

Trauma:
Impact on Children and Opportunities for Healing

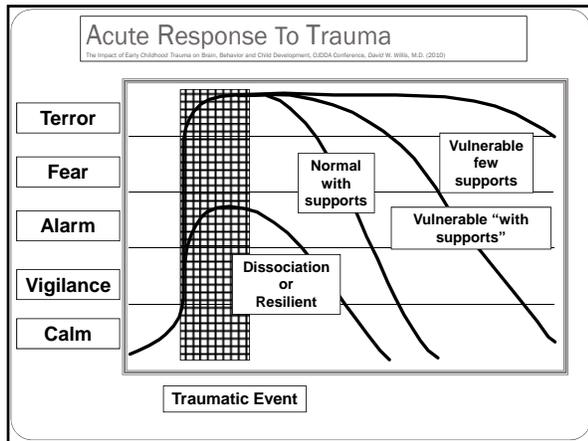
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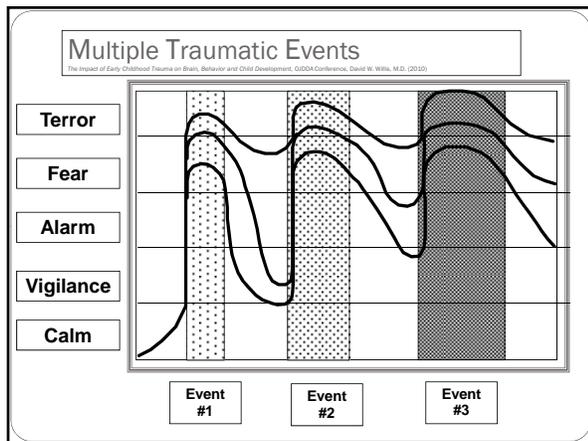
Types of Child Trauma

- Natural disasters
- Kidnapping
- School violence
- Community violence
- Refugee and war zone
- Terrorism
- Homicide
- Physical abuse
- Complex Trauma
- Sexual abuse/assault
- Domestic violence
- Medical injury, illness, procedures
- Victim of crime
- Accidents
- Suicide
- Neglect, deprivation
- Early childhood trauma
- Traumatic grief

Acute, Chronic, Complex Trauma

- **Acute:** Single incident (crime victim, serious accident, natural disaster)
- **Chronic:** Repeated, prolonged trauma (domestic violence, abuse, war)
- **Complex:** chronic, interpersonal trauma; varied and multiple traumas; early onset; often by trusted caregivers





Trauma Rates

- 69% of the general U.S. population report exposure to traumatic event(s)
- 14 to 43% of children/adolescents report having experienced a trauma
- Up to 91% of African American youth in urban settings report violence exposure
- Among refugee children, rates of trauma exposure approach 100%
- Adverse Childhood Experiences (ACE) reported by adults:
 - 28% physical abuse, 21% sexual abuse, 15% emotional neglect, 10% physical neglect, 13% battered mother, 27% substance abuse in home

Maltreatment Statistics

<http://www.childhelp.org/pages/statistics#abuse-conseq>

- A report of child abuse is made every ten seconds
- More than five children die every day as a result of child abuse.
- Approximately 80% of children that die from abuse are under the age of 4.
- More than 90% of juvenile sexual abuse victims know their perpetrator.
- Child abuse occurs at every socioeconomic level, across ethnic and cultural lines, within all religions and at all levels of education.
- About 80% of 21 year olds that were abused as children met criteria for at least one psychological disorder.
- Children who experience child abuse & neglect are 59% more likely to be arrested as a juvenile, 28% more likely to be arrested as an adult, and 30% more likely to commit violent crime.
- Abused children are 25% more likely to experience teen pregnancy.
- Children whose parents abuse alcohol/drugs are 3 times more likely to be abused and >4 times more likely to be neglected than children from non-abusing families.

Risk Factors for Post-Trauma Adjustment Problems

- | | |
|---|---|
| • Severity, chronicity of trauma | • Parent psychopathology; parent distress |
| • Extent of exposure | • Genetic predisposition |
| • Proximity of trauma | • Close, familial relationship to abuser |
| • History of other multiple stressors | • Use of threat |
| • Preexisting psychopathology | • Early onset (infancy-preschool) |
| • Interpersonal violence | • Multiple types of maltreatment |
| • Personal significance of trauma | • Lower cognitive functioning |
| • Separation from caregiver | • Female |
| • Extent of disruption in support systems | • Passive coping style |
| • Lack of material/social resources | • Unsupportive caregiver |
| • High physical pain | |

Protective Factors for Post-Trauma Adjustment

- Strong academic and social skills
- Active coping, self-confidence
- External blame for abuse
- Social support
- Secure attachment
- Positive parenting practices
- Family cohesion, adaptability, hardiness
- High neighborhood/school quality
- Strong religious beliefs, cultural identity
- Effective coping and support by parents

Tasks of Normal Development

- Form secure attachment
 - Separate from caregiver
 - Explore environment
 - Cognitive/language development
 - Emotional and behavioral development
 - Develop sense of self
 - Social Development
 - Autonomy
 - Sexuality
 - Achievement
 - Abstract/moral reasoning
 - Future perspective-taking
- **Child Trauma causes developmental regression or derailment**

What is Attachment?

- "Attachment is an interactive process, brain to brain, limbic system to limbic system, a synchronicity of parent and child. Attachment in the child's first three years centers on communication between the right brains of both parent and child, especially visual, face-to-face images of one another, touch and tone of voice... The infant absorbs the care from the parent and essentially absorbs the self-regulatory system of the parent... They are shaped by the sensitivity and responsiveness of their parents. (Kagan, 2004, p. 7)
- "Cradle of reciprocal joy and family intimacy" (Hughes, 2007, p. 22)
- A relationship pattern *between* the child and another important person.
- It is *not* an inherent trait. It can vary across and over time.



Why is Attachment So Important?

- Ensures survival
- Stimulates brain growth and development
- Template (implicit memory) for future relationships
- Gateway for exploration, learning, mastery
- Influences moral development, empathy, social skills, ability to read social cues, self esteem, language development, problem-solving, and reasoning
- Predicts achievement, stability of future relationships, and quality of parent-child relationships when you are grown.
- Provides traumatized child with a relationship-based recovery

Normal vs. Institutional vs. Abusive Attachment Process

- See handout



Attachment Patterns

See Handout

- Secure (60-70%)
 - Insecure-Avoidant (15-20%)
 - Insecure-Anxious/ Ambivalent (10-15%)
 - Also referred to as Insecure-Resistant
 - Insecure-Disorganized (5-10%)
- So, what is Reactive Attachment Disorder?

