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**Symptoms Which May Develop When Age-Appropriate Mastery is Interrupted by Abuse**

**AGE 1 Stage: Trust vs. Mistrust**

**Boundary Disorders Attachment Disorders**

**MPD/DID and “Frozen watchfulness”**

**Affect Dysregulation (Borderline)**

**Cut off from sensory awareness of body functions**

**AGE 2 - 3 Stage: Autonomy vs. Shame/Doubt**

**Poor communication skills Shame & Doubt Guilt**

**Inappropriate sexual language Pathological Lying**

**Can over-control and over-constrict themselves**

**Enuresis Encopresis**

**AGE 4-6 Stage: Initiative vs. Guilt**

**Poor peer relations Poor social skills Over-docility**

**Obsessive compulsive Paralysis Withdrawal Seizures**

**Stomachaches Showing off Danger seeking Fire setting Rage**

**Exploitation/manipulation of others Mutilation of animals**

**AGE 7-11 Stage: Industry vs. Inferiority**

**Poor school performance School phobia**

**Sexual reenactment w/peers, younger sibs**

**Secrecy Elective mutism Memory loss**

**Age 7-11 (cont.)**

**Daydreaming/nightmares Fear of retaliation Anxiety Inadequacy**

**Identification with the oppressor Over-parentification**

**Inferiority No real concept of sexuality Lack of empathy**

## **PROTECTIVE FACTORS and RISK FACTORS FOR CHILDREN IMPACTING ON MENTAL HEALTH**

### **Protective Factors:**

Dispositional attributes of child (e.g., ability to adjust to new situations)  
Internal assets (recognition of strengths, interests, talents, abilities)  
Healthy coping skills, (e.g., positive self-talk, sense of humor)  
Positive adaptation to learning environment at school  
Positive self-esteem and feelings of competence  
Self-control and self-discipline  
Optimism – seeing obstacles as challenges to confront  
Achievement motivation  
Social comprehension (interpersonal understanding)  
Problem-solving ability  
Sense of purpose and future  
Insight  
Growing autonomy, empowerment  
Ability to seek out assistance and nurturance appropriately  
Ability to define aspects of their lives over which they have control  
Positive attachment to primary caretaker, and supportive family members  
Watchful parents who practice the art of sensitive parenting  
Support persons outside the family (e.g., teachers, coaches, friends)

Caring environmental systems (e.g., faith community, drama club)

**Risk Factors:**

Frequent moves, chaotic residency (temporary stays at motels, shelters)  
Loss of close family members (death, divorce, dislocation, incarceration)  
Loss of neighborhood, friends, changing schools multiple times  
Consequences of poverty (lack of food, medical care, clothing)  
Loss of possessions, toys, books, pets, favorite furnishings, etc.  
Pre-existing conditions (cognitive, mental or physical disabilities)  
Family history of mental illness, substance abuse, disability  
Family history of domestic violence, lack of safety/stability  
History of trauma (medical, accidental, physical/sexual abuse)  
Attachment disorders  
Arrest history  
Being teased/shamed about homeless status  
Exposure to the elements  
Lack of positive role models; negative peer pressure

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**Silent victims revisited: the special case of domestic violence.**

**(Commentaries)**

Barry Zuckerman; Marilyn Augustyn; Betsy McAlister Groves; Steven Parker.

Abstract: Pediatricians should address the needs of children who witness domestic violence. Children, even toddlers, may experience serious adverse emotional and behavioral symptoms such as appetite, play, and sleep disturbances as a result of witnessing domestic violence. Teenagers may do poorly in school or become drug or alcohol abusers. Children from abusive homes are also more likely to grow up to be victims or abusers themselves. In addition, the abused mothers, struggling with the distress of their own lives, may be unable to meet their children's emotional needs. Pediatricians should ask open ended questions about the child's exposure to violence and about how conflicts are resolved in the child's family. If domestic violence is exposed, the pediatrician should offer community resources to the mother and help her formulate a safe plan of action. Pediatricians can also help counsel the child, modeling how the mother can help her child cope

with frightening or distressing events.

