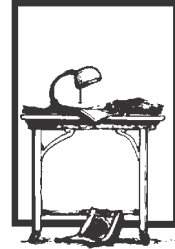

EDITORIAL



When Treatment Fails
with Traumatized Children . . . Why?

Childhood dissociation continues to be under-recognized and under-reported, regardless of the availability of many books on childhood dissociation (Silberg, 1996; Putnam, 1997; Shirar, 1996), peer review articles, child dissociative checklists (Armstrong, Putnam, Carlson, Libero, & Smith, 1997; Putnam, Helmers, & Trickett, 1993; Ruths, Silberg, Dell, & Jenkins, 2002; Stolbach, Silvern, Williams, & Reves, 1997), and published research on the impact of traumatic events on abused children and their memory system. Although there is discussion in the literature about the association of dissociation with chronic traumatization in childhood (e.g., Terr's (1991) Type II trauma and Herman's (1992) complex PTSD), sadly, many child therapists lack even a minimal understanding of the impact of trauma on a child's identity and development. There are, no doubt, multiple reasons for this lack of recognition and understanding and in this paper I will discuss some of those reasons and describe some common errors made by child thera-

pists in treating traumatized children (Waters, 2004). I will also discuss efforts made by The International Society for the Study of Dissociation to address these problems.

LACK OF UNDERSTANDING OF THE OVERALL IMPACT OF TRAUMA ON IDENTITY, PERCEPTIONS AND BEHAVIOR

Many professionals serving maltreated children often do not see “the big picture” of the long-term and far-reaching effects of chronic childhood trauma. Child therapists frequently do not understand that sudden changes in behavior and affect and contradictory perceptions of self and the world are the result of segmenting terrifying experiences and, sometimes oneself, to survive. Inattention, poor concentration, sudden destructive or aggressive behaviors, or rapid switching of moods characterized by anxiety, depression, or raging are often ascribed to other diagnoses, such as, attention deficit/hyperactivity disorder, oppositional/defiant disorder, conduct disorder, mood disorders, etc., which then becomes the focus of a different type of treatment. Thus, the treatment course is different than within a trauma focused paradigm, and too often the underlying causes for a child’s disruptive behavior are forgotten.

LACK OF A THOROUGH TRAUMA ASSESSMENT

It could be said that *some* professionals themselves have a type of “amnesia,” a predisposition or a disinclination to fully explore a child’s possible trauma history unless it is blatant, e.g., referral from protective service workers or court personnel resulting from an immediate disclosure. Many of the children who are referred to me, sometimes after years of treatment, have never been queried about traumatic events (e.g., sexual, physical and emotional abuse, witnessing interpersonal violence, chronic neglect, attachment losses, painful medical conditions, exposure to catastrophic events). Or, if they were questioned, the traumatic events in their lives were skimmed over or deemed inconsequential to current behavioral difficulties. Consequently, the symptomatology that an abused child displays is seen through different diagnostic lenses, which significantly affects the course of treatment.

***NOT UNDERSTANDING THE ENCODING OF EARLY
TRAUMA***

Frustrated, exhausted, and despondent adoptive parents of children with histories of early child abuse and repeated years of failed treatment have reported being told, “It doesn’t really affect him because he was too young to remember.” “Don’t cause anymore problems by bringing it up.” “If he doesn’t bring it up, it doesn’t bother him.” and “It’s best to forget it.” While the brain development that is critical to our conscious memory system does not become fully functional until around three years of age, research clearly indicates that early emotional/traumatic memories are encoded on a sensory level, in our unconscious memory systems, especially the amygdala, which is functional at birth (LeDoux, 1996). In my practice, many children have described sensory based—visual, auditory, tactile, and gustatory—traumatic memories. For example, I treated an adopted 10-year-old boy who came into foster care at 16 months old with gonorrhea of the mouth. Although he had no conscious recall of sexual abuse, he vividly recounted preverbal, visual memory of his biological father “sticking a toothpick down my throat,” feeling suffocating sensations, and accompanying rage toward his father. Professionals need to be aware of the possible connection between current idiopathic symptoms, such as, stomachaches, headaches, genital pain, difficulty in breathing, or somatic numbing to traumatic events.

