Understanding and responding early to childhood trauma

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Summary: This presentation will describe psychoanalytically-informed efforts to deepen and apply our understanding the phenomena of trauma to the development of successful intervention strategies and treatment approaches that can decrease the immediate suffering and long-term burdens on children who have been victims or witnesses of violence and other catastrophic events.

Paper

In her 1968 paper, "Indications and Contraindications for Child Analysis" Anna Freud discussed the dilemma that often confronts analysts when their assessment indicates that the damage to a child's development is "caused and maintained by active, ongoing influences lodged in the environment" (p. 115). She pointed out that in the face of toxic external factors "……every single aspect of the child's personality is affected adversely unless definite sources of supply and support are made available…" As such, Anna Freud pointed out that while the child victim is in need of therapeutic help, the type of help is not clearly indicated, "nor [is] the therapist's role in the process clearly circumscribed" (p. 115).

In addition to my clinical work in the consulting room or in my role as a teacher and supervisor, a major focus of my work as a psychoanalyst has been on understanding the impact of traumatic impact of "toxic external factors" in the lives of children. I

have also tried to learn about the types of therapeutic help that could decrease the long-term effects of traumatic experience on the unfolding development of the child's personality. The fact that the trauma of vast numbers of children and families overwhelmed by violence and other catastrophic events so often went/goes unrecognized and were rarely rarely seen in our consulting rooms or clinics led to the development of the psychoanalytically informed collaborations and treatment approaches that I will describe today.

Yale Center for Traumatic Stress and Recovery's (YCTSR) collaboration with law enforcement, child protective services, forensic child abuse evaluators, pediatric emergency department staff, domestic violence advocates and with state and federal agencies has led to our involvement with thousands of children and their families during the past three decades. The events that have initiated our contact have included: murders, murder-suicides, domestic violence, sexual assaults, physical abuse and neglect, suicides, motor vehicle accidents, as well as mass-casualty events such as school shootings (including in Newtown, CT and Uvalde, TX), terrorist attack of 9/11, and natural disasters. Our contact has ranged from acute responses to brief follow-up contact during the peri-traumatic period (meaning, the first 12 weeks after the recent traumatic event) to longer-term clinical engagement.

Anatomy of a nightmare

In order for us to get closer to children's experiences of traumatic events, consider for a moment the experience of a childhood memory of waking from a nightmare. Remember your heart racing, rapid breathing, sweating, and confused thinking—desperately trying to locate the boundaries of experience; trying to determine what is real of the terror/threat that has awoken us? In those post-nightmare moments, many of us automatically sought sources of safety and relief. Sometimes we looked for it in the presence of others and stood stricken, wordless in front of parents who may have asked solicitously about the bad

dream we must have had, before sending use back to bed. With few other words available, we may have repeated, mantra-like, their reminder: "it was only a dream" and returned to our rooms. For some there was no one to whom to turn. We did the best we could, turning lights on, staving off a return to sleep and the dreams where our terror resided. Vigilant to hopeful reminders of reality and the remaining uncertainty that perceived threats were really only in our minds, we did everything we could to change the channels, and disable the instant, involuntary replay of themes that evoked fear and dread. In spite of the highly individualized and varied nightmare scenarios, we all shared the underlying themes and versions of their terrifying effects.

As psychoanalysts we know a great deal about the psychic dangers and fears against which we all defend. our unconscious lives. Beyond the direct experience of the nightmare, we are regularly reminded in our clinical work—and in our own lives—of our most prominent and sources of danger and fear that reside in our unconscious, inner worlds: (1) loss of life and the lives of those we love and upon whom we depend; (2) losing the love of others and the love of ourselves; (3) damage to our bodies and impairment of functioning; (4) losing control of impulses, affects, and integrative thought; and, (5) and, losing the external structure, predictability and order that provides the basis for anticipating, planning and responding to the new challenges.

As we know all-to-well, these broad set of dangers that fuel our nightmares, also lurk in the background of our waking lives. While our efforts often come with high costs, our experience of signal anxiety alert, prepare, and enable us to take protective, defensive action. And, in the aftermath of the nightmare, fear and arousal are diminished as reality reasserts itself and sleep can once again provide the opportunity for multiple narratives that afford pleasurable alternatives to dreaded aspects of our imagination.