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In a commentary published previously, we communicated our concern regarding the plight of children who witness violence.[1] Research suggests that children who witness violence suffer significant psychologic and behavioral problems that interfere with their ability to function in school, at home, and with peers. The primary focus of that commentary was children who witnessed community violence. Our ongoing clinical experience, heightened by media attention on domestic violence, including the O.J. Simpson case, leads us to revisit silent victims with a sole focus on those children who witness domestic violence. Domestic violence is a particularly devastating event for a child who, in the presence of danger, typically turns to a parent for protection and for whom there is no comfort or security if one parent is the perpetrator of violence, and the other is a terrified victim.

Only recently has public attention and physician education focused on women who are victims of domestic violence, and, as of yet, little or no attention has been paid to the consequences and needs of children who witness that violence. For example, in 1992, the American Medical Association published separate booklets containing diagnostic and treatment guidelines on child sexual abuse, child physical abuse and neglect, and domestic violence. The Massachusetts Medical Society published and disseminated a guide for all physicians and medical students in the state on violence between partners. None of these guides discussed the problems of children who witness violence.

## EPIDEMIOLOGY

The source of the first exposure to violence for children is often domestic violence. Occasional wife battering is estimated to exist in 16% of all families, and 3.4% (or 1.8 million women) are beaten regularly by their husbands.[2] One study reported that 40% of mothers reported violence in their families as a way of "settling disagreements." [3] In families in which women are being battered, the majority of the children in these houses will have witnessed that violence. In 1985, a National Family Violence Survey showed that more than 3.3 million children per year witnessed Physical assaults between their parents.[4] In a study at the Pediatric Primary Care Clinic at Boston City Hospital, 10% of children witnessed shootings or stabbings before the age of 6 (half of which occurred at home).[5] In Los Angeles County, the sheriff s sexual assault

investigators estimated that a child is present at 50% of rapes occurring at home, and that 10% had directly witnessed the rapes.[6]

## IMPACT ON CHILDREN

### Psychological and Behavioral Effects

Witnessing violence in the home can be as traumatic for children as being a victim of violence. Those children may suffer posttraumatic stress disorder (PTSD) or show evidence of behavioral or emotional problems that do not meet the full criteria for PTSD. Research has shown that even expressions of anger between parents negatively affect children's emotions and behavior.[7] Children who witness severe and/or chronic violence are more likely to develop symptoms of PTSD, especially if they are younger, if the violence is frequent, and if it is perpetrated in close proximity to them.[8]

Even infants and toddlers may suffer symptoms in response to witnessing violence. Boston City Hospital's Child Witness to Violence Project documents symptoms associated with PTSD in their youngest referrals (ages 20 through 36 months). There are also clinical reports of young children who have stopped eating and/or "lost their appetite," leading to failure to thrive. Published case studies show that children are able to nonverbally register specific details of traumatic events by 16 months of age.[9] Young children who witness violence may engage in "posttraumatic play," ie, play that contains themes associated with the trauma but is repetitive, monotonous, and never achieves a satisfactory resolution. Although posttraumatic play often is a reenactment of a violent event, it does little to relieve the anxiety stirred by psychic trauma.[10]

Recurrent images of the traumatic event or fatigue caused by sleep disturbances may disrupt children's concentration in school.[11] They may become fearful of leaving their mothers alone because of their worries about the mothers' safety. Some children heroically attempt to protect their mothers, and, in acting tough to mask their fears, seem callous and uncaring. They may avoid certain activities, exploration, and thoughts for fear of reexperiencing the traumatic events. These symptoms interfere with normal behavior and development and during adolescence may lead to poor grades, dropping out of school, or self-medication with drugs and alcohol.[12]

## Social Modeling

Violence between parents teaches children powerful lessons about the role of violence in intimate relationships. Children who grow up in violent homes, for example, are more likely to be aggressive with peers.[13] They are also more likely as adults to become batterers or victims themselves.[14,15] A disproportionately large number of men who batter have grown up in homes where their fathers battered their mothers. Girls who grow up in violent homes are more likely to be battered as adults than girls who do not grow up in such homes.[14,16] Additionally, there is a high correlation between spousal abuse and child abuse: in 40% to 60% of the homes where there is interparental violence, child abuse also occurs. Half of these children who are abused are caught in the middle of assaults between parents.[17]

