Deborah Gray 'Nurturing Adoptions' 2007

The rates of symptoms in children who have been traumatized by abuse under the age of 14 include the following:

- 77% reported affective dysregulation or anger problems.
- 80% were dissociative
- 54% described chronic pain
- 66% reported being or having been suicidal
- 75% experienced hopelessness (van der Kolk, 1994)

(Statistics were gathered prior to treatment) p35

What predicts success in recovering from Trauma's effects?

- The quality of close relationships is the factor that most accurately predicts which people will go on to develop the long-term symptom patterns of PTSD after trauma (van der Kolk 2002). Children who experience a sense of safety with a parent learn to calm with that person. They borrow from their caregiver's coping abilities, and use that person as a base as they calm and feel safe. Even if the parent is not available, they remember the soothing of their attachment figure and use that to reduce their stress level right after the trauma. The key to determining who recovers after trauma, then, lies in the ability to control levels of emotional arousal. In other words, the person who can calm herself down or talk herself through situations is likely to recover. The key determinant behind this capacity is early attachment experiences.

Adoptive parents must understand that they will have to teach their children soothing, alming, and emotional regulation through their attachment relationship.

Another distortion after early trauma is the assumption that 'They must be right and I must be wrong, since they are so powerful. I should not regard my own feelings, but instead should be observant of their feelings.' This is a set-up for future high-risk situations and/or relationship. Cloitre (2003) work has shown that 65% of rape victims have been maltreated as children…..Traumatized people ignore their feelings about whether they are safe and comfortable, or scared and anxious, or whether they are being set-up or treated with respect.

It is critical to recognize that it is not just the traumatic event that needs to be addressed in treating traumatized children. *It is the meaning of the event to the child's sense of self and to the fabric of relationships in children's lives.* The source of the trauma can be the very person who ws supposed to be keeping the child safe.

A child may be 'wooden' when telling their story because:

- Can not revisit any of the feelings without believing that she was back in the event – re-experiencing the trauma.
- She was filled with grief and shame at her part of the story.
- Had not developed a sturdy stress regulation system – she learnt an adaptive response of just waiting helplessly, rather than showing initiative.
- Chose to avoid the issues that came up eg lying and hiding underwear.
- Avoidance of trauma-related themes and frustrating problems is characteristic of maltreated children – they do not expect that they can go to adults in order to calm down or to get help when life exceeds their capabilities – need to talk to children about the tole of parents as helpers should be done in a scripted, specific manner eg come get me or call if you are having a bad dream. I want to help you feel safe again. So what are you going to say?'

Effect of Trauma on Children Stage by Stage

Phase 1: Birth through 7 months of life

- Babies are wired during this stage to be welcomed, soothed, and socialized – or to be worried, fussy, reactive, frozen and watchful, or 'still-faced'. 'Still-faced' describes an early form of dissociation, also called conservation withdrawal, in which infants freeze in silence so that they are not noticed and can avoid detection.
- Children look to parents to organise their feelings, to know what is important to attend to, what to feel about it, and what to think and feel about other people and themselves.

A sudden move from the caregiver will result in massive disequilibrium in their neuroendrocrine levels. This does not mean that they should not be moved out of situations of maltreatment, but sudden shifts are to be avoided.

Children who have been traumatized, whether by neglect or abuse, will not have regulated moods. He will already show 'conservation withdrawal. After trauma babies will startle easily, seem anxious and wary, freeze easily, and often show eating and sleeping problems. They may withdraw and seem harder to connect with.

Phase 11: 7 month to 18 months

This is typically the stage in which an exclusive attachment to a parent forms. It is also a time of increased vulnerability to developing borderline/PTSD personality disorder.

Babies at this state need:

- A consistent and nurturing parent who is emotionally available to the little one. Separations of more than a day should be avoided unless they are emergencies.
- A parent who can be patient with the baby's need for proximity
- A safe home with parents who are neither frightened nor frightening
- Parents who can celebrate the baby's movement into more mastery – standing, crawling, and speaking
- Parent who are 'in synch' at least 30% of the time – the definition of the 'good enough' parent. That is the percentage that the parents need to aim for when creating an emotionally healthy environment (Fosha, 2004)
- Parents who can stimulate language by speaking with and responding to their babies.
- Parents who continue to provide buffering and soothing, as well as play and social experiences.

Children who are traumatized at this stage learn to ready themselves for constant danger. Some babies and toddlers adjust by

- lowering their level of alertness. They have a low arousal level – it takes much more to get their attention.
- Others have high arousal ie they are always somewhat overstimulated and stressed. They move quickly into overarousal. They tend to show anxiety, quick startle, and anxious scanning. By the end of this phase they feel shame.
- By this stage babies form a sense of attunement or a feeling of being 'in-synch' with family and use parents to get back into balance. In adverse settings they follow parents' dysregulated states or enter their own dissociative states in response to an over-whelming world.

Trauma symptoms at this stage include:

- Sleep problems
- Over and under eating
- Growth problems caused by cortisterone inhibition of growth hormone

- A dazed or shocked look, with rigid body, arched back, feet up to kick, elbows out
- Head butting instead of nestling when being held
- Night terrors and many large motor movements at night.

Phase 111: 18 months to between 30 and 36 months

Toddlers think of themselves as good or bad by the end of this stage. Almost all maltreated children think of themselves as bad.

Needs at this stage:

- Close nurturing relationships to support their exploration
- Rules, to learn the process of learning limits and staying safe
- Limits and expansion of empathy so that children learn to care and contain aggression
- New experiences that enhance mastery in play, speech, and social interactions with peers.
- Shared enjoyable activities between parents and children
- Assitance with building a positive gender and self identity as 'good'
- Opportunities to make choices or to say 'no'
- Ability to retreat to parents when life feels overwhelming.

