

Sarah Lawrence College

DigitalCommons@SarahLawrence

---

Child Development Theses

Child Development Graduate Program

---

8-2017

## A Reflection on How Children with Insecure Attachments in Foster Care Experience Trauma

Khadija Bleasdel  
*Sarah Lawrence College*

Follow this and additional works at: [https://digitalcommons.slc.edu/child\\_development\\_etd](https://digitalcommons.slc.edu/child_development_etd)



Part of the [Child Psychology Commons](#), and the [Early Childhood Education Commons](#)

---

### Recommended Citation

Bleasdel, Khadija, "A Reflection on How Children with Insecure Attachments in Foster Care Experience Trauma" (2017). *Child Development Theses*. 17.

[https://digitalcommons.slc.edu/child\\_development\\_etd/17](https://digitalcommons.slc.edu/child_development_etd/17)

This Thesis - Open Access is brought to you for free and open access by the Child Development Graduate Program at DigitalCommons@SarahLawrence. It has been accepted for inclusion in Child Development Theses by an authorized administrator of DigitalCommons@SarahLawrence. For more information, please contact [alester@sarahlawrence.edu](mailto:alester@sarahlawrence.edu).

**A Reflection on How Children with Insecure Attachments in Foster Care Experience**

**Trauma**

**Khadija Bleasdel**

*“Submitted in partial fulfillment of the requirements of the Master of Arts degree at Sarah Lawrence College, August 2017”*

## **Abstract**

Attachment and the impact of trauma on children in foster care are reviewed and discussed from my relational perspective as a therapist. I draw upon my clinical experiences with three children in foster care who experienced some form of neglect. One child engaged in play to express her experiences of trauma, another child embodied a very mature stance to feel accepted by adults, while another child struggled with impulse control, fluctuating between being withdrawn and overly aggressive. Attachment theory as well as the implications of trauma are reviewed and discussed through the relation to my experiences with my clients during therapy sessions.

### Through the Eyes of a Child in Foster Care

Do you want to play today?  
Play as if we have no cares.  
Play so you can't see me wipe away my tears.  
Play so I can forget the burden my heart bears.  
I would rather play than talk about my fears  
of abandonment, of ache, of darkness throughout the years.

Don't look at my mirror, reflecting doom.  
I will be perfect in all that I do.  
I will be perfect so you can't see how hard I try  
to hide my insecurities on the inside.  
I will be perfect so you will accept me,  
to be whoever you want me to be.  
Like a flower that blooms in the night, I am surrounded  
by darkness, evading light.

I can't speak because my mouth is sealed shut.  
I can't speak because my mother doesn't love me much.  
I can't speak because I want her to stay but I want her to go.  
I can't speak because there is so much inside me that I do not know;  
how to cope, how to feel, how to let myself go.  
In a world of imagination is how I will grow.

I come to you as a child who wants to play.  
I come to you as a child where being perfect  
is a price too high to pay.  
I come to you as a child who tries to say,  
I need love, I need hope.  
Please teach me how to cope.

**- By Khadija Bleasdell**

## TABLE OF CONTENTS

### INTRODUCTION AND LITERATURE REVIEW

INTRODUCTION.....	1
LITERATURE REVIEW.....	2
Defining Trauma, Complex Trauma, Neglect.....	2
The Impact of Trauma, Complex Trauma and Neglect.....	4
The Effects of Trauma on Children in Foster Care.....	9
What is Attachment.....	11
The Different Types of Attachment.....	13
The Impact Insecure Attachment has on Children Who Experienced Trauma.....	16
Coping & Resilience.....	18
Trauma Treatment.....	21
REFLECTIONS ON CLINICAL WORK	
Case 1: Beth.....	22
Case 2: Nicky.....	32
Case 3: Rosalind.....	38
DISCUSSION.....	45
CONCLUDING REMARKS.....	48
BIBLIOGRAPHY.....	49

## **Introduction**

Trauma during early childhood is one of the many areas that can create a better understanding of trauma across the lifespan. This is of particular concern for young children because they are at high risk of being exposed to potentially traumatic events due to their dependency on a caregiver. There is an interface between attachment and traumatic experiences which needs to become an integral component in the assessment and treatment of young children in foster care. The incidence of traumatic events is pervasive in infancy and early childhood, but it is not consistently investigated as a possible factor in the etiology of psychological and behavioral problems in young children. The quality of attachment is also an important factor in young children's capacity to process and resolve traumatic experiences. Traumatic events in children have the potential to damage the quality of other existing adult attachments by introducing unmanageable stress to the relationship (Chu & Lieberman, 2010; De Young, Kenardy & Cobham, 2011; Lieberman & Van Horn, 2009)

## Literature Review

### Defining Trauma, Complex Trauma and Neglect

**Trauma.** The American Psychological Association defines trauma as an emotional response to a terrible event. Children who enter foster care typically experience multiple traumatic events which often times occur by the hands of their caregivers. This leads to them being removed from their homes. “Trauma during early childhood is one of the many areas that has been largely neglected and represents a significant gap in our understanding of trauma across the lifespan. This is a significant issue as infants, toddlers and preschoolers are at particularly high risk of being exposed to potentially traumatic events” (De Young, Kenardy & Cobham, 2011)

When children experience traumatic events, it can be very distressing, it puts them at a greater risk of adverse psychological outcomes. Infants, toddlers and preschoolers are at an especially high risk for exposure to trauma. Young children undergo a rapid developmental period with limited coping skills and a strong dependency on their primary caregiver. They are dependent on their caregivers to attend to their needs, protecting them physically and emotionally. Unavailable, inattentive, neglectful or abusive caregivers promote an increased likelihood of potential traumatic experiences for the child (De Young et.al, 2011).

