

Therapeutic Protocol for Attachment, Trauma, and Loss

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Children who have been traumatized pose a special challenge in attachment work, as trauma impairs their response to their parents' attachment invitations. Some children have experienced specific traumatic events that numb and emotionally flood them, making them unable to respond to their parent figures. The main difficulty encountered when working with young, traumatized children with attachment issues, however, is that their traumatic responses are triggered by exposure to their caregivers, not just by traumatic events. Having and recognizing safe parents, with the abilities to calm, protect, and buffer children, is essential to the process of recovery from trauma. Unfortunately, these required caregivers paradoxically elicit conditioned emotional responses caused by experiences with the former caregivers who were traumatizing (Briere, 2002a.)

Children who are showing traumatic responses to parents, not simply to events, must have a detailed home and therapy plan. They may benefit from a de-sensitization to caregivers program at the beginning of treatment. This de-sensitization constitutes the beginning of attachment work for children who have traumatic responses to their caregivers. Begin the treatment plan with attachment work in cases of trauma that lack this conditioned traumatic response to the caregiver as well. The children in the latter category usually respond to the highly nurturing attachment exercises with less resistance.

Attachment work is not as simple as "Put a caramel in his mouth and rock him," which was the summary of attachment work by a naïve mental health worker. Attachment work is complicated and difficult; remember that, when parents attempt typical parenting tasks, children will access memories and fight, freeze, or dissociate as if their lives depend upon it.

As mentioned before, many of these traumatic memories are stored in implicit memory systems, rather than in the explicit memory systems. That being the case, children are not even aware of the learning that informs their reactions. Children can repeat, "I have a great parent and I love having him as a foster or adoptive parent." This belief is part of their explicit memory system. They believe it and they know this to be true. When they go through their normal day, however, their implicit memory system is triggered by the frequent need to depend upon and yield to this parent. They begin to react in a traumatized fashion as a result of the "other" belief system that, while subconscious, is fully operational. This "other" belief system, the implicit memory system, may result in actions such as the child elbowing or kneeling their approaching parent. Or, they may spit and arch their backs while sitting on their parent's lap. These children's traumatic memories were laid down in the earliest phases of childhood, and are not verbal or narrative. When questioned, "Why are you doing this?" the child will have no answer. Instead, they express anger, shame, and sometimes fear.

Usually, maltreated children have a combination of two types of traumatic issues. The first type will be their conditioned emotional responses to the caregiver, as described above. The second type will be a reaction to the actual traumatic events in their lives. Of course, there is an interplay between these two issues during trauma work. Be sure to explain these two types of traumas to adults.

Attachment helps children with basic regulation and safety, so forge ahead in forming some attachment with children in spite of the trauma history. Like the invasion of Normandy, we

begin to establish the beachhead of attachment so that children can experience some emotional relief. This gives them a place in which to retreat when they feel overwhelmed. It becomes the safe beginning in the process of emotional regulation.

It is on the lap of their parents, or sitting beside their parents, that children can first begin reporting what is happening within them. This gives them the first experience of actually talking about their feelings, without the intense and overwhelming sense of re-experiencing the trauma and being back within it. And, with the help of the safe person, kids begin to experience affective regulation. Someone, the parent, is there to help them breathe out and feel a little better. This begins their process of being able to talk about, draw, or role-play their feelings rather feeling like they are in the throes of them. While they may still be avoidant about their therapeutic work, they will begin to experience a fundamental change—that adults supply comfort and emotional and problem-solving resources. This experience encourages them to continue forward. It forms a template for seeking and receiving help when they feel overwhelmed.

Untreated grief and trauma constantly intrudes upon children's lives. It silently shapes everyday experiences. The children who have not worked on trauma maintain trauma-contaminated core beliefs that distort their developmental perspectives of themselves and others. They either do not develop, or they lose confidence in the protective function of adults or of rules governing other areas of their lives. Beginning therapy with attachment work reasserts the healthy developmental perspective. It shows children that they will not have to face life's challenges alone.

The disturbing beliefs and images caused by trauma can gain momentum, rather than recede, as the years pass. Researchers note a "sleeper effect" in psychological damage resulting from sexual abuse. As time goes on, children with untreated sexual abuse issues have more marked impairment in social relationships, exhibit disruptive behavior, have concentration problems, and show poor tolerance for frustration (Putnam, 1999).. These children's brains are constantly preparing for quick responses to a perceived dangerous world; the brain either fails to develop or it loses its ability to adapt and function in a safe world.