When, however, when the underlying themes of our nightmares are unexpectedly played out in real life, our ability to quickly reclaim the distinction between inner and outer worlds and drifting back to sleep is simply, and tragically not an option. Unlike the nightmare experience, the traumatic situation is one

in which the most powerful of our unconscious fears converge with their sudden realization in events over which we have no control and from which there is no escape.

Definition of trauma and phases of trauma

We define the traumatic situation as an injury precipitated by exposure to an overwhelming, unanticipated danger that leads to the immediate experience of loss of control, helplessness and terror; the absence of signal anxiety and the immobilization of usual methods for decreasing or, defending against intense arousal associated with danger (fight or flight responses); and, neuro-physiological dysregulation that compromises somatic, affective, cognitive and behavioral responses to stimuli. Following exposure to traumatizing events, children's reactions can manifest/occur in three phases: (1) the acute phase, from within moments up to several days; (2) peri-traumatic phase, up to 12 weeks; and (3) longer-term phase beyond 12 weeks following a traumatic experience when chronic PTSD and related disorders emerge, reflecting chronic adaptations to failures of recovery that can disrupt and derail a child's optimal developmental trajectory.

In children, the immediate or acute disruptions are reflected in symptoms in the following areas: a) somatic (e.g., increased heart-rate, changes in respiration); b) affective (e.g., blunted, distraught/chaotic); c) cognitive (e.g., self-blame, failures in executive and integrative functioning); and d) behavioral (e.g., withdrawal, agitated, aggressive interactions).

Peri-traumatic symptoms reflect more organized and persistent expression of traumatic dysregulation, and can be observed in a range of symptoms including: sleep disturbances (including increased nightmares); separation anxiety and clingy behavior; hyper-vigilance; somatic complaints; irritability and oppositional behavior; regression; impulsivity, distractibility and poor concentration; re-experiencing and re-enactment of the event in play and discussion; blunted emotions, numbing and social isolation; avoidance of activities and places; dissociation;

aggressive behavior; and school difficulties or risk-taking behaviors. Many children and adolescents who have demonstrated the traumatic impact of exposure to violent events recover and continue on what Anna Freud described as the "optimal path of development." However, for too many children, the latest experience of uncontrollable danger is all too familiar and too often negotiated without either internal, familial and environment resources to support and aid recovery.

When children fail to recover from acute and peri-traumatic reactions/symptoms, longer-term reactions reflect alterations of basic neural systems, as well as chronic symptomatic adaptations. These can severely alter the normal course of development in children and result in lifelong psychological, physiologic and social consequences. These can include: attachment/relationship problems; PTSD; anxiety disorder; mood disorders; substance abuse; anti-social behaviors; violent and/or abusive behaviors; chronic illness; and character disorders. These long-term outcomes not only exact an enormous toll that unresolved trauma takes on individuals, but secondarily on family members and the broadercommunity. aThese broader impacts are even more profound and critical when we consider the volume of children who are at risk for both short- and longer- term suffering as a result of their exposure to overwhelming violence and other catastrophic events.

Understanding childhood trauma symptoms

As with the nightmare, following the acute/immediate traumatic dysregulation of executive ego functions, physiologic systems of arousal, somatic and cognitive experience, the traumatized child seeks to protect himself, to undo the original experience of helplessness by assuming a vigilant stance toward the external world, externally "locating" the source of danger in an effort to develop strategies to avoid its repetition. With the aim of reversing the traumatic experience the child attempts to take control by reinstating signal anxiety and assigning threat to an

identifiable source. If danger can be externally located and anticipated, action can be taken to avoid being rendered passive, out of control and helpless once again. As we know, however, the symptoms of avoidance and bids for control bring their own heavy prices as children attempt to turn away from the arousal of the most basic of human fears. The challenge to regain a sense of personal control is exacerbated as original event-related experiences of traumatic loss of control are revisited when physiologic changes —particularly dysregulation of the nor-adrenergic system— make bodies more vulnerable to lower thresholds for startle, rapid changes in heart-rate, respiration and muscle tension. These somatic symptoms may be especially distressing when individuals are unable to consciously locate the traumatic reminders or triggers that gave rise to them.