## IMPACT ON PARENTING

Parenting under any circumstances is difficult and challenging. However, when a woman (as is true in 95% of cases) is the victim of domestic violence, the difficulties take on a new dimension. As a victim, she may become so preoccupied with the critical issues of safety and survival that she is unable to fully assess her children's needs or mental states. Symptoms of PTSD, depression, and/or emotional constriction may develop. Her ability to be empathetically attuned to her children suffers. As she becomes numb or desensitized to the violence in her life, she begins to minimize its impact on her children. Parents often feel children are unaware of the violence in the home. We have found that parents consistently underreport what children have seen; in separate interviews, though, these children give painfully vivid accounts of fights or assaults in the house.

## THE PEDIATRICIAN'S ROLE

Because the scars of children who witness violence are invisible, the primary care clinician may not fully appreciate their distress and miss the opportunity to provide needed help. Primary care clinicians need to identify mothers in their practice who are victims of domestic violence and children who have witnessed violence.[18] Asking families questions about exposure to violence demonstrates the pediatrician's concern about violence in children's lives. For example, the clinician might say, "know that there is a lot of violence in our world these days. I have begun to ask all of my patients about their experiences with violence. I would like to ask you a few questions .... Has your child witnessed violence on the

streets, in your neighborhood, or in the home? What happened? What did the child see or hear? Have you noticed any changes in your child you feel might be related to these events?" A related line of questioning focuses on conflict resolution and on how parents or other people in the house settle arguments, eg, "Do they yell, push, hit, threaten or use a weapon?"

If the parent responds positively, the clinician can inquire about the occurrence of injury, the parents' safety, and whether the child witnessed these events. If there is a disclosure of domestic violence, it is essential that the pediatrician first assess the safety of the mother and her children and whether the child was abused. Maximizing safety may be a difficult task when the mother feels unable to leave the batterer because she does not have the financial means or because she is too frightened. Her fear may be well founded; women are at greatest risk for severe injury immediately after leaving their partners.[19] The discussion between the pediatrician and the mother should include the clinician's concern about the impact of violence on the mother and children and should express the clinician's willingness to support the mother whether she is able to leave the batterer or not. A plan should be formulated for the mother in the event of future violence. This includes the telephone numbers of local domestic violence hotlines and battered women's shelters. A referral for counseling should be encouraged, preferably with a therapist who is familiar with battered women's services and the legal system.

In some cases a mother may bring a child to the pediatrician because of her concern about the effects of having witnessed violence. Often this occurs after the issues of safety and survival have been resolved when they have left the batterer (perhaps while living in a shelter for battered women).

Some families of children who witness domestic violence can be effectively counseled by the primary care pediatrician. Counseling should include a careful review of the facts and details of the violent events. By asking sensitive and detailed questions, the clinician models for the parent how to talk to children about frightening and unpleasant events. It is helpful to children to be able to talk about such events with their mothers. For some children the process of telling their stories in detail is, in itself, therapeutic. Children's behavioral symptoms should be monitored closely. The pediatrician should recommend strategies to enhance children's feelings of safety and security, such as establishing consistent routines. If violence has been severe and/or chronic, and if the child's symptoms are significant and interfere with school work and

relationships with peers and family, a referral to a mental health professional is indicated.

If information is shared by the mother indicating that the child has been injured or is at high risk of abuse, the physician is obliged to follow appropriate legal guidelines for reporting to the state child protection agency. In addition, the physician should document both the mother's disclosure of the abuse she experienced and referral for her and her children for counseling and/or emergency shelter.

The judicial systems have become increasingly sensitive to the plight of women who are victims of domestic violence. This includes, among other things, a greater use of restraining orders against batterers and more careful judicial decisions regarding visitation and custody. Pediatricians should be aware of the potential stress of a child visiting with a parent whom the child had witnessed beating his mother. This is especially true if the violence has been chronic and severe. Visitation with a father who has beaten the mother may elicit traumatic memories or flashbacks for children.