Prior to beginning the treatment, therapists should determine the emotional health of the parents, as well as obtain as much history as possible on the child. Often it is necessary to do some work on stabilizing parents and home situations before undergoing specific therapeutic tasks with the child. Develop a basic home program with some strategies for self-care for the parents and behavior management for the most difficult child behaviors. It may take several weeks to accomplish this initial pre-work. Therapists should provide support and help improve or maintain the parents' and also other family members' emotional well being throughout the entire course of treatment.

While the phases in this protocol are listed as three points for cognitive clarity, they will blur into each other in actual practice.

Attachment-specific work/stabilization

As explained above, the first phase of treatment should be attachment-focused. Attaching to safe adults helps children begin to feel safe and protected. Until children have some sense of safety and connection of helping adults, they do not have the emotional resources to deal with trauma. They must use a combination of trauma-ready emotional defenses. These defenses include avoidance, dissociation, fighting, controlling parents, and so forth. Until children begin

to accept safety, they cannot leave behind the artillery and armor necessary for their unsafe world.

For children who have just experienced trauma and who are in a new placement, our goal is to help them to calm down and feel safe in any manner that seems reasonable. This is a critical time frame in terms of the prevention or acceleration of the onset of PTSD.

In spite of the circumstances of the original trauma, maintain an environment that seems as familiar and normal feeling to the child as possible. If there is any possibility of keeping the child in a familiar surrounding, great efforts should be made to enable it. Even if the child is in a new, emergency placement, at the very least bring the child's belongings and offer familiar foods. If children are moved to new parents, avoid the trauma work until they show some beginning attachment.

Attachment will not develop optimally until the trauma and grief work are done. However, children will need some emotional support through attachment to even begin that work. I look for ways to buffer children from stress, even within the family. If children begin to regress and to look needy, meet those needs, encouraging the child to depend on the parents. For example, a child who begins to speak "baby talk" should not be told, "Stop talking like that; you are not a baby." Instead, notice the regression, ignore the baby talk as a topic, and add extra acts of comfort and security to the day. Try to maintain consistency and predictability in the child's care, as this will sooth the overstimulated or dissociative child.

Use markedly nurturing techniques with children during the attachment-producing phase. Encourage them to depend on and trust in parents. Some children who have been traumatized, neglected, and moved, but who are not specifically afraid of their caregivers, will respond to attachment-producing techniques by looking still, flat, shut down, or out-of-sync rather than resistant. In these cases, parents and children should practice ways of being close. Give homework for in between the sessions so that parents can give their children a nurturing home program with closeness exercises every day. These children tend to move into closeness with dependence upon and reciprocity with their parents with less resistance as compared to children who have conditioned emotional responses to their caregivers.

Children who have been physically or sexually abused by their earlier caregivers may arch, spit, kick, and pull away from new caregivers. They way they hold their bodies or what they say will often make it painfully obvious how they have been physically or sexually abused. The therapist does not delve into that abuse at this time, but instead helps provide safety by using reassurances. While this is a type of trauma work, its desensitization techniques are aimed towards the goal of encouraging some beginning attachment. Work at this time is not oriented towards the goal of desensitizing the traumatic events or in the creation of a narrative. Rather, this work is skill-based and present-focused. Children will often, but not always, look forward to these sessions..

The therapist should gauge the amount of emotional resources that the child has, working near the limit of the child's therapeutic potential. For example, a child might be encouraged to count up to ten while sitting in a parent's lap. If she becomes arching and fearful at the count of five, the therapist can encourage her, pointing out that she is safe. The therapist can point out that the child can see the parent's hands, or that she may get up and try again in a minute, and other specific reassurances. The vocal tones of the therapist and parents should be reassuring and gentle, but at the same time upbeat in order to positively challenge children.

One preschooler got quiet and stiff, shaking her head to show me that she was too afraid to sit with her father. “Maybe next week, then,” I said.

The next week she said, “I’m ready now!” She eventually became her father’s shadow. When later describing an incident of abuse by a father figure, it was especially helpful to have given her the chance to have her feelings valued in the first situation.