Multiple factors including physical and emotional proximity to overwhelming danger; pre-existing developmental vulnerabilities; significant trauma history; level of distress of caregivers and continued disruptions of routines of daily life all contribute to the extent to which the traumatic impact of events is sustained. In addition, he two most powerful predictors of poor post-traumatic outcomes are, (1) the failure to recognize a child's post-traumatic distress and, (2) the absence of social/familial support.

While we may feel overwhelmed by the sheer number of children who are at such risk for failure of recovery from trauma, when we apply what we know about the phenomena of trauma and about the protective factors of early identification and social support, there is also reason for hope and action. However, in order to first identify and then better address the needs of traumatized children, as psychoanalytic clinicians, we at the YCTSR needed to move beyond our consulting rooms and to work with partners who regularly see and provide early identification for those children who are at greatest risk because of their exposure to violence and catastrophic. In New Haven, we first turned to a novel collaboration with professionals who continue to make house-calls 24/7—the police.

Child Development-Community Policing

The coordination of policing and mental health activities that began in New Haven, Connecticut in the early 1990's originated out of shared concern and frustration about the unmet needs of traumatized children and families. Police officials were particularly disturbed by the vast number of children encountered in police calls for service that never received any form of trauma-informed intervention or care. Learning from each other's professional perspectives and seeing children and families through the eyes of the other's professional activities, over time, led to the evolution of the Child Development Community Policing (CD-CP) which includes the following elements:

1) Training of all police officers in psychoanalytic principles of child development and human behavior; trauma-informed policing on-scene responses to violent and other catastrophic calls for service.
2) Training for all CD-CP clinicians in basics of police operations, responsibilities, structures and responses including patrol, securing scenes, investigation, probable cause and use of force.
3) On-call service operating 24/7, offering acute, on-call phone consultation and on-scene response and collaborative officer-advocate/clinician follow-up visits to victims and families following initial police calls for service.
4) Weekly case review conference with police, mental health and child protective service partners to plan case follow-up and disposition based on needs identified by the multidisciplinary team.

The collaboration, now in operation for 30 years, recognized that with appropriated cross-training, police and mental health partners can effectively identify children at-risk as a result of their exposure to traumatic events to which police regularly respond. Responding together, CD-CP partners are well positioned to initiate immediate and early interventions that can reduce acute and early suffering from traumatic dysregulation and, decrease poor longer-term outcomes associated with fail-

ures of recovery. Since its origins in 1991, the partnership between the Yale Center for Traumatic Stress and Recovery and the New Haven Department of Police Service, have jointly responded to over 15,000 children and their families locally. The Child Development-Community Policing program has been replicated and adapted in numerous communities across the United States and abroad and continues to provide training and technical assistance requested by communities seeking to replicate the CD-CP model.

When responding acutely, on-scene, the police-clinical team works together to re-establish order and psychological stabilization; assess and attend to basic needs of the victims including immediate safety; assess behavioral health status of family members and provide them with information about potential post-traumatic reactions, basic developmental phase-specific symptom reduction strategies as well as referral for follow-up clinical care. Consider the following case vignette.

Mike R.

Nine-year-old Mike witnessed the shooting death of an idolized teenage neighbor, John. The older boy had squarely beaten his opponent in a basketball game who then accused him of cheating. The two teenagers got into a shoving match that culminated in John's challenger pulling out a gun and shooting him twice in the chest. John died almost immediately. At their request, Mike and his mother were initially seen by our on-call clinician immediately after the police interview. In the acute phase of the intervention, the therapist invited the boy to draw pictures. Without any suggestion about the content, the boy immediately drew picture after picture in which the shooter and gun grew larger and larger while the boy and his teen-age friend shrank to mere dots on the page. In the weeks that followed, Mike had frequent nightmares; he was irritable at home and school, and engaged in increased physical fights with his younger brother and peers. Prior to the shooting Mike had done

fairly well in school and in spite of the fact that father had abandoned the family when the boy was three years old, mother described an unremarkable developmental history. Her only concern was that her son spent too much time away from home, often spending hours on his own or watching the older boys play basketball on the courts where the shooting had taken place.