## IMPLICATIONS AND CONCLUSION

Pediatricians have long considered parental and family dysfunction and child and sexual abuse within their clinical purview. We have not yet, however, focused on the needs of children who witness violence. We no longer can afford to ignore this problem. Children are being traumatized and are learning maladaptive lessons about the use of violence in relationships. From a policy perspective, it is important that data be generated to provide accurate information regarding the number of children who witness domestic violence. This could be done, for example, by tabulating police reports of domestic violence. We also need further study to understand how children are affected by witnessing violence, especially why some children seem to be more resilient to its effects than others. At a clinical level, all care givers, parents, health professionals, and police need to work together to identify children who witness violence and to ensure that they get the counseling services and interventions they need. These services represent secondary prevention by breaking the cycle of children who witness violence and later engaging in violent behavior as adults. Training and reimbursement for pediatricians and other child clinicians should have high priorities. Reimbursement for these services in the present health care climate may be difficult, because this intervention, like many other pediatric interventions, potentially will accrue savings for social service and/or education and not for the

health sector. Finally, we need to focus our efforts on primary prevention: educating our patients, supporting stronger sanctions for batterers, and teaching children that intimate relationships don't have to be violent.

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## SCREENING FOR CHILD WITNESSES OF DOMESTIC VIOLENCE

### Framing Questions:

**It is helpful to start with a statement that talks about the common occurrence of violence and normalizes the questions you are about to ask.**

**When asking questions, frame your questions in a way that is reflective of the significant relationships in the child's life. For example, be aware the perpetrators may be parents, step-parents or other relatives.**

**Note: Children (which includes teens) may not be able to answer all your questions at one time. If you need to ask them over time, that is ok. Also, you may need to ask the questions more than once. It is not uncommon for children to say "no" when first asked about experiences with family violence.**

Here are a few suggestions:

- "Because violence happens in a lot of families, I am asking everyone about it."
- 
- "I am concerned that you are behaving \_\_\_\_\_ (describe) because someone is scaring you."
- 
- "I don't know if this is happening to you, but many children I see are being scared by other people. Some children are too scared or do not know that it is okay to talk to me about it. So, I have started asking everyone if they are being scared by someone."
- I am going to ask you some questions.
- We can stop whenever you want to stop. You can tell me to stop. You can hold up your hand to stop me. It is okay for you to stop me at anytime.
- If you do not want to talk to me, it is okay.
- You do not have to answer all my questions.

### Possible Screening Questions:

Do you feel afraid at anyone in your family?

Who?

What did she/he do to scare you?

Do you feel angry of anyone in your family?

Who?

What did he/she do?

Does someone say things to you that make you feel bad about yourself?

Who?

What did he/she say to you?

What happens when people in your family get angry?

Did you see or hear something scary that you think a lot about now?

If you want to, tell me about what happened.

Has anything happened to you that you cannot talk about?

If you want to, tell me why you cannot talk about what happened.

Has anyone taken or broken something in your home that was important to you?

Has anyone hurt your pet? Who? What happened?

Have anyone in your family had to go to a doctor because someone hurt them?

Are you worried that your mom or dad (or other relative) may get hurt by someone in your home while you are in school?

Have the police ever come to your home because someone was getting hurt?

Have you ever hidden in a safe place in your home because someone scared you?

Adapted from VSDVAA document on Working with People with Disabilities, 2005.

## THE EFFECTS OF VIOLENCE ON CHILDREN

*The Domestic Abuse Intervention Project (DAIP) in Duluth, Minnesota,*

All children are affected by violence. The signs may be different in each child because of the way children:

- Decode and interpret the experience
- Have learned to cope and survive in stress
- Use support people, like teachers and grandparents

### **Emotional Effects:**

- Guilt- responsible for violence

- Shame- doesn't happen anywhere else
- Fear- of expressing feelings (anger), of divorce or separation, of the unknown, of injury, of a hostile world
- Confusion- conflicted loyalties (love/hate)
- Anger- about violence, chaos
- Depression/Helplessness/Powerlessness- to change things ( especially caretaker children)
- Grief- of losses
- Burdened- inappropriate roles as caretakers, parents, etc.

