Understanding the " Progression of Aggression" in Complex Children

- ALL Violence and out of control behaviors has an " evolution" founded on fear
- Starts with unfulfilled needs/fear/anxiety
- Progresses to debilitating anxiety/ frustration and depression
- Rapidly moves to " acting out " emotions
- Shifts to Verbal and Physical Aggression
- Deteriorates to " Predatory Aggression"

Understanding and Treating Developmental Traumas and Academic Failures in Abused, Neglected and Adopted Children

Proper assessment of child's cognitive and emotional functioning leads to multi-discipline treatment

Children with damaged brains and trauma have more prominent academic and psychological failures

Knowledge of the brain helps the child and family

Psychological interventions must be "individualized"

How Do Damaged Children Perceive Reality?

1. Intelligence contributes to perception.
2. Language deficits impede understanding.
3. Perceptual deficits affect "view of reality".
4. Trauma often "lost" in cognitions and repression.
5. All damaged children struggle with "attachment".
6. "Safety and Security" are tenuous concepts.
7. Traumatized children seek "rapid solutions" or avoidance.
8. Most effective treatment is "reconstructive".

What is Lost, and What is Gained?

1. Traumatized children lose safety, security, attachment and "rational" perceptions of reality.
2. Loss of a family, even a disturbed family.
3. Premature independence and "survival".
4. Indiscriminate friendliness or withdrawal to avoid further pain and trauma.
5. "Failure of Historicity" (limited recall of early years).
6. Living in one's own reality is principle coping mechanism

How Do We Assess and Plan Treatment?

1. Knowledge of cognitive strengths, weaknesses and emotional organization/disorganization.
2. Does the child have any “attachment potential”?
3. Comprehensive assessment of developmental traumas (abuse, neglect and deprivation).
4. What are the strengths of the child?
5. Under what circumstances has the child functioned?
6. Who are the strongest attachment figures available?
7. Assess child’s potential to “recover”.

What People Call Traumatized Children

1. AD/HD, Oppositional-Defiant, Reactive Attachment Disorder, Bipolar Disorder, Anti-social, Depressed
2. Post-Traumatic Stress Disorder (and walk away)
3. A child “at risk” for abusing others
4. A child who becomes “lost in the system”
5. An “untreatable child”
6. A child who is “coping well” but still acting out
7. A child who should “get past the abuse”

Neuropsychology of Complex Neurodevelopmental and Attachment Related Disorders

1. Attachment is a complex developmental process.
2. Traumatized children have “mixed attachments” (all children remain attached to abusive parents).
3. Attachment requires cognitive processing, language, visual-perceptual, sensory-motor and emotional reciprocity
4. Traumatized children “cling” to attachments in fear of being left alone.

5. Traumatized children have skewed perceptions of relationships, reality, and performance requirements.
6. Cognitively-limited children struggle the most to overcome trauma and regress quickly.
7. Children with “challenges” frequently give up, shut down, and regress to an “autistic world”.
8. Pain and despair become a way of life.
9. “Learned helplessness” sets in making treatment difficult.
10. Cognitively intact children can analyze damage and are at even higher risk for acting out.

What Happens in School? Academic and Social Failures

1. Trauma “slows down” attention, concentration, rate of information processing and organization.
2. Chronic stress from trauma affects brain chemistry and stress hormones (Mason, 1999, 2000, 2001).
3. Guilt, self-debasement, isolation, and profound feelings of inadequacy contribute to school failure.
4. Acting out takes the place of “expression”.
5. Teachers focus on manifest symptoms versus etiology.

Where Treatment Begins: Developmental Retracking

1. Analyze the healthiest moment in child’s development.
2. Assess traits of strongest “attachment figures”.
3. Gradually move child back to safest level in development (prior to onset of trauma).
4. Recreate and rehearse appropriate developmental experiences (nurturing, attachment, safety).
5. Provide strong and stable role models that will be available for long-term attachment.
6. Create a “parallel family system” for child to work through developmental failures and experience success

Family Intervention Program

1. Assess and alter home-physical environment and make adaptations.
2. Eliminate extraneous stimuli, isolation time and utilize only primary caregivers.
3. Schedule all activities as “Adults Only”.
4. Parents or pseudo-parents adopt a “24 hour monitoring position” for all interactions and behaviors.
5. Enhance physical nurturing and “connections”.
6. Containment of aggressive and destructive urges.

7. Focus on eye contact, physical closeness, role playing, rehearsal of old and new behavioral patterns, and practice “language-interactive behaviors”.
8. Utilize “Applied Behavioral Analysis (ABA)” to contain defiance and enhance positive interactions, compliance training and motivation building.
9. Be concrete, specific, time management oriented, organized, and behavioral in orientation.
10. Teach and practice all desired behaviors (no lecturing, criticizing, begging or bribing).
11. Medical and pharmacological interventions.