During the course of the twice-weekly psychotherapy that continued for eight months after the shooting, Mike's drawings and accompanying narratives grew more elaborate. In them he revealed the central role that John had played in his inner life as a more proximal representation of a dimly remembered and highly idealized father —strong, competent and interested in him. Mike could increasingly describe how John's attention —letting him hang out at the basketball court and occasionally teaching him some shots— had been an important contrast to his mother's nagging and worries about his safety that made him feel like a baby. In this context, as Mike repeatedly returned to the moment that John was shot and his sense of disbelief and confusion that would then turn from grief and to rage and then to guilt. As he described the enduring image of watching John fall to the ground with an expression of surprise, Mike could now put into words what constituted the essence of his traumatic moment: the figure/representation of strength and competence with whom he so desperately identified could fall like a helpless baby and leave him. With the recognition of the link between the past and the present, associated with his longings for a father and friend who had now "abandoned" him, Mike and his therapist could begin to make sense of the irritability and fighting that served to re-establish power, express rage and defend against unwanted "babyish" feelings associated with longings for a father and friend who had abandoned him. Most important perhaps was Mike's ability to acknowledge that his "tough-guy" behavior reflected his driving wish to reverse his original experience of traumatization; for Mike, the convergence of internal and external dangers —of loss, bodily vulnerability and damage; crazy behavior and complete helplessness. His traumatic loss of control confirmed not only his own sense of "being a baby" but destroyed, again, his necessary idealization

of a powerful paternal/masculine figure with whom he could identify. Increasingly, Mike was alerted to those situations in which his sense of competence felt under attack —whether the joking of friends, teasing of a younger brother, or the concerns and expectations of his mother—, and gave rise to angry counter-attacks. His irritability and fighting diminished and eventually stopped as did the nightmares which captured his terror and robbed him of the safety of sleep. In addition, to individual sessions, the therapist met with Mike and his mother together. As they were able to identify problematic behaviors as "symptoms," and sources of battles/struggles, Mike could begin to experience a very different kind of support from his mother. In her shift from frustration, angry struggles and worry, Ms. R. could now point out to Mike when she thought he was having a tough time and to help remind him that fighting with others wouldn't make the upset about his older friend disappear or make him feel better about himself. In turn, Mike felt less "babied" by his mother while more able to tolerate his genuine need for her attention and support at a time when he was feeling so sad and distressed. While he could not control what he had happened to his friend, he could now take some pride in his greater ability to be in control of the symptoms that followed.

Parents/caregivers as mediators

Central to child psychoanalytic concepts is the notion that in each phase of development, a primary role of adult caregivers is to help children until they are able to rely on their own unfolding capacities to mediate and master internal and external experiences. As Mike's story illustrates, when the level of stimulation/demands outweigh a child's mediating capacities the risk for overstimulation and distress are greater as is the need for adult support and buffering. This role is especially crucial when children are forced to deal with overwhelming events and overstimulation that reaches traumatic proportions for which they have neither the cognitive nor psychological maturity necessary for processing.

The CD-CP partnership addressed the need for acute stabilization and early identification of children in need of clinic-based care and also provided us with regular opportunities to directly observe children and parents across all phases of traumatic reactions. These observations informed the development of our early, peri-traumatic treatment, The Child and Family Traumatic Stress Intervention (CFTSI) which capitalizes on the central role of parents as mediators on childrens' increased self-observing capacities as critical to achieving order and mastery in the face of traumatic dysregulation.

CFTSI

CFTSI is a 5-8 session psychoanalytically/developmentally-informed treatment model with demonstrated effectiveness in reducing traumatic stress symptoms and reducing or interrupting PTSD and related disorders, which was developed specifically for implementation with children, adolescents, and their caregivers during the early or peri-traumatic period trauma response, soon after a potentially traumatic event or the recent formal disclosure of physical or sexual abuse (such as in a forensic interview). CFTSI focuses first on establishing a shared frame of reference for both child and parent about the phenomena of trauma and post-traumatic symptoms; (2)increasing parents' appreciation those symptoms in the context of phases of development and the child's developmental history; (3) maximizing self-observing capacities in both child and parent; (4) enhancing communication between the child and caregiver about the child's trauma symptoms; and, (5) providing strategies to help children and families master trauma reactions. In addition, CFTSI improves screening and initial assessment of children impacted by traumatic stress, offers an opportunity to assess the child's needs, and seamlessly introduces longer-term treatment when indicated. Treatment applications of CFTSI for young children aged 3 to 6 years as well as for children recently placed in foster care have also been developed.