#### **Behavioral Effects:**

- act out vs. withdraw
- Overachiever vs. underachiever
- Refuses to go to school
- Caretaking- filling adult roles
- Aggressive or passive bullying or "doormats"
- Rigid defenses- aloof, sarcastic, rigid, blaming, defensive
- Seeking attention in behaviors
- Bedwetting, nightmares

#### **Physical Effects:**

- Somatic complaints (headaches, stomach aches, asthma, etc.)
- Nervous, anxious- short attention span (seems like hyperactivity)
- Tires, lethargic (seems like lazy)
- Often sick with colds, flu, etc.
- Neglect personal hygiene
- Regression in developmental tasks (regressive behavior)
- No reaction, at times, to physical pain

#### **Social Effects:**

- Isolated- no friends or distance in relationships
- Relationships with friends may start intensely and end abruptly
- Difficulty trusting others
- Poor conflict resolution skills
- May be excessively socially involved (overcompensates by staying away from home)

#### **Cognitive Effects:**

- Feel responsible for violence
- Blame others for their behavior (to not act responsibly)
- Feel that it is OK to hit others for whom they care in order to:
  1. Get what you want
  2. Express anger
  3. Feel powerful
- Low self-concept (cannot succeed in changing violence)
- Don't ask for what they need
- Don't trust (promise to change)

- Feel anger is bad- people get hurt  
Being a boy means....being a girl means....being a man/woman/parent means.....strict gender

## **GOALS FOR INTERVENTION IN DOMESTIC VIOLENCE CASES**

- 1. TO PROTECT THE CHILD**
- 2. TO HELP THE ABUSED MOTHER PROTECT HERSELF AND HER CHILDREN, USING SUPPORTIVE, NONCOERCIVE, AND EMPOWERING INTERVENTIONS;**
- 3. TO PROVIDE (OR MAKE REFERRALS TO) SERVICES TO FAMILIES WHERE DOMESTIC VIOLENCE HAS BEEN IDENTIFIED (EVEN IF CHILD ABUSE HAS NOT BEEN SUBSTANTIATED).**
- 4. TO HOLD THE DOMESTIC VIOLENCE PERPETRATOR (NOT THE ADULT VICTIM) ACCOUNTABLE FOR THE ABUSE AND RESPONSIBLE FOR STOPPING THE ABUSIVE BEHAVIOR.**

**Bonding and Attachment in  
Maltreated Children: How You Can Help\***

**Dr. Bruce Perry**

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### **BONDING AND ATTACHMENT IN MALTREATED CHILDREN – HOW YOU CAN HELP** By [Bruce D. Perry, M.D., Ph.D.](#)

The most important property of humankind is the capacity to form and maintain relationships. These relationships are absolutely necessary for any of us to survive, learn, work, love, and procreate. Human relationships take many forms but the most intense, most pleasurable and most painful are those relationships with family, friends and loved ones. Within this inner circle of intimate relationships, we are bonded to each other with "emotional glue" — bonded with love.

Each individual's ability to form and maintain relationships using this "emotional glue" is different. Some people seem "naturally" capable of loving. They form numerous intimate and caring relationships and, in doing so, get pleasure. Others are not so lucky. They feel no "pull" to form intimate relationships, find little pleasure in being with or close to others. They have few, if any, friends, and more distant, less emotional glue with family. In

extreme cases an individual may have no intact emotional bond to any other person. They are self-absorbed, aloof, or may even present with classic neuropsychiatric signs of being schizoid or autistic.

The capacity and desire to form emotional relationships is related to the organization and functioning of specific parts of the human brain. Just as the brain allows us to see, smell, taste, think, talk, and move, it is the organ that allows us to love — or not. The systems in the human brain that allow us to form and maintain emotional relationships develop during infancy and the first years of life. Experiences during this early vulnerable period of life are critical to shaping the capacity to form intimate and emotionally healthy relationships. Empathy, caring, sharing, inhibition of aggression, capacity to love, and a host of other characteristics of a healthy, happy, and productive person are related to the core *attachment* capabilities which are formed in infancy and early childhood.

## What Can I Do To Help Maltreated Children?

Responsive adults, such as parents, teachers, and other caregivers make all the difference in the lives of maltreated children. This section suggests a few different ways to help.