Attachment Summary

<u>Style</u>	<u>Anxiety Avoidance Value</u>		<u>Self Other Value</u>	
<i>Secure</i>	Low	Low	High	High
<i>Avoidant</i>	Low	High	High	Low
<i>Resistant</i>	High	Low	Low	High
<i>Disorganized</i>	High	High	Low	Low

Attachment and Acute Trauma

- Disrupted attachment is usually temporary and responsive to treatment
- Possible behaviors: Clingy, whining, separation anxiety, stranger anxiety, hypervigilance, frozen watchfulness, excessive worry about well-being of others, resists leaving “secure” places

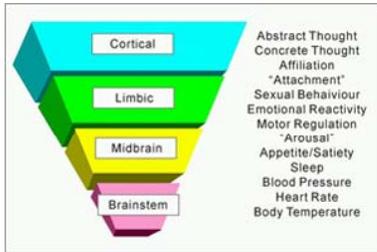
Attachment Intersects with Trauma

- Secure caregiver
 - Child: PTS buffered, modulated by parent soothing
- Frightening caregiver (child abuse)
 - Child: Hypercompliant, frozen watchfulness, sneaking to get needs met, appeasing at surface level
- Frightened, inconsistent caregiver (DV, adult trauma)
 - Child: Dysfunctional/erratic attention-seeking (not comfort-seeking) such as whining, demanding, clinging, angry
- Unresponsive, depressed caregiver fails to attune
 - Child: aloof, distant, unaffectionate; indiscriminate with others; provocative, oppositional
- Pervasive Neglect (Chronic institutionalization)
 - Child: Inhibited, withdraws, doesn't attach
- Persistent Disruption in Caregiving
 - Multiple placements, attachment disruptions
 - Child: Disinhibited, attaches indiscriminately

Principles of Neurodevelopment

- The brain is underdeveloped at birth
- The brain organizes from the “bottom” up - brainstem to cortex and from the inside out
- Organization and functional capacity of neural systems is sequential
- Experiences do not have equal influence throughout development (sensitive periods)

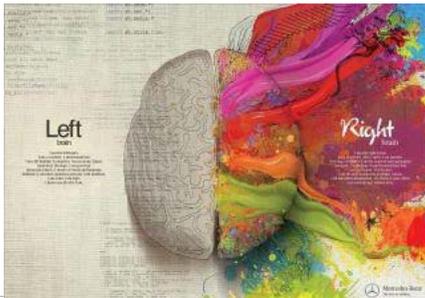
Heirarchy of Brain Function



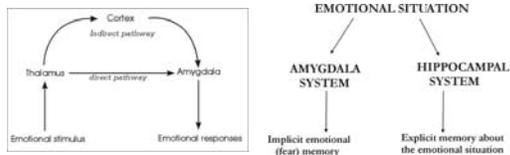
www.cftrc.org/every-child-gets-a-chance/reflect/volume-1-september-2006
 • Bruce Perry, Child Trauma Academy, <http://www.childtrauma.org/>

• "I am the left brain. I am a scientist. A mathematician. I love the familiar. I categorize. I am accurate. Linear. Analytical. Strategic. I am practical. Always in control. A master of words and language. Realistic. I calculate equations and play with numbers. I am order. I am logic. I know exactly who I am."

"I am the right brain. I am creativity. A free spirit. I am passion. Yearning. Sensuality. I am the sound of roaring laughter. I am taste. The feeling of sand beneath bare feet. I am movement. Vivid colors. I am the urge to paint on an empty canvas. I am boundless imagination. Art. Poetry. I sense. I feel. I am everything I wanted to be."



Trauma and Memory



Key Brain "Parts"

- Upstairs: cerebral cortex, prefrontal, orbital; thinking, planning, empathy, morality, emotional control
- Downstairs: Brain stem-Limbic, basic functions, fight/flight reactions, strong emotions
- Left: Linear, logical, language
- Right: Social, emotional, autobiographical
- Implicit memory: Unconscious, trauma, early, mental models
- Explicit memory: Conscious recollection of past experience
- Mirror Neurons: Parent brain and child brains wire together; play critical role in empathy, reading cues

Integration of the Brain

- Left-Right
- Upstairs-Downstairs
- Implicit-Explicit

- Integration leads to coherence, emotional regulation, positive sense of self, and me-we integration

Impact Across Developmental Domains

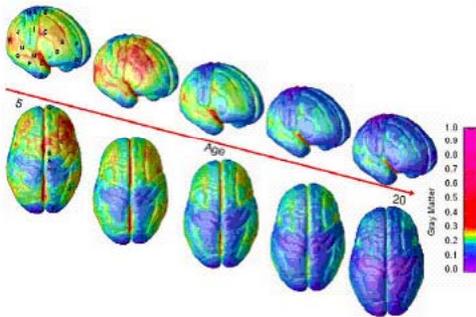
- Biological – Neurodevelopment, physical development
- Cognitive - IQ, language, academic, memory, executive
- Emotional
- Behavioral
- Personality/Coping style
- Moral
- Social

Neurodevelopment and Biological Impact



- Chronic stress > elevated stress hormones, altered biochemistry
- Suppression of brain development, altered brain structure
- Reduced hippocampus
- Smaller corpus callosum
- Enlarged, overactive amygdala
- Lower intracranial and cerebral volume
- Impact worse if complex, early trauma, longer duration of trauma, and diagnosis of PTSD
- Physical delays most pronounced for neglected children (motor development, FTT)
- Compromised immune system

Normal Brain Development Age 5 – 20 Years



Growth of the Human Brain from birth to 20 years



FIGURE 1.1. Growth of whole brain compared when mature weight is taken at 12.5 years and at 20 years. Note the accelerated growth in the first 2 years. (From Himwich.)

Cognitive Impact

- Delays most profound for PN and EN, followed by PA and DV; cumulative effect if both neglect and abuse
- Lower IQ
- Poor school performance
- Rigid, limited problem-solving
- Math, reading deficits
- Low standardized scores
- Receptive/Expressive Language delays
- Poor concentration (PTSD +)
- Explicit memory deficits (PTSD +) but buffered by positive parenting practices

Emotional Development

- Limited self-calming, emotional regulation
- Hypersensitive to anger
- Difficulty recognizing/verbalizing emotion
- Depression, anxiety
- Anger
- Poor frustration tolerance
- Lack of affect
- Impulsivity
- PTSD symptoms

Behavioral Development

- Early pathological behaviors
- Violent play
- Aggressive, oppositional
- Labile, erratic, "rages"
- Impulsive
- Antisocial, delinquent
- Vulnerability to short-term "dopamine fixes"
- Sexual behavior problems (SA)
- Regressive behavior
- Early sexual activity
- Pseudomaturity
- Self-destructive, suicidal
- School avoidance

Social Development

- Poor social skills
- Socially immature
- Peer rejection
- Deviant peers
- Poor social problem-solving
- Difficulty understanding complex social roles
- Poor boundaries
- Withdrawal
- Resist affection
- Passive, overly dependent

Moral Development

- Decreased moral development
- Limited empathy skills
- Stealing, hoarding
- Lying, cheating, rule-breaking
- Deficient moral reasoning
- Antisocial reasoning