More specific nurturing techniques to promote attachment are age-dependent, and are well-described in *Attaching in Adoption* (Gray, 2002). I like to approach the attachment work as a skill set: “learning to be close to their parents.” I like to take children’s pictures with an instant camera throughout their attachment work. Children can review the pictures and also the great feeling of closeness with their parents. The pictures help anchor the safe feelings. Children who begin to breathe out with an audible exhale and drop their eyelids a little while sitting on their parent’s lap, or lean into the parent with a delicious little giggle and grin are showing the ability to “down-regulate,” or reduce emotional intensity. This skill is a pre-requisite for trauma and grief work.

Trauma and traumatic grief-focused therapy

Move into trauma-focused work after children have some attachment and some basic family stability. The goals of treatment are twofold: correct distorted and self-toxic beliefs, and desensitize the child to trauma-related memories. Help children develop a narrative of their lives that makes sense of their lives’ events. In the order of the tasks of therapy, concentrate on attachment first, trauma second, and grief last. Young children who have not clearly separated their identities from former parents will flip the last two tasks. They will work on attachment, then work on grief, accomplishing some clarity from the identities of the former parents, then move into trauma work, and then move back once again to finish their grief work. Continue to focus on and build attachment throughout the grief and trauma work, regardless of the order.

In these sessions, the therapist must constantly assess children’s abilities to process memories. The therapist uses her skills to expose children to material in a manner that neither overwhelms them, nor undershoots the therapeutic window.

The sessions are divided into three parts and vary in length, from fifty-five minutes to two hours, depending on the needs of the child and the commuting distance for the family. In the first part of the session, the therapist talks with the parent while the child waits outside of the room. The therapist gets a report on the past week. This report usually helps the therapist gauge the amount and degree of traumatic memory the child is experiencing. The therapist also supports the parents as they continue therapeutic parenting at home. This support helps the parents maintain their sense of stability or regulation. The therapist co-regulates with the anxious, shocked, or worn parent so that they can calm and the child can enter into a regulating environment. One parent said, “I feel like I just got a message. It is so calm here after you have talked to me. Even though you are working with my daughter, I get to sit back and give the job to someone else for a while.”

In the second part of the session, the therapist makes an alliance with a child to work on a certain amount of the traumatic material. Usually this material is tied to whatever is bothering children. The therapist takes on the responsibility of calibrating the amount of material covered in the session. The parents may either overexpose or want to protect children from working on

trauma. While I choose to have the parents present in many sessions, I control the pacing and the amount of work attempted in the session.

Work on de-sensitization, the impact of the trauma, and the meaning of the trauma during the second part. There are a variety of therapeutic techniques that can be used; choose the most appropriate one, depending on the age of the child, learning style, and presence or absence of prenatal exposure to substance. When in doubt as to how much trauma work to attempt, I attempt less, rather than more. For example, if a child comes in looking more dissociative than usual, the parent has a cold, and I have a headache, I back up into stabilization and surface little trauma.

Therapists should have inquiring minds, and encourage parents to do as well, in response to episodes of acting out behavior.

A child was quite difficult to manage after his mother went on a short trip, and did not improve after she came home. He finally revealed that a woman he thought of as his mother in a former setting would leave, calling a sexual predator, who masqueraded as a volunteer, to come spend time with him, i.e. abuse him. He had forgotten his anger at this woman and the similarities she had to his mother. He did not calm until we processed the abuse, his feelings of betrayal, and worked on de-sensitization through phone conversations. This is a typical pattern when trauma memories surface in very traumatized children.

In the last part of the session, we work on affective regulation, to making certain that the child is able to calm and cope after the session. Attending to this segment is critically important. In fact, the goal is not to speed through the trauma work, but to help the child to cope with life. The parents are regularly used to help the child modulate affect, comforting and calming their child.

The third segment of the session is also the time that the therapist works with the child and parent to make a plan for the coming week. The plan includes times in the week that the child can access comfort and support from parents, and plans for coping with daily challenges, for example, the school bus, an overnight visit from relatives, or an out-of-town trip by a parent. For fragile children, it includes check-ins with the therapist by phone and the possibility of an extra session.

In the first and last segment, especially, I talk to children about their progress, how much I appreciate the chance to work with them, and celebrate their advances. When they tell me about good things that have happened in their lives, I am excited with them. Following Diane Fosha's sound advice, I want to spend as much time processing the positives as the negatives so that the positives are integrated into their life narrative (2004).

Grief

The sessions that are focused more on grief are set up similarly to the trauma sessions. Meet with the parents first, work specifically on grief second, and do affective regulation and plans for coping third in the sessions. Usually the grief work and trauma work are intermingled to some degree, since most children's losses have traumatic features.