**Nurture these children.** They need to be held, rocked, and cuddled. Be physical, caring, and loving to children with attachment problems. Be aware that for many of these children, touch in the past has been associated with pain, torture, or sexual abuse. In these cases, make sure you carefully monitor how they respond — be "attuned" to their responses to your nurturing and act accordingly. In many ways, you are providing replacement experiences that should have taken place during their infancy — but you are doing this when their brains are harder to modify and change. Therefore, they will need even more bonding experiences to help them to develop attachments.

**Try to understand the behaviors before punishment or consequences.** The more you can learn about attachment problems, bonding, normal development, and abnormal development, the more you will be able to develop useful behavioral and social interventions. Information about these problems can prevent you from misunderstanding the child's behaviors. When these children hoard food, for example, it should not be viewed as "stealing" but as a common and predictable result of being deprived of food during early childhood. A punitive approach to this problem (and many others) will not help the child mature. Instead, punishment may actually increase the child's sense of insecurity, distress, and need to hoard food. So many of these children's behaviors are confusing and disturbing to adults. You can get help from professionals if you find yourself struggling to create or implement a practical and useful approach to these problems.

**Interact with these children based on emotional age.** Abused and neglected children will often be emotionally and socially delayed. And whenever they are frustrated or fearful, they will regress. This means that, at any given moment, a ten-year old child may emotionally be a two-year old. Despite our wishes that they would "act their age" and our insistence to do so, they are not capable of that. These are the times that we must interact with them at their emotional level. If they are tearful, frustrated, or overwhelmed (emotionally age two), treat them as if they were that age. Use soothing non-verbal interactions. Hold them. Rock them. Sing quietly. This is not the time to use complex verbal arguments about the consequences of inappropriate behavior.

**Be consistent, predictable and repetitive.** Maltreated children with attachment problems are very sensitive to changes in schedule, transitions, surprises, chaotic social situations, and, in general, any new situation. Busy and unique social situations will overwhelm them, even if they are pleasant! Birthday parties, sleepovers, holidays, family trips, the start of the school year, and the end of the school year — all can be disorganizing for these children. Because of this, any efforts that can be made to be consistent, predictable, and repetitive will be very important in making maltreated children feel safe and secure. When they feel safe, they can benefit from the nurturing and enriching emotional and social experiences you provide them. If they are anxious and fearful, they cannot benefit from your nurturing in the same ways.

**Model and teach appropriate social behaviors.** Many abused and neglected children do not know how to interact with other people. One of the best ways to teach them is to model this in your own behaviors, and then narrate for the child what you are doing and why. Become a play-by-play announcer: "I am going to the sink to

wash my hands before dinner because..." or "I take the soap and put it on my hands like this...." Children see, hear, and imitate.

In addition to modeling, you can "coach" maltreated children as they play with other children. Use a similar play-by-play approach: "Well, when you take that from someone, they probably feel pretty upset; so if you want them to have fun when you play this game, then you should try..." By more effectively playing with other children, they will develop some improved self-esteem and confidence. Over time, success with other children will make the child less socially awkward and aggressive. Maltreated children are often "a mess" because of their delayed socialization. If the child is teased because of their clothes or grooming, it would be helpful to have "cool" clothes and improved hygiene.

Maltreated children have problems with modulating appropriate physical contact. They don't know when to hug, how close to stand, when to establish or break eye contact, what are appropriate contexts to wipe their nose, touch their genitals, or do other grooming behaviors.

Ironically, children with attachment problems will often initiate physical contact (hugs, holding hands, crawling into laps) with strangers. Adults misinterpret this as affectionate behavior. It is not. It is best understood as "supplication" behavior, and it is socially inappropriate. How adults handle this inappropriate physical contact is very important. We should not refuse to hug the child and lecture them about "appropriate behavior." We can gently guide the child on how to interact differently with grownups and other children ("Why don't you sit over here?"). It is important to make these lessons clear using as few words as possible. They do not have to be directive — rely on nonverbal cues. It is equally important to explain in a way that does not make the child feel bad or guilty.

**Listen to and talk with these children.** One of the most helpful things to do is just stop, sit, listen, and play with these children. When you are quiet and interactive with them, you will often find that they will begin to show you and tell you about what is really inside them. Yet as simple as this sounds, one of the most difficult things for adults to do is to stop, quit worrying about the time or your next task, and really relax into the moment with a child. Practice this. You will be amazed at the results. These children will sense that you are there just for them, and they will feel how you care for them.