Sense of Self/Others

- Negative, ineffective view of self
- Low self-esteem
- Expect rejection, hostility from others
- Expect others to be unresponsive, unavailable
- Distrust others

Mental Models for Relationships

- **Survival:** Don't upset people because they will hurt you, shut down to avoid pain, don't trust others to help you or keep you safe, control what you can, get whatever you can get, reject before getting rejected, fight your battles yourself, charm and recruit and manipulate others to get what you need, make sure you have back-ups in case you lose a caregiver, always be ready for danger
- **Family:** Expect care and protection from parent, trust parent to be there for you, seek attention and proximity with parent, look to parent for guidance when unsure, communicate feelings and needs to parent, cooperate, share, trust that you can handle upsets or pain if parent is there to calm you, calm in response to parent comfort, connection and touch and interdependence feel good

Assessment Protocol for Children and Adolescents

- Assess for trauma symptoms, behavior problems, cognitive distortions, functional impairment, attachment to caregiver, family functioning, strengths, parent trauma history and symptoms, and resources*
 - Direct clinical interview with child and non-offending parent/caretaker;
 - Behavioral observation (child play, parent-child interaction, parenting skills, family/dyad interactions)
 - Direct questioning about trauma exposure
 - Consider including self/other-report measures to assess for trauma symptoms, behavior problems, depression, and cognitions
- *See Family Trauma Assessment Tip Sheet for Clinicians available through www.nctsn.org

Assessment of Attachment Problems in Infants, Preschoolers

- **Caregiver** - emotional availability, nurturance-warmth-sensitivity, protection, provision of comfort, appropriate limits, matched affect and rhythm
- **Child** - emotional regulation, trust-security, vigilance-self protection, orientation to parent, comfort-seeking, show/accept affection, cooperation, exploratory behavior, independent/collaborative play, controlling behavior, ability to separate, reunion responses, eye contact, caution with unfamiliar adults
- Need to assess in natural and clinical settings across each major attachment figure

Trauma Exposure Measures for Children and Adolescents

- **Traumatic Event Screening Inventory (TESI; Ford, 1996):** Child/parent interview or checklist
- **TESI - Parent Report Revised (Ghosh Ippen et al., 2002):** Brief parent-report or interview format, ages 0-6
- **UCLA PTSD Reaction Index (PTSD-RI; Steinberg, Brymer, et al., 2004):** Parent report, child (6 and up) report measure; exposure and trauma symptoms

Assessment of PTSD in Preschoolers

- Observation during free play with parent, compliance situation, therapist-guided play with trauma themes
- Measures of PTSD
 - **Trauma Symptom Checklist for Young Children (TSC/YC)** - ages 3 to 12
 - **PTS Inventory for Children (PT-SIC)**- ages 4 to 8
 - **CBCL** -age 1.5 to 5- PTSD scale for screening
- **Checklist for PTSD Symptoms in Infants and Young Children** - ages 0 to 3
- **Levonn** - preschoolers

Screening for PTSD in Children and Adolescents

- **UCLA PTSD Reaction Index (PTSD-RI; Steinberg, Brymer, et al., 2004):** Parent report, child (6 and up) report measure; exposure and trauma symptoms
- **Child PTSD Symptom Scale (CPSS; Foa, Treadwell, Johnson et al., 2001):** 17-item child interview or self-report measure for school-age
- **Trauma Symptom Checklist for Children (TSCC, Briere, 1995):** 44-item self-report for school-age
- **Trauma Symptom Checklist for Young Children (TSC/YC;Briere et al., 2001):** 90-item parent-report for ages 3 to 12

Cultural considerations

- Increased risk for certain types of traumas
- Environmental risk factors (inadequate housing, single-parent, substance abuse, acculturation stress, discrimination, lower levels of education, cultural history of oppression)
- Use interpreter rather than available family member
- Attitudes, expectations about treatment
- Transgenerational acculturation differences
- Family support
- Beliefs about the cause of the presenting problem
- Emphasize family engagement, integrate cultural values in approach
- Spiritual, religious beliefs
- EBPs that fit cultural context

Common signs of attachment problems



- Excessively clingy with parent; panics upon separation
- Inappropriate attachment-seeking (e.g., aggressively sexualized)
- Shut down, passive, flat expression, "sleeps"
- Doesn't call out for help or seek parent support
- Avoids eye contact, proximity, touch with parent
- Unable to be soothed by parent
- Inappropriately friendly, affectionate with others
- Doesn't orient to parent for "safety check"

Trauma Symptoms: Infants and Toddlers

- **Pattern A:** Withdraws, rejects affection, stops exploring environment, lacks trust in others, appears "unattached", gaze aversion, preoccupation with objects, sensory blocking
- **Pattern B:** Clingy, anxious, sleep disturbances, toileting problems, temper tantrums, regressed, disorganized, rages/aggression, crying irritability, sensory reactivity, separation anxiety
- **Other findings:** poor verbal skills, memory problems, poor appetite, weight loss, FTT, digestive problems
- Based largely on behavioral observation and reaction to sensory input

Trauma Symptoms: Preschool

- Regressive behaviors
- Separation fears
- Eating and sleeping disturbances
- Physical aches and pains
- Crying/irritability
- Appearing "frozen" or moving aimlessly
- Perseverative, ritualistic play
- Reenactment of trauma themes
- Fearful avoidance and phobic reactions
- New fears, new aggression
- Magical thinking related to trauma
- Poor concentration, difficulty learning
- Behavior problems (e.g., tantrums)
- New sensory reactivity
- Delay in skill development

Trauma Symptoms: Elementary School-Age

- Sadness, crying
- Irritability, aggression
- Nightmares
- Abuse themes in play/art/conversation
- School avoidance
- Behavior/academic problems
- Physical complaints
- Concentration problems
- Regressive behavior
- Eating/sleeping changes
- Attention-seeking behavior
- Withdrawal

Trauma Symptoms: Adolescence

- ❑ Similar to adult response to trauma
- ❑ Feelings of shame/guilt
- ❑ Increased risk-taking behaviors
- ❑ Withdrawal from peers/family
- ❑ Pseudomature behaviors
- ❑ Substance abuse
- ❑ Delinquent behaviors
- ❑ Change in school performance
- ❑ Self-destructive behaviors

Common Trauma-Related Cognitive Distortions

- Self-blame
- False blame of others
- Guilt, survivor guilt
- Shame/embarrassment b/c of trauma or symptoms
- Hero fantasies related to trauma
- Overgeneralization of danger/risk
- Minimization of trauma
- Omen formation
- Foreshortened future
- Magical thinking

When Stress Symptoms Become a Disorder

- Acute Stress Disorder (ASD)
- Posttraumatic Stress Disorder (PTSD)
- Reactive Attachment Disorder (RAD)
- Depressive Disorder
- Anxiety Disorder
- Behavior Disorder