In the grief segment of the work, the child not only mourns for the people that she lost, but for the loss of the life that she once lived. Children do not have the emotional resources to grieve alone, so most children will not have progressed through the grieving process until they

are attached to their parent. The child needs to have a consistent adult who can support her through her grief in order to get through the grief staging. In most cases, this adult is the parent. Occasionally, children will use the therapist instead. I will take on this role if children do not have a parent who can do this grief work.

During this phase, whether it comes largely before or after the trauma work, children will need:

- Factual information about the loss; what really occurred and who was there.
- Assistance in reality testing; most children want to deny certain things. They need help with talking about their feeling. Most maltreated children report anger when they are feeling anger, sadness, or fear.
- Help determining their part in the loss. Almost all children place themselves as central to both trauma and loss.
- The ability to share their feelings about the lost person.

Encouraging children to share feelings about the lost person can manifest an especially tough dilemma in therapy.

One boy, who was nearly lethally neglected as well as sexually abused by his birthmother, still missed her. Before he worked on trauma, he successfully dissociated from the trauma and only felt his desire to be close to her. It took patience and a firm grip on theory for his parents to hear and to support his grief work. Because of his age, it was necessary that he grieve and separate from his birthmother before moving into his trauma work.¹ In this case example, I supported the parent as they supported their child as he grieved. After completing his grief and trauma work, this same child concluded that his birthmother should be incarcerated due to her ongoing threat to the community.

It can be trying for parents to hear the loss their children feel towards the same people who harmed them. Alternately, sometimes the parents want their children to feel something less intense.

One teen said, “My mother wants a normal child and says, ‘See, it worked out for the best.’

I think, What’s best about having traumatic stress? My birthmother was an idiot! I wouldn’t treat an animal the way she treated me. My mother just doesn’t want something like that to be part of my adoption story.’

Parents--In or out of the therapy room?

Obviously, parents should be in the room during attachment work so that therapists can use the most effective model for attachment work. During the trauma and grief stages, however, the decision concerning whether parents stay in or out is individualized to what works best for a particular family. (Sometimes two parents are in the room for sessions. Often that feels like too many adults to children, so one adult is in the room at a time.)

¹ This child was in addition, psychologically unprepared to integrate his birthmother’s malevolent intent with his sense of self. That would have been too devastating to present during this stage of therapy.

I do the first part of the session, as described above, with the parents in almost all sessions with children under 12 years old. For the grief and trauma work, I will often work with children separately. I tend to finish the sessions with the parents and their children together. Typically, children want their parents to know what they worked on and want to get support for their work.

Some parents cannot contain their own grief and trauma when they hear what happened to their children. Or, this information can re-activate the parents' own past grief and trauma issues. Some children are too humiliated to talk about the worst of the worst experiences in the presence of their parents. In all of these cases, I work with the children separately, and then tell parents what we worked on, in a global way, later.

I will often say to children, "It doesn't matter to me whether your parent(s) are here or not for this part. What do you want? How will you work best today?" Parents will agree with this, giving children the ability to assess what is best for them. Some children will say, "Mom, are you sure you don't mind?" or, "Dad, will you come back in at the end?"

By this time I have enough history with parents that they are comfortable. Sometimes children will specifically ask for parents to be with them. Usually this is because they are still using their parents a lot for comfort and support as we go through trauma work. Sometimes we need parents part-way through the session, because we have a question or because children need a hug. So parents usually do not go far.

Finally, as children mature into teens, I typically work with them alone. They are being prepared for self-sufficiency. The parents, the teens, or the therapist may ask for some time working altogether as a family, however.

Overlapping themes in grief and trauma

There are overlapping themes in grief and trauma. These overlaps cause confusion and make it difficult to determine which needs the child is presenting. It is important to make attempts to determine what the need is in order to best help the child by using an appropriate treatment approach.

Recently, a boy came into session after showing minor concentration symptoms all week. As he sat on his mother's lap and we sorted out the feelings, he said. "Deborah, I am sad all the time about being abused." He went on to say that he was thinking about what he would have been like if he had had a better start in life. He was grieving for himself and the meaning of these losses in terms of his identity. Working on his sad losses was exactly what he needed help in verbalizing. Working, in error, on traumatic de-sensitization, would not have been helpful.

What are some of the overlapping issues?

Hypervigilance is present in both grief and trauma. The search for the lost person is notable in grief, and especially pathological grief. Hypervigilance in trauma takes the form of children looking for former abusers, signals of upcoming violence, and searching for individuals who might be unsafe.

