive–Behavioral strategies
- Culturally attuned

(Lieberman & Van Horn, 2005)

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# Therapeutic Strategies

- Foster mutual understanding:  
Translate the parent's and child's meanings
- Promote protectiveness, empathy, trust, pleasure:  
Find the positive, reframe the negative
- Show that love helps to tolerate ambivalence
- Instill hope: Give meaning to trauma
- Foster pleasure in daily pursuits

# Child-Parent Psychotherapy Intervention Modalities

1. Reflective developmental guidance
2. Modeling protective behaviors
3. Addressing traumatic reminders
4. Retrieving benevolent memories
5. Linking the present with the past
6. Emotional support
7. Attention to reality: Concrete assistance, case management, crisis intervention

# Getting To Know Each Other: Assessment As Cornerstone of Treatment

- Who are we working with?
- What are the parents' goals?
- What are the therapist's priorities?
- What works for whom? What should we be doing?

# Assessment As Pre-Treatment

- Safety versus danger in family life
- Parents' emotional stability
- Parental reliability as reporters
- Parental perception of child
- Parental responsiveness to therapist's trial interventions
- Parental self-absorption vs. child focus
- Child developmental milestones and strengths
- Child severity/chronicity of symptoms
- Parent-child relationship
- Balance of risk and protective factors

# What Did We Learn?

## Preparing A Treatment Plan

- Who are we working with?
- What are the parents' goals?
- What are the therapist's priorities?
- What are the institutional expectations/constraints?
- What works for whom: Parent? Child?
- What is our case formulation?

# Putting It All Together: Components Of A Case Formulation

- Risk and protective factors now and in the past
  - In the family's cultural group
  - In the environment
  - In the parent
  - In the child
- Developmental considerations: Parent and child
- Psychodynamic considerations: Internalization
  - Ghosts and angels in the nursery
  - Parent negative attributions to child
  - Child quality of attachment to parent
- Choosing therapeutic targets and clinical strategies

# Using A Trauma Lens In Case Formulation

- Identify possible triggers to trauma stress responses
- Monitor intrusive imagery and sensory experiences
- Remember that triggers operate outside consciousness and may be external or internal
- Reactions may be associated with secondary stresses
- Parent and child may be traumatic reminders to each other

# The Feedback Session: Co-Creating A Treatment Plan

- Ask before we tell: What was the parent's experience of the assessment?
- Build on strengths: Did the parent learn something new? About self? About child?
- Describe Formulation Triangle for Parent and Child: Linking Events, Responses/Symptoms, Treatment
- Assess parental responsiveness to the triangle
- Co-create what to tell the child about the treatment

# The Feedback Session

## Engaging The Parent As A Partner

- Does the parent buy into the formulation triangle?
  - What is acceptable to the parent, what is not?
- Among multiple stressors and trauma, choose the most relevant to the presenting problems
- Explain the role of play as vehicle: "Freedom of Play"
- Create a common ground for what can be addressed
- Anticipate and strategize about possible dilemmas

# First CPP Session Guidelines

## Explaining Treatment To The Child

- Address child and parent simultaneously
- Did (mom, dad) tell you what we will do together?
- Parents may agree to something in the feedback session and not be able to follow through
- Build on what the parent said and did about bringing the child to treatment
- Create a connection between what happened, how the child is responding, and the parent's wish to help the child
- Highlight your role as someone who knows how to help children and parents feel better

# First CPP Session Guidelines

## Creating A Safe Space For Treatment

- Cultural considerations: What is permissible?
- Developmental considerations
  - How to speak with an infant
  - How to speak with a toddler
  - How to speak with a preschooler
- Choosing toys: Not too many
  - Toys that evoke the trauma
  - Toys that promote nurturing themes
  - Toys that can be used interactively