PTSD Diagnostic Criteria DSM-IVTR

- **Criterion A1:** Person experienced, witnessed, or was confronted with a traumatic event(s) that involved actual or threatened death or serious injury, or a threat to the physical integrity of self/others.
- **Criterion A2:** The person's response involved intense fear, helplessness, or horror.
- **Criterion B. Re-experiencing Symptoms (need 1)**
 - Recurrent, intrusive, distressing memories
 - Recurrent, distressing dreams
 - Acting or feeling as if trauma is recurring
 - Intense distress at exposure to trauma cues
 - Physiological reactivity upon cue exposure
- **Criterion C. Avoidance Symptoms (need 3)**
 - Efforts to avoid thoughts, feelings, or conversations associated with trauma
 - Efforts to avoid reminders of trauma (activities, places or people)
 - Inability to recall important aspects of trauma
 - Diminished interest/participation in activities
 - Feeling detached or estranged from others
 - Restricted range of affect
 - Sense of foreshortened future
- **Criterion D. Arousal Symptoms (need 2)**
 - Sleep difficulties
 - Irritability
 - Angry outbursts
 - Difficulty concentrating
 - Hypervigilance
 - Exaggerated startle response
- **Criterion E.** Symptoms must be present for at least one month since the event.
- **Criterion F.** Disturbance causes clinically significant distress or impairment in social, occupational or other areas of functioning.
 - **Subtypes:** Acute (<3 months), Chronic (>3 months), Delayed (onset post 6 months)

DC:0-3R PTSD criteria

- Threat to *psychological* or physical integrity
- Only one avoidance symptom needed
- Reexperiencing includes trauma themes in play
- Avoidance includes restricted, perseverative play
- Associated symptoms: regression, new aggression/fears, inappropriate sexual behaviors
- Consider ongoing trauma

Prevalence of PTSD

- Lifetime prevalence for PTSD: 1 to 14% (APA, 1994)
- Approximately 25% of individuals exposed to acute trauma will develop symptoms of PTSD (Pine & Cohen, 2002).
- Up to 80% of children experience PTS after life threatening illness, injury, or painful medical procedures; 15-25% have persistent PTS symptoms.
- 3 to 15% of girls and 1 to 6% of boys exposed to trauma could be diagnosed with PTSD
- 6 to 8% of children in U.S. will develop PTSD during childhood.
- For severe, chronic, or interpersonal traumas, rates of PTSD are as high as 90% (Hamblen, 2002).
- Underdiagnosed in young children
- In younger children, highly related to maternal distress, maternal PTSD, and maternal responsiveness (Lieberman, 2011)

Natural Course of PTSD

- Complete recovery in 50% of PTSD cases after three months
- Between 25 and 50% of PTSD cases are likely to have chronic PTSD without intervention.
- Chronic PTSD predictors: Severe acute trauma, high trauma exposure, repeated abuse, and interpersonal violent trauma

Other Stress-Related Disorders

- 80% of people with PTSD also meet criteria for another mental disorder
- Other disorders include adjustment disorder, depression, separation anxiety, general anxiety, attachment disorders, ADHD, and other behavior disorders.

RAD diagnosis

- Proposed changes in diagnosis for DSM-V
- Inhibited, Disinhibited, Mixed
- Exclude PDD
- “rarely or minimally turns to a discriminated attachment figure for comfort, support, protection, and nurturance”
- RAD versus “attachment problems”

Proposed DSM-V changes

- New diagnosis of Developmental Trauma Disorder (Bessel Van der Kolk) – for complex trauma impact on regulation (affect, physiology, behavior, cognitive, relational)
- PTSD revisions to include decreased avoidance symptom criteria; addition of trauma-related mood/cognitions; addition of behavioral dysregulation

Traumatized Kids Who Make It

- Secure attachment early on
- High current supports
- Low current stress
- Other supporters available as child
- Supportive mates later on
- Therapy
- Ability to self-reflect and tolerate strong emotion



ABC's of Attachment

- Attune
 - Parent resonates, accepts, is curious, actively discovers, experiences child's uniqueness, reflects, feels child's impact, matched vitality
 - Connect with the right
- Balance
 - Co-regulation of affect experienced by child
- Coherence
 - Co-create meaning, mental models, sense of self
 - Redirect with the left

The Power of Reflection

- Integrates brain functioning, facilitates resolution
- Fosters High road (vs. low road) processing
- Can shift parent's attachment style to secure (most robust predictor of child's subsequent secure attachment to parent)
- Critical skill to model and foster in child
- Allows for rupture-repair to happen
- Leads to responsive (not reactive) parenting

Attachment hinges upon parent attachment capacity

- Parent radar = only good if secure attachment history or resolved attachment history
- Parent emotional regulation > Child emotional regulation
- Parent self reflection > Child self reflection
- Strongest predictor of child attachment patterns

Attunement Exercise

- Mirror child's behavior, comments, tone, facial expressions, and mannerisms
- PLACE (playful, loving, accepting, curious, empathic) stance
- PRIDE (praise, reflect, imitate, describe, enthusiasm)
- 100% focused with shared joy

Nonverbal communication

- Eye contact
- Facial expression
- Tone of voice
- Posture
- Touch
- Gesture
- Timing
- Intensity of response



Balance



- Create safety
- Calm, nonreactive, regulated, mindful parenting
- Soothe in way your child will receive
- Notice child's successes with regulation and self-soothing
- Coping skills must be practiced before a crisis
- Balance/regulation exercise

Coherence

- Make meaning of experience
- Mantras ("Mommy always comes back.")
- Use play and storytelling
- Don't talk too much!!!!
- Process and reason while also tolerating emotion
- Be creative
- Look for natural moments
- Model reflection
- May vary from gentle correction, reassurance, carrying on, collaborative problem solving, calming self-talk, reality-testing, or creation of coherent autobiographical story

Discussing Trauma with Child

- Do not ask leading questions, particularly if abuse investigation is underway
- Do not over-interview or bias child's report
- Encourage child to talk about the trauma but don't pressure
- Need to convince child of benefits for sharing
- Emphasize child's safety now
- Praise child for telling; encourage honesty
- Be an active listener
- Remain calm when answering questions and use simple, direct terms
- Outline first, then return to details, worst moment; allow for "remote control feature"

Discussing Trauma with Child (cont.)

- Don't "soften" information you give to child
- Help child develop a realistic understanding of what happened
- Gently correct trauma-related distortions
- Be willing to repeat yourself
- Tolerate retellings (this is good!)
- Protect other children from exposure to trauma retellings/reenactments
- Normalize "bad" feelings or symptoms

Helping Traumatized Children

- Provide realistic reassurance of safety and security
- Allow child to be more dependent temporarily if needed
- Follow child's lead (hugs, listening, support)
- Use typical soothing behaviors
- Use security items and goodbye rituals to ease separation from caregiver
- Distract with pleasurable activities
- Let child know you care
- Maintain normal routines when possible
- Avoid exposing child to unnecessary reminders of the abuse

Helping Traumatized Children (cont.)