Facilitating Healthy-Interactive Attachments

1. Healing damaged children requires strong attachments and strong attachment figures/role models.
2. Attachment is a “developmental process” and not a specific intervention.
3. Requires multi-discipline interventions involving cognitive rehabilitation, perceptual training, “hands on” rehearsal, consistently available role models.
4. Traumatized children “deny and avoid” the need for attachment, but it must be encouraged, pushed and “redeveloped” beginning at the level of damage.

The Concept of Attunement: Goals for Healthy Developmental Attachment

1. “Corrective Emotional Experiences” via developmental retracking, family-dynamic role playing (with a strong, available caretaker) moves in the direction.
2. Working with “feelings” is only a portion—must work with actions, behaviors, attitudes, traumatic defensiveness, PTSD, psychiatric co-morbidities.
3. “Sharing interactions and amplifying positive affective states and reducing negative patterns” is key.
4. Securing the most stable and available “models of security” is critical and must be a priority.

(Facilitating Developmental Attachments, Daniel Hughes)

Remediating the “Neurobiology of Trauma”

1. Human beings have multiple memory systems for factual data and emotional experiences.
2. Trauma impacts memory systems and provides a “set of experiences” which become deeply rooted and alter brain chemistry and subsequent behaviors.
3. “Talk therapy” does not alter the brain—new, practiced, repetitive experiences prevail.
4. Proper pharmacological intervention combined with new “sensory input and experiences” are key.
5. Emphasis on expanding language organization, conceptualization and visual-perception in relationships provides “new data”.

Trauma Therapy: Controversies

1. Traditional “Talk Therapy” versus “Holding Therapy” versus multi-discipline “Reconstructive Therapy” (Federici, 1998, 2000, 2003).
2. Recovery takes place only in the context of secure and available relationships—not isolative therapies.
3. Identification of trauma is critical, but working towards resolution and acceptance is paramount.
4. “Systematic de-sensitization” is a key element of counter-conditioning negative cognitive and behavioral patterns.

5. A “Comprehensive Model” of recovery is needed.

- Identification of trauma points
- Identification of developmental failures
- Resurrection of repressed or “lost” emotional experiences
- Constructive-interactive-dynamic “expressive therapy”
- Gradual and safe “re-exposure” to trauma
- Provide “holding environment” to work through trauma (not holding therapy or evocative techniques)
- Reconstructing cumulative emotional experiences
- Creating past, current and future life goals

Cognitive-Behavioral-Reality Treatment for Traumatized Children: The Key

1. Trauma is a “skewed reality”.
2. Trauma alters cognitions and behaviors and produces “repetition compulsion” .
3. “Cognitive Reconstruction” involves problem-solving, brain storming, rational behavior therapy, and homework assignments.
4. Reality Therapy is the Key to Success
   - Accept reality at face value
   - Know the difference of right versus wrong
   - Develop respect for self and others

Reality Therapy as a “Reconstructive Tool”

1. Confrontational, directive and reconstructive.
2. “Sounds tough” but gets to the trauma.
3. Immediately puts traumatized child in charge of their lives and destiny.
4. Develops a “Life-Picture Album” via “hands on” exercises, trainings and experiences.
5. Does not accept failure or “giving up”.
6. Pushes in a healthy way to overcome detachment, apathy, and depression.
7. Establishes safe and trusting relationships

8. Continually provides concrete and specific information and treatment goals.
9. Stimulates cognitive-neural networks that have been “damaged and disassociated”.
10. Utilizes “positive stress” to reconstruct trauma.
11. Improves independence, growth and self-integration.
12. Involves “common sense” and practical applications—not long, drawn out and painful individual counseling techniques.
13. Initially increases stress which changes to motivation.

The Case of “Anna”

8 year old, adopted Chinese girl. Abandoned at birth, lived in orphanage where she was severely abused, tied down, beaten, starved, and left to die. Agency said “child was excellent”. Single mother adopted Anna, started “aggressive holding therapy” which re-traumatized Anna. Anna is cold, indifferent, lies, hoards food, is aggressive and sexual, defiant, unmotivated, apathetic, and profoundly depressed with suicidal thoughts. These behaviors were evident at the time of adoption and have intensified despite multiple interventions. Mother is at a total loss.

Going from Bad to Worse: Facts

1. Aggressive “Holding Therapy” done 2 weeks after adoption failed and re-traumatized the child.
2. Child non-responsive to any therapies or medications.
3. Mother has given up and detached.
4. Child completely out of control.
5. Child was never properly evaluated.
6. Child may be institutionalized.

Reconstructive Interventions

1. Comprehensive neuropsychological assessment showed multiple linguistic, perceptual and intellectual limitations.
2. Profound physical, sexual and psychological trauma permeates child’s “sense of being”.
3. Post-Traumatic Stress with Major Depression results in cognitive and emotional confusion and profound “disassociation from reality”.
4. “Traumatic/Institutional-Autistic patterns” evident.
5. Proper medication to stabilize stress syndromes.