Trauma at this stage may lead a child to excessive protest or a learned helplessness. Play and rituals may become inhibited or exaggerated after trauma. Behaviour symptoms at this stage include:

- Nightmares
- Avoidance of gaze
- Difficulty calming
- Freezing in place
- Difficulty engaging socially
- Difficulty knowing where her own body is or what it is feeling
- Aggression: hitting, feet up, elbows out
- Dissociation
- Avoidance of certain trauma-related places or situations, ie the bath, belts, loud voices.

Phase IV: 30 to 36 months through 48 to 54 months

When they are not in a safe place children tend to oppose, control, threaten, or hide, depending on their attachment pattern. Children are egocentric at this age therefore they tend to incorporate any trauma into their identities. 'I made this happen'. After traum children have more difficulty with peers. They often withdraw or control and bully. If trauma is a lifestyle, rather than an event, peer problems are particularly severe.

Children need:

- Nurturing and sensitive parents
- What different for traumas that occurred eg 'Scary people are not allowed in our house. We don't let them in. It's our rule. Your birth family did not have that rule. I'm sorry that you were scared there'.
- Support of children's exploration
- Rules and structure so that children continue the process of learning limits and staying safe.
- Expansion of empathy so that children learn to care, compromise, and contain aggression
- Experiences that enhance mastery in play, speech, social interation.
- Shared enjoyable activities between parents and children
- Assistance from adults in building a positive gender and self identity as 'good'
- Opportunities to make choices or to say 'no'
- Ability to retreat to aprents or trusted adults when life feels overwhelming.

Trauma symptoms include:

- More marked difficulty in social contexts with aggression in play
- Nightmares with real themes related to traumatic incidents
- Talking about or acting out sexual themes not typically know by children this age
- Bullying behaviour of peers or adults
- Angry tantrums that are more frequent than other children's tantrums
- Frenetic over, activity when remembering traumatic material.

Trauma symptoms from stages above which may also be present include:

- Avoidance of gaze
- difficulty calming
- Freezing in place
- Difficulty knowing where her own body is or what it is feeling
- Aggression: hitting, feet up, elbows out, head butting
- Avoidance of certain trauma-related places or situations ie the bath, belts, loud voices

By this stage it is clear that trauma is shaping the way children are developing their sense of themselves – as good or bad.

Phase V: 4 ½ through 6 ½ to 7 years of age

Typically they are mastering language, play themes, and are eager for social relationships. They may hope to have a romantic relationship with an opposite sex parent. Chidlren of this age need a life story that has a 'why' in it, but their life stories are quite concrete. They may want to know more about the events that happened pre-adoption in a search for what explains their feelings.

Children need:

- Support for speech and learning skills
- Continuation of a nurturing, sensitive relationship with parents
- Safety
- The ability to retreat to parents or trusted adults when life feels overwhelming
- A simple 'why' for the events that have shaped their lives
- Therapy for trauma
- Help in handling their feeling extremes
- Buffering and soothing help when they need to retreat for comfort
- Social experiences that help them to develop peer relationships
- Basic chores so they contribute to the family
- Structure in going to bed, brushing teeth etc along with consequences to maintain this structure
- Positive statements about their gender
- Help in organising their life story, social contexts and increasingly complex worlds

Trauma symptoms at this stage include the earlier listed behaviours:

- Night terrors
- Dissociation at reminders of trauma
- Quick startle reflex
- Social withdrawal or heedless approach of strangers
- Playing out trauma themes in playtimes
- Identification with the brutal 'victor' who might be an abuser
- Complaints of body pains (somatization)
- Avoidance of gaze or staring
- Difficulty engaging socially or highly controlling social behaviours

- Difficulty knowing where her own body is or what it is feeling
- Aggression: hitting, feet up, elbows out, head butting or verbal aggression
- Avoidance of certain trauma-related places or situations
- Sexually acting out if there has been sexual abuse

Traumatized children may confuse simultaneous events with cause and effect eg conclude that they were responsible.

Phase VI: Ages 6 ½ to 8 and ages 8 to 10

Rigid in defining what is normal. They may avoid any talk about trauma or other painful topics. By this stage children who have experienced trauma usually have a sense of shame about who they are, related not just to traumatic incidents but also to early neglect. Children after trauma often miss social cues or may misinterpret cues as threatening. The abilities to share, to join ideas together, to compromise, to feel one's feelings and to be simultaneously aware of another's feelings are all processes that may not have developed in children raised in foster care or orphanages. They must be taught during this stage.

Needs at this stage are for:

- Safe, nurturing homes and parents
- Experience-rich lives that help them to develop a sense of mastery
- Academic successes
- Social success
- A life story that helps them cope with adoption issues and trauma/neglect issues. It should both give facts and correct distortions
- Therapy that helps them to process and de-sensitize to trauma and shame
- Building of moral, spiritual development and empathy
- Structure and discipline
- Help in handling feeling or behavioural extremes. Consequences are given to help enforce limits.

Trauma symptoms at this stage include:

- Exaggerated startle reaction
- Difficulty with friendships
- Knowledge of adult sexual information or sexual acting out
- Night terrors
- Body symptoms
- Paranoid thoughts
- Worries that an abuser will return
- Bullying of small children or pets
- Anxieties that are specific to the trauma
- Generalized anxieties
- Concentration and memory problems that interfere with learning
- Loss of optimism about the future
- Emotional dysregulation including aggression.

Children who are too busy keeping themselves protected have difficulty connecting with others.