- Minimize contact with others who upset child
- Continue to set limits for inappropriate behavior as needed
- Anticipate temporary increase in problem behaviors
- Identify antecedents of problem behaviors and develop behavior management plan
- Redirect/Stop trauma reenactment play as needed
- Facilitate resolution of trauma themes in play/art if possible
- Assist child in coping with trauma reminders
- Attempt to alter negative association with nonharmful trauma cues

Helping Potentially Abusive/Neglectful Parents

- Gently point out concerns by focusing on observable facts and behaviors
- Offer assistance, support, resources
- Do not hypothesize, stick to observable facts
- Acknowledge parents strengths, efforts
- Focus concern on child's welfare and present as "common concern"
- Model effective parenting skills
- Catch parent doing well; reinforce successes
- Don't get caught in triangles with parents

Helping Non-Offending Parents of Abused/Neglected Children

- Model soothing behaviors with younger children
- Assist in developing plan for behavior mgmt.
- Guide foster parent in getting to know child
- Advocate for continuity of school placement if child is placed out of home
- Equip parents with good skills through workshops, references, modeling
- Encourage parent involvement in classroom

Empathic Parenting

- Kids do well when they can
- Behind challenging behaviors are lagging skills
- Ideal parent response lowers parent and child distress
- Red flag parent words that lead to reactivity
 - He wants to get to me...She doesn't care... There he goes crying like a baby again...She tries to make me mad by...She likes to pitch a fit...

Establishing Healthy Boundaries

- Kids WANT limits; it's frightening without them.
- Parent = traffic light
- Relationship rules for disinhibited attachment situation



Separation Anxiety Solutions

- Develop and practice self-soothing rituals and calming statements
- Transition, security items
- Practice separation with gradual increase in time, high opportunity for success, and incentives
- Quick, direct, loving exits
- Empower child in finding solutions

When you have missed the critical window...

- Stay calm, close, and confident
- Attempt touch, comfort if child is ready
- Attune!
- Name it to tame it
- Distract
- Mantras, few words "It's okay... You're safe... It's just a feeling... It will pass... I'm here."
- Connect before redirect
- Better to model self-calming than to suggest it
- Get moving, go outside together
- Don't discuss consequences until after the storm

Attachment Solutions

- Create circle of safety and enforce
- ABC—Attune, Balance, Coherence
- Shared attention to same experience
- *Frequent* shared positive experiences
- Right hemisphere soothing/balance
- Turn Implicit to Explicit
- PLACE
- Mindfulness by parent
- Repair breaks



Attachment Pitfalls for Parents

- Unaware of triggers
- Tired, exhausted, overwhelmed; neglecting self care
- Reactive discipline
- Minimizes own role, fails to see gains
- Lacks support team
- Personalizes; misunderstands root of child's provocative behavior or resistance
- Fears setting limits because of child's previous loss
- Pushes child to deal with trauma prematurely
- Resists repair when child is ready to reconnect
- Overestimates child's ability to handle stress, change, freedom
- Own history/personality interferes with PLACE

Jump starts off of Low Road Rut

- Labeled praise
- 5 connections per 1 correction
- Shared joy
- Overt modeling of self-calming
- Incentive for target behavior
- Increase proximity, structure
- Anticipate & plan for problems
- Switch parenting roles
- Respite (carefully planned)
- Replenish yourself
- Shared reflection on + memories



Patterned, rhythmic interactions and relationships



Sequential Neurodevelopment and Therapeutic Activity (adapted list)

Perry, B. (2006). *Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics*. In N. Webb (Ed.), *Working with Traumatized Youth*. New York: Guilford Press.

- Massage
- Rhythmic/drumming
- Riki touch
- EMDR
- Sensory bath
- Pressure points
- Yoga
- Rocking
- Controlled breathing
- Walking
- Therapeutic massage
- Equine/canine interactions
- Repetitive comfort rituals
- Swimming
- Running
- Skating
- Frequent positive interactions
- Knitting
- Music and movement
- African dancing
- Tinkertoys
- Art
- Nature discovery
- Pottery (wheel)
- Parallel play
- Play therapy
- Puppetry, etc...
- Trampoline
- Turn-taking games
- Drama, storytelling
- Journals
- Anthropology
- Life book
- Humor
- Psychoeducation
- Insight-oriented, talk-based, and cognitive-behavioral therapies



Healing smorgasbord

- Speech, language
- Medical specialists
- OT
- Educational specialists
- Social skills training
- Psychology – evaluation, treatment
- Psychiatry
- Attachment and trauma-focused therapy
- Neurosequential processing implications (EMDR, brain gym, neurofeedback, equine therapy...)

Evidence-Based Trauma Therapies

- Trauma-Focused Cognitive-Behavioral Therapy (TFCBT)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Alternatives for Families CBT (AF-CBT) for Preschoolers
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Preschool PTSD Intervention
- Attachment, Self-Regulation, and Competency (ARC)
- Cognitive Behavioral Therapy for PTSD (CBT-PTSD)
- Structured psychotherapy for adolescents responding to chronic stress (SPARCS)
- Parent Child Interaction Therapy (PCIT)
- Child-Parent Psychotherapy (CPP)
 - www.nctsn.org for review

TFCBT core components

- **P**sychoeducation*, Parenting component
- **R**elaxation skills to address behavioral dysregulation
- **A**ffective modulation skills, emotional regulation*
- **C**ognitive coping and regulation skills
- **T**rauma narration and cognitive processing*
- **I**n vivo mastery of trauma reminders
- **C**onjoint child-parent sessions
- **E**nhancing safety and future developmental trajectory

• *Considered to be first-line intervention by trauma experts

Psychoeducation

- Common reactions to trauma (parent, child)
- PTSD in children
- Accurate trauma-related information
- Self-care after trauma; supporting child
- Purpose, rationale, estimated length, typical course of treatment
- Ensuring safety
- Healthy discipline; Healthy sexuality
- Appropriate developmental expectations

Parenting Component

- Assessment feedback
- Psychoeducation
- Parallel work in areas of SIT, GE, and CP
- Parenting Skills Building, Behavior Mgmt.
- Joint parent-child sessions
 - Continuation of GE and CP jointly
 - Parent models positive coping with trauma
 - Parent assumes role of therapist as child's supporter related to trauma

Relaxation Skills

Stress Inoculation Training (SIT)

Goal: Reduce physiological stress reactions to trauma reminders

Techniques:

- Deep breathing
- Mindfulness, visual imagery
- Progressive muscle relaxation
- Thought-stopping/replacement
- Cognitive coping skills (positive focus)
-

Affective and Cognitive Processing (CP)

- **Goal:** Increase ability to identify thoughts, feelings, behaviors; Challenge distorted or hurtful thoughts
- **Techniques:**
 - Feeling Identification and Expression
 - Cognitive Triangle
 - Practice generating helpful thoughts
 - Identify trauma-related inaccurate or unhelpful thoughts
 - Model helpful trauma-related thoughts
 - Correct distortions