***IGNORING THE SIGNIFICANCE
OF THE EARLY ATTACHMENT RELATIONSHIPS, ESPECIALLY
TO THEIR ABUSIVE BIOLOGICAL PARENTS***

Early relationships lay the foundation for future relationships. Abusive biological parents can have an insidious impact on the child’s sense of identity, trust in others, and ability to regulate affect (Schorer, 1994; Siegel, 1999). Unresolved attachment issues get replayed with other parental/adult figures throughout the child’s life. Even after being placed with safe and protective caregivers, frequently traumatized children relate through cyclical patterns of acceptance/closeness, avoidance/withdrawal, and anger/rage. However, a common mistake made by professionals is to focus primarily on the current relationship problems with behavior modification as the main treatment modality, without addressing the dissociated, unresolved connections to their biological parents. Instead, with careful intervention, the aware therapist can help the child see the connections between his responses to current caregivers and disquieted feelings from his past. Helping a child to process his pain, hurt, sadness, and grief is an

integral part of healing that will ultimately pave the way for the child to trust again, accept nurturance, and engage in reciprocal relationships.

***EXCLUSIVE FOCUS ON ALLEVIATION OF SYMPTOMS
AND FAILURE TO IDENTIFY THE TRIGGERS
OF DISTURBED BEHAVIORS AND AFFECT***

Too often, child therapists ignore the meaning of abused children's symptoms, their traumatic origins, and the triggers that cause escalating symptoms. Without such a focus, behavioral interventions generally have limited to no long term success. The child does not make the critical connection between behavior and unresolved traumatic incidents, and learns new coping mechanisms to override these triggers. While symptoms may be momentarily reduced or dissipated, they frequently reappear later or are displaced by other symptoms. For example, I treated an 8-year-old sexually abused girl who had obsessive thoughts of looking at male and female genitalia. She would replace these obsessive thoughts with finger tapping and counting when she would enter or leave a room to avoid the distressing thoughts. Much of these behaviors were rooted in shame and guilt related to engaging in sexual behaviors with age mates. Once a dissociated "shame state" was accessed and processed the guilt of her sexually acting out behavior and feelings associated to the sexual abuse by her father, the obsessive and compulsive behavior ceased (Waters, 1999).

MULTIPLE DIAGNOSES AND DERAILED TREATMENT

Traumatized children usually present a perplexing picture of a myriad of symptoms. They often have poor ability to concentrate, difficulty controlling impulsive behavior, and show frequent fluctuations in affect and self-states. As a result, sometimes even very young abused children have been diagnosed with Attention Deficit/Hyperactivity Disorder or Bipolar Disorder, diagnoses that reinforce the assumption that these are genetically driven conditions without etiological environmental factors. Consequently, medication and behavioral therapy are the primary treatment modalities. Furthermore, disturbing and escalating problems such as behavioral and sexual problems accompanied with cyclical affective states of anxiety, depression, and rage occur as the child ages. When these problems are viewed in isolation, rather than within an abuse con-

text or framework and a sequel to childhood trauma, the child will not receive assistance in disrupting this destructive cycle. In all likelihood treatment will fail; the child will continue to replay and react out past traumas, reinforcing the child's sense of failure, decreased self-esteem, and recrimination for non-compliance.

POLY-PHARMACY WITH MINIMAL EFFICACY

When trauma-related symptoms are ignored and children assumed to have strictly biological phenomena that can only be cured with medication, treatment often fails. While medications can often be a useful adjunct treatment that can dampen the arousal system and elevate mood, there are side effects that require careful monitoring. Physicians will often increase dosages and/or add new drugs because each new drug results in some minimal improvement in the traumatized child's behavior and affect. In addition, when caretakers feel overwhelmed, therapists feel frustrated, the child feels powerless, and relationships are stressed, the physician will continue to modify the prescriptions to deal with an increasingly desperate situation in the hope of calming the child's escalating symptoms, but with little avail and increased side effects.