# Explaining Treatment To The Child

## Protective Steps:

Highlight when parent tried to help/created safety

## Hope:

Things can change for the better

## Experience:

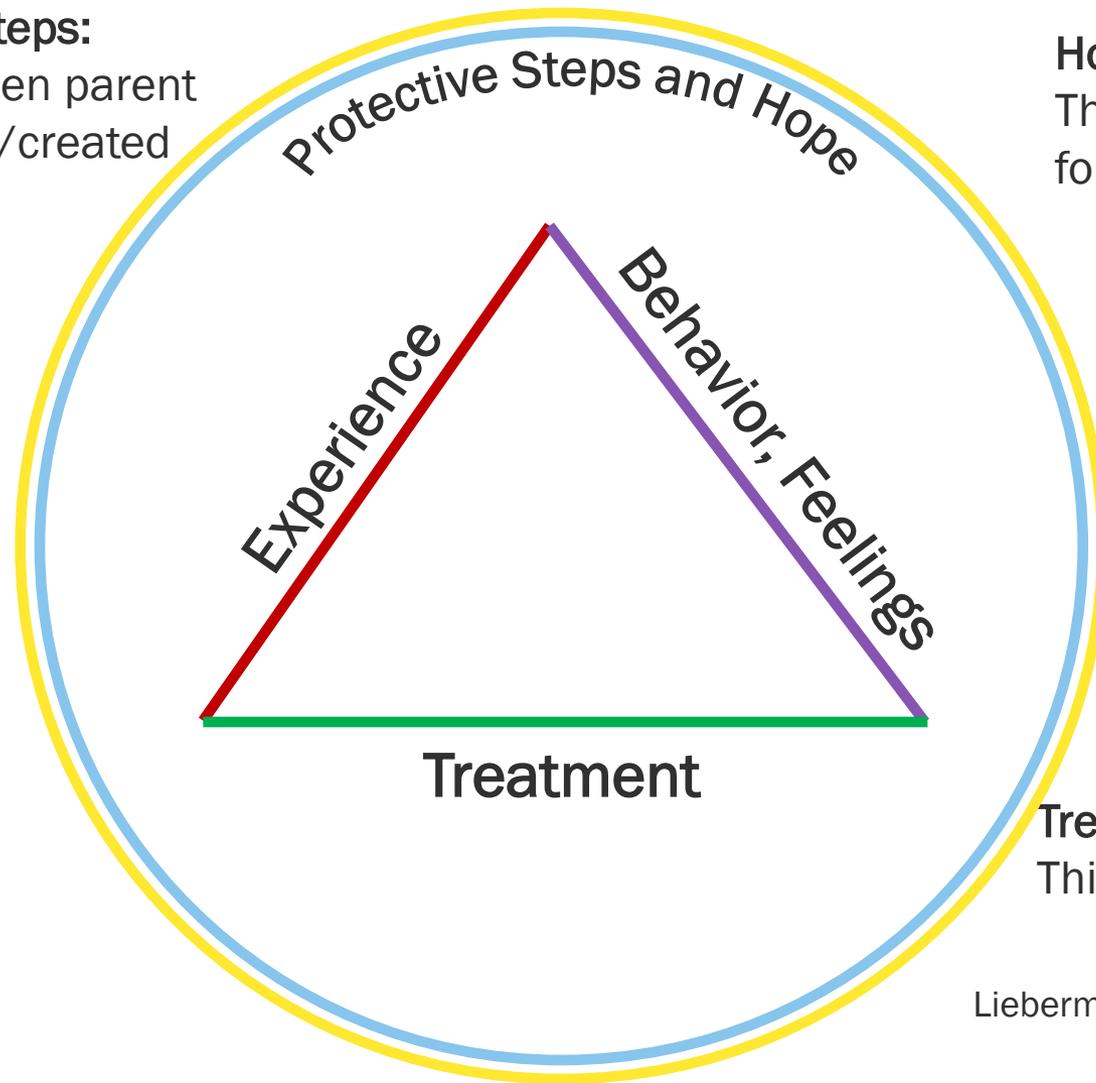
--You saw...  
--You heard..

## Behavior, Feelings:

--And now you...

## Treatment:

This is a place where...



# First CPP Session

## Some Things To Keep In Mind

- Make sure the triangle is presented, but respect the child's response to it
- Children need time to process
  - Defenses serve a valuable function
  - Therapeutic setting must convey acceptance
- Tailor presentation to child's and parent's levels
- Our job is to articulate the unspeakable and then become the child's and parent's partners as they respond to it in their own style
- Timing is everything: Avoid premature comments
- Commit to ending the session on a hopeful note

# Therapeutic Strategies

- Translate the parent's and child's meanings for one another to foster mutual understanding
- Reframe meanings to promote protectiveness, empathy, trust, and pleasure
- Help parent and child use love to tolerate ambivalence

# What Is A Trauma Narrative?

- Premise: Having our pain validated is healing
- Telling what happened takes many forms
  - Somatic re-experiencing
  - Behavioral re-enactment
  - Symbolic behavior
  - Symbolic play
  - Verbalization
- Observer/Listener's tolerance of unbound feeling helps towards eventual modulation

# Who Knows What Happened? Facilitating A Trauma Narrative

- Parent as informer, observer, re-enacter
  - Parental role in the traumatic event
  - Parental tolerance of child's enactment
  - Parental capacity to help the child
- Child as informer, observer, re-enacter
  - Developmental stage: language and play
  - "Acting out is a form of remembering"
- There are things we will never know and should not presume to know

# Trauma Narrative In Early Childhood: Developmental Considerations

- Memory is not a photograph
- Multiple narratives of the same event
- Traumatic events can merge with each other
- Developmental anxieties color the narrative:
  - Loss, losing love, body damage, being bad:
  - “I made it happen”
- Give space to play and fantasy
- Protection narrative to counterbalance trauma

# The Parent's Role: Shared Trauma Narratives

- Assessment process enables clinician to elicit parental report of trauma(s)
  - to self
  - to child
- Parent's clarity and coherence as narrator
- Parental reflective capacity for self and child
- Parental tolerance of child's trauma narrative
- Parental experience of the traumatic event

# Following The Child's Rhythm

- Children are often readier than the adult to create a narrative
- “Knowing what we’re not supposed to know, feeling what we’re not supposed to feel”
- Parental capacity to witness
- Clinician’s split loyalties between parent and child

# Dilemmas In Understanding What The Trauma Narrative Tells Us

- What is included?
- What is missing?
- What is contradictory?
- Reality, fantasy, distortion, fear?

# How Mutative Are Trauma Narratives?

- Group findings versus individual differences
- Approximation towards trauma narrative
- Respecting defenses versus collusion with avoidance
- The real dangers of telling versus the urge to be known

# Tolerating Ambiguity

- Trauma Narrative
  - terminable and interminable...
  - knowable and unknowable..
  - evolving
  - fragmented
  - imperfect
  - creating some kind of meaning
  - never an end in itself

# The Dangers Of Caring

- Working with traumatized parents and children is stressful:
  - Hopelessness, anger, rescue fantasies
- Burnout and vicarious traumatization are real
- Self-care is essential to be effective

# Obstacles To Effectiveness

- Insufficient knowledge
- Losing perspective
- Emotional over-involvement
- Too many service providers:
  - Fragmentation of relationships
- Lack of agency support
- Conflicting inter-system priorities
- Over-riding financial considerations

# PRACTICE WHAT YOU TEACH

- Take care of yourself
- Cultivate time out
- Protect your private life
- Seek out supervision or consultation
- Build support systems at work

# TAKE HEART!

- Small changes matter
- Mistakes can be repaired
- You don't need to be a therapist to be therapeutic
- Define yourself as part of a therapeutic community