Trauma Narration Gradual Exposure (GE)

- **Goal:** Increase tolerance for upsetting memories and decrease avoidance of nonharmful trauma cues
- **Techniques:**
 - Hierarchical exposure starting from moderate distress and working toward extreme distress
 - Modalities: play, art, visualization, narratives, drama, in vivo exposure if appropriate
 - Reduce arousal through reprocessing and elaboration across sessions
 - SIT skills as needed during GE

Safety Skills

- Recognize dangerous situations
- Good touch/bad touch (SA cases)
- Problem-solving skills
- Support-seeking skills
- Calming skills if risk of self-injury
- Present carefully so as not to blame
- Develop safety plan

Parent-Child Interaction Therapy (PCIT)

- **Goal:** Parent-child relationship enhancement; increase child's compliance; increase positive parenting skills; decrease parent's abuse risk
- For children ages 2-12, Short-term (12 to 14 sessions)
- Involves active live coaching of parent and overlearning of positive parenting behaviors
- Integrates play therapy techniques and operant conditioning
- Child Directed Interaction (CDI)
 - Praise, Reflect, Imitate, Describe, Enthusiasm (PRIDE) skills
- Parent Directed Interaction (PDI)
 - Behavior management-reward praise, clear directions, time outs for noncompliance

New promising trauma treatments

- KIDNET – Kid Narrative Exposure Therapy, for severe, complex trauma; child/human rights focus
- SSET – Support for Students Exposed to Trauma (SSET), CBITS adaptation of skills building without trauma narrative, led by non-mental health professionals
- TGCT – Trauma Grief Component Therapy

• Cohen & Mannarino, 2010

Promising Attachment Therapies

- Dyadic Developmental Psychotherapy (DDP) – Hughes, Becker-Weidman
- Real Life Heroes – R. Kagan
- Connected Child, Hope Connection - Karyn Purvis
- Family-Centered Therapy – B. Post
- Neurosequential Model of Therapeutics (NMT) – Perry
- Theraplay
- Child-Parent Psychotherapy (CPP)- Lieberman
- See www.attach.org for review

**Pharmacotherapy for
Children and Adolescents**
Practice Guidelines for ISTSS (2009)

- Serotenergic Agents (Fluoxetine, Sertraline, Citalopram)
 - Levels A, B (AHCPR classification for level of evidence)
 - Anxiety, mood, PTSD symptoms
 - First choice given "broad spectrum" activity
- Adrenergic Agents (Clonidine, Guanfacine)
 - Levels B, C, E (AHCPR classification for level of evidence)
 - Hyperarousal, activation, impulsivity, nightmares
- Dopaminergic Agents (Risperidone, Quetiapine)
 - Levels E, F (AHCPR classification for level of evidence)
 - Refractory PTSD, comorbid psychiatric disorders

**When to Refer for
Psychological Care**



- Intense anxiety or avoidance behavior if reminded of trauma
- Inappropriate social behaviors
- Unable to regulate emotions
- Poor academic performance and decreased concentration
- Continued worry about the trauma (primary focus)
- Intense separation difficulties
- Persistent physical complaints (nausea, headaches)
- Continued trauma themes in play, art, conversation, behavior
- Sexualized behavior

**When to Refer for
Psychological Care**



- Appear depressed, withdrawn
- Strong resistance to affection or support from caregivers
- Suicidal or homicidal ideation
- Dangerous behaviors to self/ others
- Increased usage of alcohol or drugs
- Rapid weight gain/loss
- Significant behavioral change
- Poor hygiene
- Significant acute stress symptoms (e.g., nightmares, startle easily, hypervigilance)

Referrals and Resources

- www.nctsn.org
- www.attach.org
- www.istss.org (access to free TFCBT training)
- www.childtrauma.org
- www.traumacenter.org
- Cohen, Mannarino, & Deblinger (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*.
- Perry & Szalavitz (2007). *The Boy Who Was Raised as a Dog and Other Stories From a Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing*.

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Why is Attachment So Important?

By Ally Burr-Harris, Ph.D.

Attachment provides the scaffolding for relationships. It is the template that we use to decide whether to lean on others, to trust others, or to be intimate with others. A child's healthy attachment with a caregiver provides the springboard for future development, and that includes cognitive development, social development, emotional development, language development, and moral development. Attachment is not an innate quality. Rather, it is a relationship pattern between a child and caregiver. Even though we cannot recall the first several years of our lives, we do store memories from this period of our life. These types of memories are implicit memories. Our early attachment experiences are stored as implicit memories. Without attachment repair over time, children with early attachment problems are at risk for going through life with faulty mental models of how relationships work. This child may assume that adults cannot be relied upon to meet his or her needs, that the child might as well not cry out because there's no point, that the child must rely upon him or herself for needs to get met. On the other extreme, the child might conclude that he or she must do whatever it takes to secure the attention of adults in order to ensure that his or her needs get met. This can set the child up for relationship patterns in which the child is constantly seeking attention and approval. The child might play the "chameleon," changing on demand in order to ensure that others will focus on his or her needs.

The good news is that children are resilient. Even as adults, we can change our attachment patterns. The key is to provide the child with a high frequency of positive, loving, responsive parent-child interactions over time. In addition, as the child gets older, the child must learn to make sense of the earlier relationship problems. The more that we make sense of our histories, the less we react to them and repeat the negative cycles. This is where we as adults come in. We play a critical role in our own relationship patterns. Research has shown that adults who had secure attachments with their parents are much more likely to establish secure attachments as an adult with their own child (Siegel and Hartzell, 2004). Interestingly, adults who had unhealthy attachment patterns as a child can also go on to establish secure attachments as an adult, provided that they have resolved their own attachment histories. This is the take-home message. We must make meaning of our histories. We must know our triggers. Our relationship roadmaps must be prepared for the challenges that children will present, and this is particularly true if raising a child who was previously traumatized. Children will misbehave, tantrum, and even reject their parents from time to time. As the adults, we must strive to not personalize this and to not let it trigger our own unresolved attachment histories.

Many adoptive parents make the faulty assumption that they can stop worrying about attachment once they see signs of affection and bonding within the parent-child relationship. The reality is that children adopted after a period of neglect, exposure to violence, abuse, disrupted placements, or institutional care have started life with a high level of distress and suboptimal attachment. Why is this so important as long as the child shows signs of secure attachment after adoption? The answer is that brain development

is affected by trauma and attachment within the first year of life. In an ideal world, an infant cries, a parent responds, and the parent looks into the baby's eyes and connects. The parent soothes and meets the infant's need, and the infant calms back down. Over time, the baby internalizes the parent's soothing, responsive efforts, and the baby learns to self-soothe. A child who attaches to a caregiver after the first year may be at risk for not having learned to seek comfort and to self-soothe. This means that the child is at risk for emotional regulation problems. If this is not rectified, this child is at risk for a trajectory of other problems such as rages, criminal behaviors, self destructive behaviors, and substance abuse. Thus, in addition to a high level of attuned (emotionally matched), sensitive, responsive caregiving, children with early attachment problems also need to learn how to emotionally regulate or self-soothe. The first step in this process is for the child to accept soothing from the parent. This can be challenging for some small children who are not even accustomed to the feeling of being held or rocked. The second step is for the child to learn to recognize the signs of emotional upset and to ask the parent for soothing. The third step is for the child to develop healthy tools for calming him or herself.