EXCLUSIVE USE OF TALK/COGNITIVE BEHAVIORAL THERAPIES

Traumatic memories, encoded in the amygdala, are experienced on sensory and visceral levels (Van der Kolk, 1994). Of significance, research on traumatized individuals indicate that the Broca's area of the brain which regulates speech is deactivated under stress accounting for the "silent scream," described by survivors who experienced terror without accompanying words. Additionally, research indicates that the prefrontal cortex and hippocampus do not process traumatic material in the same way they do with non-traumatic material (Bremner, 1999). This results in a lack of conscious awareness and integration into the memory system. Consequently, children may not be able to verbalize memory of traumatic events.

In therapy sessions I have seen children spontaneously act-out of traumatic incidents using dolls or draw pictures to describe their abuse, in which there apparently were no conscious memories. For example,

an 8-year-old boy depicted fellatio with a male adolescent with anatomically similar dolls, but when I verbalized what he had demonstrated, he was not unconscious of what he portrayed. Of note, when children can symbolically project their unconscious or painful thoughts and feelings and spontaneously reenact traumatic incidents in art therapy or with dolls they are not likely to be triggered by direct questioning of such potent events.

The successful processing of traumatic material requires a multimodal approach. Modalities may include therapeutic techniques using art therapy such as drawings and clay, play therapy using puppets, a dollhouse and action figures, as well as, music, symbolic story-telling, role playing, and body-oriented techniques. The later technique particularly focuses on sensorimotor processing of traumatic material to effectively address somatoform and psychoform dissociation (Ogden & Nijenhuis, 2003).

Primary reliance upon using only verbal or cognitive therapy with severely traumatized children and adolescents who have expressive deficits due to early age of onset or the traumatization itself can be unrealistic and increase the propensity for the flight/fight stress response system to be activated. An integrative approach in which cognitive and behavioral processing is combined with the non-verbal therapeutic techniques can minimize avoidance, dissociation, and increased anxiety.

OVERALL LACK OF UNDERSTANDING OF DISSOCIATIVE PROCESSES OR STATES

In the severely traumatized child, dissociative symptoms and processes invariably play a significant role in the child's affect regulation, behavior, identity, and environmental perception. Unfortunately, it is rare for clinicians to use child dissociative checklists to determine the prevalence and degree of dissociative processes or symptoms. Moreover, assessment questions about internal voices, internal influences, abrupt and erratic changes in behavior and affect are often not explored and if they are, they tend to be misunderstood. If a child or adolescent does talk about internal voices, the voices are often assumed to be a manifestation of psychosis. If segmented and unconscious states, triggered feelings, thoughts, and memories are not recognized, understood, and considered in treatment, the efficacy of therapy will be seriously

compromised. This lack of validation will only reinforce a child's sense of identity confusion, failure, and hopelessness.

ISSD'S ROLE IN PROMOTING EFFECTIVE ASSESSMENT AND TREATMENT

What can the ISSD do to promote an understanding of the efficacy of this specialized treatment of severely traumatized children? First, a pilot project is soon to be launched of a Child version of the Dissociative Disorders Psychotherapy Training Program (DDPTP), which is a nine month program for training clinicians working with dissociative adults. Second, the development of a Child-DDPTP online course is in the planning stages, which will expand participation nationally and internationally. Third, the Child Adolescent Treatment Guidelines are now on the ISSD Web site and are being advertised at conferences, and publications. Fourth, there are more scheduled ISSD workshops on dissociation throughout the world—including presentations concerning dissociation in children, and the ISSD is collaborating more with other professional societies. Fifth, our Web site will soon have a child dissociation section for professionals and the public to access information about indicators of dissociation. Sixth, with the launching of the ISSD Capital Development Fundraiser, many initiatives are planned including educating care providers, medical and protective service personnel, and child placement agencies, and others by mailing educational materials about the symptoms that traumatized children exhibit.

Through the dedication, foresight, and creativity of past and current board members, our invigorating and expanding membership, and outreach through conferences, our journal, Web site and courses, ISSD is leading the way for professionals to better collaborate with each other to help and heal those who were hurt so badly in their early years. As your incoming president, I am pleased and proud to be a part of this exciting, groundbreaking effort to explore, understand, and educate about the impact of trauma on children and how professionals can help maltreated children find healthy expression and resolution.

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