It is during these moments that you can best reach and teach these children. This is a great time to begin teaching children about their different "feelings." Regardless of the activity, the following principles are important to include: (1) All feelings are okay to feel — sad, glad, or mad (more emotions for older children); (2) Teach the child healthy ways to act when sad, glad, or mad; (3) Begin to explore how other people may feel and how they show their feelings — "How do you think Bobby feels when you push him?" (4) When you sense that the child is clearly happy, sad, or mad, ask them how they are feeling. Help them begin to put words and labels to these feelings.

**Have realistic expectations of these children.** Abused and neglected children have so much to overcome. And, for some, they will not overcome all of their problems. For a Romanian orphan adopted at age five after spending her early years without any emotional nurturing, the expectations should be limited. She was robbed of some, but not all, of her potential. We do not know how to predict potential in a vacuum, but we do know how to measure the emotional, behavioral, social, and physical strengths and weaknesses of a child. A comprehensive evaluation by skilled clinicians can be very helpful in beginning to define the skill areas of a child, as well as the areas where progress will be slower.

**Be patient with the child's progress and with yourself.** Progress will be slow. The slow progress can be frustrating, and many adults, especially adoptive parents, will feel inadequate because all of the love, time, and effort they spend with their child may not seem to be having any effect. But it does. Don't be hard on yourself. Many loving, skilled, and competent parents and teachers have been swamped by the needs of a neglected and abused child.

**Take care of yourself.** For parents and other adults, caring for maltreated children can be exhausting and

demoralizing. Adults cannot provide the consistent, predictable, enriching, and nurturing care these children need if they are depleted; it is important to get rest and support. Respite care can be crucial for parents, who should also rely on friends, family, and community resources.

**Take advantage of other resources.** Many communities have support groups for adoptive or foster families; as an education professional, you might help by suggesting some, or asking a school psychologist or other counselor to do so. Professionals with experience in attachment problems or maltreated children can also be very helpful. You too will need help; don't be afraid to ask for it. Remember, the earlier and more aggressive the interventions, the better. Children are most malleable early in life, and as they get older, change is more difficult. Take advantage of this time to make a difference in a child's life.

\*Adapted in part from: *"Maltreated Children: Experience, Brain Development and the Next Generation"* (W.W. Norton & Company, New York, in preparation)

## **Decreasing the Alarm State: The Core of Therapeutics**

Bruce Perry, M.D., Ph.D.

How do you begin to help the traumatized child -- the child that has been living in the vortex of violence? The frustrating fact is that whether teacher, caseworker, mental health professional, pediatrician, police officer or any other caring adult, we often are unable to remove a child from the Vortex. We see the impact, we know the home, the community, the peer group, and the gang will stay the same. We know that for '24-7' the child is in settings where we may have no control or impact. This need not be reason for despair -- motivation for outrage and action, yes -- but there is no reason for hopelessness.

An amazing quality of the human brain is to create an image of the future. To make an internalization of a better place, a better way, a better life, a better world. This capacity is called hope. We can give children hope that not all adults are inattentive or abusive or unpredictable or violent. Some of the most influential people in any person's life may be someone they have never even met. They have used that person to create an inner image to aspire to, to idealize, to idolize. Role models, mentors, and heroes -- all can provide critical formative experiences for children.

And what are the qualities that we should introduce into our work to provide the experience for the children that can give them hope and the opportunity for change? The hallmarks of the transforming therapeutic interaction are safety, predictability and nurturance. The most 'therapeutic' interactions often come from people who have no training (or interest) in psychological or psychiatric labels, theories, treatments and the adult expectations of the child that go with these. In interacting with the child, respect, humor and flexibility can allow the child to be valued as what they are.