In conclusion, attachment is not just parent-child affection. It is the process of building trust over time between a child and parent. The child learns that the parent can be trusted to soothe and respond to the needs of the child. It requires that the parent come from a securely attached PLACE (Playful, Loving, Accepting, Curious, and Empathic; Hughes , 2007). The parent must work hard to not personalize the child's behavior, to look under the child's behavior at the feelings that are driving that behavior, and to be emotionally regulated as well. The parent must have resolution of his or her own attachment histories in order to provide this secure base for a child, particularly a child who has already lost a parent or been hurt by a caregiver or parent. Once this child establishes trust in the new parent, the child must also make sense of earlier losses. The child must begin the journey of learning to soothe oneself and to trust in one's own capacity to tolerate upsetting emotions. Attachment is a long, slow dance that requires commitment, reflection, sharing of emotion, empathy, perspective-taking, and trust.

Resources for this introduction:

Hughes, D. (2007). *Attachment-Focused Family Therapy*. New York: Norton & Co.

Siegel, D. & Hartzell, M. (2003). *Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children who Thrive*. New York: Penguin Group.

Therapeutic Parenting: A Handbook for Parents of Children who Have Disorders of Attachment (October, 2008). Association for the Treatment and Training in the Attachment of Children (ATTACH).

Dr. Ally Burr-Harris is a licensed clinical psychologist at Children's Program in Portland, Oregon. She specializes in attachment, adoption, and trauma-related issues. She works with children, teens, adults, and families. She is on the board of directors for Adoption Mosaic, a nonprofit organization that provides support, education, and resources to those touched by adoption.

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Adult Attachment: Categories and Strategies

Secure

Adults with this category value relationships. They are comfortable with both closeness and autonomy. They are able to rely upon others as needed, and they are also comfortable with others leaning on them. This is also known as Free or Autonomous attachment. They are able to reflect on their own legacy of attachment issues. They can integrate their past with their present. They show flexibility and objectivity when reflecting on their own childhood experiences. They are able to identify and tolerate thoughts and feelings related to their own childhood relationships and to apply this awareness to their current relationships. They may or may not have had a happy childhood with positive parent-child relationships. The important thing is that they have made sense of their childhood relationships and resolved these issues. This category is strongly predictive of a secure attachment with one's child.

Dismissing

Adults with this category are more likely to be emotionally disconnected in their relationships. They may report limited recall of their childhood and minimize the impact of childhood events. They may talk about their childhood in simplified, general, concrete terms with little connection to thoughts or feelings of family members. They are likely to consider their childhood experiences to have little relevance to relationship issues in the present. They may tend to intellectualize and avoid emotions. They may show minimal sensitivity to others' nonverbal signals, and they may not be able to recognize their own emotions or body signals. Daniel Siegel (2003) uses the term "emotionally barren." This category predicts an insecure-avoidant attachment with one's child.

Suggestions for Dismissing parents:

Start self-reflecting! Avoid distracters such as constant media input as way of shutting off. Face the feelings. Experience the feelings. Guided imagery, quiet solitude, or meditation may help. Increase your focus on nonverbal signals, body awareness (right hemisphere). Use modalities other than logic-based, linear, language-based thinking (left hemisphere). Instead, attempt to picture memories of experiences and feel associated feelings. Reflect on current situations and your reactions, and attempt to connect these feelings to past relationship experiences in order to better understand your current reactions. Put it all into a narrative and begin to make meaning of your relationship experiences. Use attuning exercises to force yourself to be more present and in the moment when interacting with others.

Preoccupied (also known as entangled)

Adults with this category may demonstrate a high level of anxiety and self-doubt in their relationships. They may show uncertainty and ambivalence. They often have intrusive leftover issues that get mixed up in current relationship problems. They are prone to emotionally clouded parenting, as well as self doubt in the parenting role. This may manifest as a fear of being unable to handle the child's problems. They have difficulty making sense of their experiences because they become flooded by their feelings. Whereas Dismissing adults seek comfort in left hemisphere (logical, linear) processing,

Preoccupied adults get stuck in right hemisphere (emotional, experiential) processing. Thus, it is difficult for them to make meaning of their experiences. This attachment category predicts insecure-anxious/ambivalent attachment with one's child.

Suggestions for Preoccupied parents:

Practice self-soothing. Use positive, affirming self-talk. Use relaxation strategies. Provide yourself with opportunities for paced exposure to potentially anxiety-producing events in order to practice coping effectively with the situations and to provide opportunities for increased self-confidence. Make meaning of your experiences and use language (increased left hemisphere) to put together a meaningful autobiographical account of childhood experiences as they relate to current relationship functioning. What are your leftover issues? Your triggers? Explore why this upsets you and attempt to trace this same feeling or thought back to other relationships or experiences in order to gain an understanding. Write it down. Journal.

Disorganized/Unresolved

Adults with this category are prone to sudden, unpredictable rage, spacing out or dissociating in response to distress, and explosive reactions for which they later feel great remorse or shame. In essence, they are prone to emotional dysregulation. They may have poor insight into what triggered their reactions. When they space out, they may have flashbacks or fragmented memories of upsetting events that are triggered by current relationships. Most likely there is a history of significant unresolved trauma and loss that is having a strong negative impact on current relationships. This attachment category is correlated with disorganized attachment patterns with one's child, and it can also place a parent at risk for being abusive.

Suggestions for Disorganized/Unresolved parents:

Seek professional treatment to assist in expressing and resolving past trauma/loss. Increase support and respite as a parent to ensure that further breaks in the parent-child attachment are not of a toxic or damaging nature. Work to repair breaks and to build trust in your relationship with your child, and consider therapeutic support in addressing the parent-child relationship as well.

Resources for this Handout:

Siegel, D. & Hartzell, M. (2003). *Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children who Thrive*. New York: Penguin Group.

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Parent-Child Attachment Patterns for Infants and Young Children

Secure:

Child actively looks for contact with parent. Child is distressed by separation from parent. Child is calmed by parent upon reunion. Child seeks parent for comfort or assistance in interpreting stimuli as needed. Child is able to explore the environment, using the parent as her secure base as needed. Child demonstrates pleasure when he sees parent. Child relaxes in parent's presence. Child feels connected, understood, and protected with parent. Child often shows good emotional control and capacity to make friends easily.