Developmental Restructuring of Anna

1. Immediate “Holding Environment” and “Adults Only”
   - No outside factors such as school, extraneous stimuli, or anything she can attach to but parent
   - Continual 24/7 supervision, rehearsal and retraining
   - Refusal to accept avoidance and isolation
   - Hands-on activities—only with Parent
   - Homework assignments, emotional retraining, work on facial expressions, body language, nurturing-holding, reality therapy for inappropriate behaviors, and emphasis on strengths
   - Avoid “indiscriminate friendliness and compliance”

- "Rearranging Reality"
- Incremental movement towards relationships and training in social skills, time management, family hierarchy, trust, safety and security.
- Role playing and role rehearsal throughout the day.
- Continual reinforcement schedules.
- Conditioning and counter-conditioning techniques (Pavlovian and Beck theories).
- Continual work on aberrant cognitions versus aberrant behaviors.
- "Level Systems" of improvement must be maintained.

"Saving Dane, Saving a Family" (Dateline NBC, June 2003)

Dane is a 10 year old, adopted boy who had a history of undiagnosed Fetal Alcohol Syndrome, Minimal Brain Dysfunction, multiple learning disabilities, Organic Mood Disorder, aggressiveness, violence, non-compliance, academic failure and gross family dysfunction. Dane failed in every treatment modality and hospital program. Dane was about to enter the foster care system on a disruption until parents decided to embark on a "Reconstructive-Cognitive-Family rehabilitation program".

1. Full neuropsychiatric evaluation finally gave a "true picture" of Dane.
2. Immediate implementation of "Adults Only" with mandatory involvement of both parents for a 90-day trial period of in-home services.
3. Total reconstruction of "Dane's reality".
4. Extensive training to parents to control violence.
5. 12-15 hour work days of cognitive-behavioral-reality techniques which yielded huge positive results.
6. Role playing, rehearsal, charting, homework assignments, cognitive redirection imperative
7. "Never Give Up" was maintained (with difficulty)

8. Reorganization of parental-marital system to work on total consistency, limits, and non-negotiating posture.
9. "Soothing re-attachment therapy" to deal with past traumas, loss, and brain impairment.
10. Reintegrating Dane into a very complex world.
11. Moving "up the Level" to a Level II program where he could gradually practice newly developed skills under strict supervision.
12. Reinforcement, rehearsal, retraining and reintegration.
13. Reality principles prevailed.
14. Training parents to accept "trauma and disabilities".

A Case of Foster Care Disaster: John & Will

John and Will are now 4 and 5 years old, and were removed from the home of parents who were alcoholics, drug addicts, prostitutes and severely physically and sexually abused these two boys. The children witnessed every conceivable act of trauma and chaos until social services removed them approximately one year ago. The children were in five different foster care placements due to their out of control behavior, and were periodically split up. They acted out aggressively, sexually, and failed in every educational and therapy program.

Developmental Trauma and System Trauma

1. Both boys have no sense of reality, consistency, safety, security or healthy adult attachments.
2. Both boys “recreated” abuse done to them.
3. Foster system failed them due to multiple placements and separations.
4. Children were “identified patients” but never evaluated or treated properly.
5. Never a stable and consistent environment to recover.
6. Children rapidly regressed to “autistic logic” and abusive/regressive/disassociative personalities.

Reconstructing Total Chaos: An Intensive Social Service Plan

1. Find solid and stable “therapeutic foster home” with strong male-female parental system with no other children.
2. Intensive in-home therapy to recreate “safety-holding environment” and training in aggression reduction.
3. Comprehensive neuropsychiatric evaluation as there was clearly brain damage involvement.
4. In-home special education interventions.
5. No outside distractions or socialization.
6. Training therapeutic foster parents the importance of strength, trauma, “reorganization”, reparenting

7. Use intensive cognitive-behavioral-paradoxical approaches.
8. “Symptom amplification” (i.e. video and audio tape all behavioral so that children can see what they are doing).
9. Constant scheduling and monitoring of every behavior.
10. Allocated hours for training, rehearsal and providing proper attachment (not indiscriminate).
11. Providing a sense of permanency and protection.
12. Children were too young for “Talk Therapy” but responded very well to role playing and limits.

13. Use of Applied Behavioral Analysis (ABA) to enhance eye contact, behavioral compliance, listening, and immediate cooperation.
14. Guided fantasy and play therapy to work through intense trauma.
15. Scripting and training in “healthy families”.
16. Counter-conditioning for “imprints” of pathological and destructive parenting patterns during early formative years.
17. Continual training and reinforcement schedules.
18. “Earning Everything, and Everything is Earned”.