Clinical principles for effective work with children have additional critical elements. One is helping the child understand what they feel and why they behave a certain way in given situations. Traumatized children frequently act impulsively and misunderstand why this

has happened. They will often explain this (as will the adults around them) as the by-product of them being stupid, insensitive, bad, selfish, sick or damaged in some way. The false cognitions of the traumatized child need to be addressed and changed. A second important element of clinical work with traumatized children is educating the adults in the child's world about the ways in which maltreated and traumatized children think, feel and behave. This can lead to understanding rather than rage. If a clinician can make the ten adults in the child's life 5 percent more psychologically understanding, they can increase the number of neutral and positive experiences in the child's life ten fold -- and decrease the number of negative experiences dramatically. The resulting impact is much more effective than 45 minutes a week in the clinician's office.

There are many more important specific treatment aspects of working with these children that are beyond the scope of this paper. Yet even with optimal clinical 'techniques', treatment of maltreated children would overwhelm the entire mental health and child welfare community in this country. Today the number of children that would benefit from intervention far outstrips the meager resources our society has dedicated to maltreated children. At the end of the day -- and possibly at the end of our society -- we will have to focus on prevention.

### Prevention and Solution

What we are as adults is the product of the world we experienced as children. The way a society functions is a reflection of the childrearing practices of that society. Today, we reap what we have sown. Despite the well-documented critical nature of early life experiences, we dedicate few resources to this time of life. We do not educate our children about development, parenting or about the impact of neglect and trauma on children. As a society we put more value on requiring hours of formal training to drive a car than we do on any formal training in childrearing.

In order to prevent the development of impulsive, predatory or violent children, we need to dedicate resources of time, energy and money to the complex problems related to child maltreatment. We need to understand the indelible relationship between early life experiences and cognitive, social, emotional, and physical health. Providing enriching cognitive, emotional, social and physical experiences in childhood could transform our culture. But before our society can choose to provide these experiences, it must be educated about what we now know regarding child development. Education of the public must be coupled with the continuing generation of data regarding both the impact of positive and negative experiences on the development of children. All of this must be paired with the implementation and testing of programs dedicated to enrich the lives of children and families and programs to provide early identification of, and proactive intervention for, at-risk children and families.

The problems related to maltreatment of children are complex and they have complex impact on our society. Yet there are solutions to these problems. The choice to find solutions is up to us. If we choose, we have some control of our future. If we, as a society, continue to ignore the laws of biology, and the inevitable neurodevelopmental

consequences of our current childrearing practices and policies, our potential as a humane society will remain unrealized. The future will hold sociocultural devolution -- the inevitable consequence of the competition for limited resources and the implementation of reactive, one-dimensional and short-term solutions.

### Principles of Trauma Informed Services

Trauma-Informed services:

1. Recognize the impact of violence and victimization on development and coping strategies  
Validation of the pervasive impact of interpersonal trauma and childhood abuse increases a sense of safety and hope; Experiencing trauma affects how the world is understood
2. Identify recovery from trauma as a primary goal  
Services that directly attend to the consequences of experiencing trauma are integrated with the services needed for other issues/concerns
3. Employ an Empowerment Model  
Facilitating the client's growth and development to expand the client's ability to rely less on professional services; Includes recognition of the influence of public problems on personal issues
4. Strive to maximize a woman's choices and control over her recovery  
Providing opportunities for personal choice and control, replacing experiences of powerlessness with experiences of empowerment
5. Are based in a relational collaboration  
Therapeutic relationships provide opportunity to develop feelings of safety and trust; inherent power imbalances are recognized and flattened as much as possible
6. Create an atmosphere that is respectful of survivors' need for safety, respect, acceptance  
A safe and welcoming space is provided including space for comfort and privacy; client has the right to set limits and modify the process; clear boundaries and well-defined roles
7. Emphasize strengths, highlighting adaptations over symptoms; resilience over pathology  
Symptoms are understood as consequences of experiences, often a coping strategy to be seen as a strength; resilience is valued; capacity to function in other roles is highlighted
8. Minimize the possibilities of retraumatization  
Invasive, insensitive, or power-driven policies are replaced with client driven decisions; treatment modalities are critically considered before being put into use
9. Strive to be culturally competent, understanding each woman in the context of experience  
Working within the client's cultural values and understandings including areas of diversity such as: sexual orientation, religion, economic class, age, and disability status
10. Include consumers in designing and evaluating services  
Client input is essential; positions available might include advisory board participation or serving of focus groups to provide feedback

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