For children who have been traumatized by a parent, there is a true convergence of these themes. They may be searching for the lost parent, as well as terrified that they will see the parent. In therapy, we sort out the longing for the parent who terrifies.

Avoidance of Loss is a major theme in both traumatic stress and pathological grief. Due to traumatic stress, children are emotionally constricted when making new attachments. Children who have lost attachments remain past-focused, denying the reality of their loss and limiting their availability to the new parents for a new attachment.

Anger and Guilt. Children believe that it is their fault that the people they love left them. When children ponder the alternative to the loss and trauma being their fault, they alternatively believe that there is something so dangerous and overwhelming about the world that there is no shield or no social protection for them.

I ask questions carefully so that I can approach these themes correctly. I can ask some questions like, “I am not sure about something. I can’t tell whether you are looking, looking, looking, because you want to see someone, or because you don’t want to see somebody. Can you tell me more about this?” Sometimes children will describe both.

Disconnection from Trauma and Grief, Reconnection with the Present

At the end of therapy, children are able to be more fully in the here and now. Their life narrative is developed to a large degree. They are dealing with the residue of trauma, in a way where it interferes with their lives to the least possible extent. They have developed strategies to deal with scary reminders of the past, i.e. traumatic triggers or reminders.

We continue to watch for any trauma re-enactment themes. We help children who are doing this find ways of coping that are less dangerous. We work actively on developing healthy coping skills in place of arguing, fighting, withdrawing, or self-punishing. We help children make safe choices. Neglected children are particularly helped by discussions that point out the people there to help them in every part of their daily lives, and how to get help. Much of each session is spent reviewing progress and helping them develop a sense of mastery and self-esteem. This replaces helplessness, avoidance, and shame as core issues.

Recall

A pulsed therapy approach works well for children with attachment, trauma, and grief issues. Families will work hard with me for about seventy hours, in weekly 55-90 minutes sessions or twice monthly 90-120 minutes sessions, and then move into a rotating schedule of every other week, once a month, or take a break of a few months and then come back to check-in. They have a list, developed for them individually, that indicates when to come back in. Sometimes trauma and grief issues build in intensity. Other times, behavioral issues become compelling. Life’s stressful situations may necessitate coming back in for extra help.

Children also return to therapy when their developmental issues change. Children who have done work in the early elementary school years will want to review their work as they become more abstract thinkers at age 11 or 12. Some issues they will approach differently since they have the mental equipment to think about things that were too complex before. For example, they will understand status, social class, and sexual stigma at this stage in a new way. Understanding how society sees sexual abuse for a preteen who was sexually abused is a typical type of issue at this stage. Most children are ready and interested in talking about the complex issues of neglect, abuse, or being raised by parents who are not biologically similar. The need facts and emotional support during this stage. They are making meaning out of the events that shaped their lives.

At ages 13 and 14 teens will need to think about how they are the same as their birth parents and different than their birth parents, and how they are the same and different than adoptive parents, as part of forming their identities. I like to spend time with them at the 11-12 year stage in getting facts and concepts straight about their birth parents. That was they have the facts in order to sort these issues out at 13-14 years old.

Some teens need extra help with romantic relationships or as they prepare to move away from their parents. They need to do more work because the meaning of the trauma or loss to their identities is different at different ages. Sexual abuse is an example of a type of trauma that needs additional treatment at different stages of the developing identity. Children and teens usually understand the positive effects of therapy, and will request appointments with me as needed. Sometimes children will need another type of therapist in the teen years. They are either ready for another approach or think of me as the childhood therapist and feel that they have outgrown me. We discuss their needs and refer them, without giving them the sense that they have burned any bridges. They are welcome to come back if they wish.

Teens genetically at-risk for mood disorders may show some of these signs as they get older. Recall helps differentiate diagnoses, i.e. determine whether their problem is re-activated traumatic stress or a mood disorder. Seeing a familiar therapist is comforting for teens, even if they just want a referral for medication.

Teens do their work without their parents most of the time. They have already internalized the attachment and emotional modulation during earlier work, so that they are more independent in their process. At times, teens will request their parents in the sessions, as they feel the need for extra help with emotional modulation. Other times, I request the parents if I feel that family work is helpful, or if I feel that attachment is slipping. In all sessions, I continue to reinforce attachment, even when the parent is out of the room.