CFTSI is a manualized intervention that is accompanied by a standardized training protocol and is the only evidence-based treatment for the early phase of post-traumatic reactions. An early randomized controlled trial demonstrated that children who had received CFTSI as compared those to a protocolized approach to more traditional treatment approaches were 65% less likely to meet DSM IV full criteria for PTSD and 73% less likely to meet partial or full criteria for PTSD three months after completion of treatment. Numerous subsequent studies have replicated these findings and also consistently demonstrated significant increased child and parent/caregiver recognition of and communication about trauma symptoms. Most typically, children involved in these studies had extensive trauma histories prior to their referral for CFTSI. Additionally significant, parents/caregivers who participated in CFTSI also experienced clinically meaningful decrease in post-traumatic stress symptoms.

Children are most typically referred for CFTSI by the police, pediatric emergency room staff, child protective services, forensic child abuse forensic evaluators and health care providers—those who have the greatest amount of early contact with kids whose exposure to violence and other catastrophic events place them at greatest risk for post-traumatic distress.

Over 1500 mental health clinicians in the US and in Europe have been trained in CFTSI, many of whom are now contributing to an open trial of the model involving over 3500 cases.

In addition the development of the Child Development-Community Policing program and as a result of what we have learned over the years about the clinical phenomena and circumstances of childhood trauma, the Yale Center for Traumatic Stress and Recovery at the Child Study Center has developed a psychoanalytically/developmentally informed evidence-based, brief, early intervention, the Child and Family Traumatic Stress Intervention (CFTSI), that demonstrates effectiveness in preventing PTSD and related disorders in children who have been exposed to overwhelming, traumatic events, while also serving as an opportunity to determine which of these children may require longer-term psychotherapeutic treatment.

Summary

Central to the psychoanalytic process of therapeutic action is the task of closely observing phenomena, finding words and then exploring and finding meaning for what is seen. In the partnerships that we have developed with professionals outside of our traditional psychoanalytic clinical world, we have applied these same principles. We first learned about our partners' perspectives on the children they commonly see, found common language that could articulate shared observations and then translated our findings into new approaches that most closely address the range of challenges that confront traumatized children and families.

Similarly, the opportunity to more closely observe the details of the phenomena of acute and peri-traumatic experience of traumatic experience afforded by the Child Development-Community Policing partnership led to the development of a new, early intervention that can address the immediate suffering of traumatized children, help to ameliorate longer-term impact on development and more clearly identify those children in need of longer-term treatment. The Child and Family Traumatic Stress Intervention (CFTSI) reflects an integration of the growing body of knowledge about the phenomenology of childhood trauma from the fields of neurobiology and cognitive psychology with the wealth of psychoanalytic theory/knowledge about the complex interaction between internal and external worlds and the development trajectory of developing minds.

As psychoanalytic clinicians we are at our best when we adhere to our most fundamental traditions of observing closely and striving to see the world through the eyes/experience of others. Throughout our psychoanalytic history when we have shifted our place of focus beyond the consulting room, we have not only expanded our theories of development and human functioning of theory but have also extended the reach and impact of their application well beyond the small numbers those will ever enter our consulting room doors. Working in the range

of settings in which at-risk children are seen has provided psychoanalytically trained clinicians the opportunity to get close to unfolding, observable phenomena not otherwise seen. This opportunity has led to the development of new options for addressing some of the psychic and adaptive outcomes of overwhelming challenges to progressive, optimal development for the many children impacted by adversity/pressing social and public health issues. In the situation of violence exposure and trauma, the application of psychoanalytic principles has also offered institutions and professionals regularly called upon and challenged in their attempts to respond to affected children alternatives to the turning away/avoiding that so naturally occurs in the face of overwhelming situations of fear and helplessness. And, when we are successful in our applications of what we have learned together, the children about whom we share our greatest concerns no longer need to be alone in their suffering and the despair that so often follows a traumatic loss of control can be replaced by support, mastery, recovery and hope.

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