Parent tends to be sensitive, responsive, attuned, and predictable. Parent provides repeated experience of contingent connection with child.

Insecure-Avoidant:

Child may present as stubbornly independent and overly self-reliant. She appears largely unaffected by separation from parent. Upon reunion, child does not acknowledge parent, avoids parent, or pulls away from parent. Child tends to focus on toys or objects, keeps parent at a distance, and appears detached. Child may be more responsive to strangers than parent. Child may avoid strong emotions, act indifferent, and have difficulty recognizing or voicing own feelings. Child wants attention from parent on own terms.

Parent tends to be unresponsive, unable to read child's cues correctly, intolerant of child's needs, impatient, rejecting, unavailable, neglectful.

Insecure-Ambivalent/Anxious:

Child tends to have push me-pull me approach with parent. Described as "adolescent angst a decade too soon." Child may be angry, avoidant, highly immature, dependent, clingy, resistant to exploring, and inconsolably distressed upon separation. Upon reunion, child may also demonstrate emotional upset. Child appears to not trust that parent will stay and to have strong fears of abandonment. Child may use angry, resistant behavior as a means of reengaging the parent. Child may have intermittently satisfying relationship with the parent. Child may seek rough affection (e.g., crashing into parent) and resist cuddling.

Parent may tend to be inconsistently responsive, intrusive, and unpredictable.

This profile is more likely to be limited to an Insecure-Anxious presentation if the child has a history of early abandonment or institutional care, where there is no other history of abuse. This child may show a strong fear of abandonment, perpetual separation anxiety, and a strong desire to please adults. They may worry about relationship status even with non-family members, and seek a high level of reassurance. The child may not show other problems outside of the parent-child relationship, and may present as the somewhat submissive, "model child" to others.

If Insecure-Anxious, parent may also present with high level of anxiety and self doubt as a parent. Child absorbs anxiety and also doubts whether parent can calm child.

All of the above patterns are an organized strategy for coping (i.e., reducing stress) with separation and are considered “good enough” strategies for attachment. Even insecure attachment patterns are still organized attempts by the child to maintain a connection with the parent.

Disorganized:

Child lacks organized strategy for regaining proximity or reducing stress when separated from caregiver or reunited with caregiver. The child’s goal is less about a desire for connection and more about a genuine fearfulness. Child shows contradictory behaviors such as running toward the parent and then freezing and appearing dazed/confused. Child shows extreme rage. This attachment style is a predictor of serious behavior and emotional problems, including clinical disorders of attachment.

Parent may tend to be traumatizing or frightening (e.g., abusive), disorganizing, or chaotic (e.g., dissociative, distressed parent who is victim of domestic violence). Frequent placement disruptions in history.

Reactive Attachment Disorder (RAD): This is clinical diagnosis for the most serious attachment problems. It is sometimes overused by clinicians, and there may be a propensity for clinicians to jump to this conclusion if there is a known trauma history prior to adoption. The diagnosis requires that there be severely impaired and inappropriate interpersonal relations before age five. The impairment extends across social situations and is not due to another disorder (e.g., Autism). It is generally manifested across different caregivers. There is a known history of serious neglect, maltreatment, or disrupted attachment. RAD symptoms may be more severe if disruption occurs in early childhood (first three years) and if there were frequent disruptions.

Inhibited type: Ambivalent, inhibited, or hypervigilant reaction to one or more adults (one being parent); highly comorbid with PTSD.

Disinhibited type: Approach unfamiliar people for affection, comfort, or social needs; much more treatment resistant symptom.

Resources for this Handout:

Siegel, D. & Hartzell, M. (2003). *Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children who Thrive*. New York: Penguin Group.

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Normative Attachment

0-3 months:

Infant expresses physiological need (hunger, fatigue, warmth, comfort); Parent provides sensitive, timely response; Parent regulates infant's arousal; Parent holds, cuddles, rocks; High sensory exposure. Child starts to learn that parent will meet needs; Child learns she can communicate her needs; Child begins to absorb parent's regulatory system based on parent's responsiveness.

3-6 months:

Child driven by physiological needs and needs for social interchange; Child actively elicits emotional response from parent; Learns to trust parent; begins to demonstrate preference for parent; Child mimics and mirrors parent; Begins to read parents' nonverbal cues.

6-9 months:

Child able to seek proximity to preferred attachment figure; Separation anxiety begins. Emerging quality of reciprocity. Child begins to internalize soothing regulation of parent; Mobility and exploration begin.

9-12 months:

Child has strong preference for parent. Full set of operational attachment behaviors; Parent is secure base and child explores; Child cautious with stranger/novel stimuli; Cognitive, language, social, emotional, and moral development progressing appropriately.

Institutional Attachment

0-3 months:

Infant expresses physiological need (hunger, fatigue, warmth, comfort); Caregiver may not be available; Rapid, routine care with little nurturance; limited individualized attention; sensory deprivation; child begins to distrust caregiver's ability to meet needs; child distrusts own ability to communicate needs to others; child goes unsoothed and fails to internalize regulation.

3-6 months:

Child driven by physiological needs and needs for social interchange; Needs met inconsistently by multiple providers in institutional manner; little opportunity for playful or nurturing interaction. Inhibition and avoidance in child emerges. Child may begin to resist cuddling. Little opportunity for mirroring facial, emotional, or nonverbal cues.

6-9 months:

Child turns to any readily available adult. Starts to rely more on self; cries out less; expects needs to go unmet; little trust; can't internalize soothing regulation; mobility often delayed. Hypoarousal

9-12 months:

Insecure attachment pattern (avoidant or anxious) at best; cognitive, physical, language, social, moral, emotional development at risk for delays. Sensory issues (blocking, reactivity) possible. Poor read of others' facial, nonverbal cues.

Abusive/Chaotic Attachment

0-3 months:

Infant expresses physiological need (hunger, fatigue, warmth, comfort); Parent distressed, inconsistent, reactive, or hurtful with response; Parent likely to misread baby's signals; Infant's distress increases. Stress hormones increase in baby and parent; risk for abuse escalates; Child experiences prolonged distress and does not internalize ability to self soothe.

3-6 months:

Child driven by physiological needs and needs for social interchange; Child needs parent but also fears parent; Child may develop inconsistent communication of needs, further confusing parent's ability to read child's signals. Child averts gaze, shows little pleasure. Child may appear frozen, easily startled, unresponsive, or highly agitated.

6-9 months:

Child may shut down and not turn to other adults or may instead go to any readily available adult; child unable to internalize emotional regulation skills from parent; child's ability to read danger is distorted; significant impact on limbic system. Hyperarousal.

9-12 months:

Insecure ambivalent or disorganized attachment pattern likely. Internal model for relationships based on fear, uncertainty, and distress. Probable delays with noted problems in the areas of executive functioning and emotional regulation. Poor/distorted read of facial, nonverbal cues.

Developed by Ally Burr-Harris, Ph.D., Licensed Psychologist.

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