**Complex Trauma.** The term complex trauma describes both children’s exposure to multiple traumatic events, such as abuse or profound neglect, and the wide-ranging, long-term impact of this exposure. Chronic exposure to trauma involves repeated maltreatment of children by their primary caregiving system. Maltreatment can consist of physical, sexual, psychological abuse, neglect and domestic violence. This disruption usually occurs early in life and can alter

many aspects of the child's development and formation of self. Since complex trauma often occurs in the context of a caregiver/child relationship, this disturbance alters the child's ability to form secure attachments to others. Having a secure attachment can provide a source of safety and stability for children.

When these terrible events occur continuously and involve repeated interpersonal trauma by caregivers early in life, it results in dysregulation across a range of areas. Dysregulation due to complex trauma may impact children emotionally, behaviorally, interpersonally, physiologically and cognitively. Children can experience a loss of safety, direction and ability to detect or respond to danger cues. Compared to youth with other types of traumatic experiences, those who experienced a history of complex trauma had significantly higher rates of internalizing problems, post-traumatic stress, and other clinical diagnoses. These early experiences may lead to a subsequent or repeated exposure to trauma in adolescence and adulthood (Greeson, Briggs, Kissel, Layne & Ake, 2011; De Young et. al, 2011). Complex trauma can have harsh effects on a child's physiology, emotions, ability to think, learn, concentrate, impulse control, self-image, and relationships with others. Across the life span, complex trauma is linked to a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors, and other psychiatric disorders (Impact of Complex Trauma, n.d.).

**Neglect.** Under the Keeping Children and Families Safe Act of 2003, child (considered 18 years or younger) maltreatment is defined as: "Any recent act of failure to act on the part of a parent or caregiver, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act of failure to act which presents an imminent risk of serious harm."

Neglect is the most common form of abuse reported to the child welfare system. Child neglect occurs when a parent or caregiver does not give their child the care he or she needs, even though



they can afford to provide care or is offered help to give that care. Neglect has many different forms and can have many broad definitions. Neglect can mean not giving food, clothing, and shelter. It can also mean that a parent or caregiver is inadequately providing for a child's medical and mental health needs, such as withholding medication. There is also educational neglect where a caregiver is being negligent with a child's educational needs. Neglect can also occur when a caregiver exposes a child to a dangerous environment or places him/her in a setting that is poorly supervised. Neglect can also mean abandoning a child or expelling them from a home (Child Neglect, 2006).

### **The Impact of Trauma, Complex Trauma and Neglect**

**The Impact of Trauma.** Young children manifest trauma in many different ways. Some children re-experience trauma through post-traumatic play, experience hyper-arousal or avoid reminders of the trauma. In post-traumatic play, the child may continuously and repeatedly reenact the trauma, telling the story of the event over and over again. The play can be rigid, repetitive and anxious (De Young et. al, 2011, Lieberman & Knorr, 2007). Some children exposed to trauma are also at risk for developing emotional and behavioral challenges. Often times, there are high rates of oppositional disorder (ODD), separation anxiety (SAD), attention-deficit/hyperactivity disorder (ADHD) and major depressive disorder (MDD). A traumatized child may also be hyper-aroused, in a constant state of alertness to danger (Lieberman & Knorr, 2007; Briggs-Gowan, Carter, Clark, Augustyn, McCarthy, Ford, 2010)

Some children may not be conscious of their memories and may not be able to verbally recall their memories, however, it is expressed behaviorally. There are two types of memory systems: implicit / non-declarative memory and explicit / declarative memory, also known as

autobiographical memory. Implicit memories reside outside conscious awareness yet are expressed behaviorally. The implicit emotional memory system seems to be organized in such a way that the emotional aspects of events are expressed without the context and details of the events. This form of memory is mostly mediated by the amygdala and it is closely connected to the body's response systems. These systems trigger the body's natural fight or flight responses. This system is rapid and unconscious. (De Young et. al, 2011; Kaplow, Saxe, Pynoos & Lieberman, 2006; Lovett, 2007). Explicit memories are conscious and can be expressed verbally and behaviorally. This declarative or explicit memory system is organized to remember things, details of events and contextual facts of experiences. It is highly linked to language systems and is mediated by the hippocampus and higher brain systems.

In general, both the implicit and explicit memory systems are highly coordinated. When experiencing extreme stress or trauma, the two systems become uncoupled; the sensory and affective aspects become dissociated from any coherent semantic memory system. As a result, memories are recollected as feeling a certain way without knowing why. The memories continue to exist, even in an unintegrated form; they continue to impact emotions and behaviors (De Young et.al, 2007; Kaplow et.al, 2006).

Very young children have the potential to develop and retain memories of traumatic events. They can functionally present with the emotional and behavioral manifestations of trauma, however, some very young children may be limited in their verbal abilities. As a result, assessments tend to focus on behavioral presentations of internal states rather than verbal. Due to a young child's limited cognitive capacity, their memories may present as less coherent or readily understandable to both the adult and child (De Young et. al, 2011).

**The Impact of Complex Trauma.** According to The National Child Traumatic Stress Network, complex trauma can affect children in a multitude of ways. Complex trauma can affect a child's: attachment and relationships, physical health, emotional responses, behavior, cognition, self-concept and future orientation, long term health, and potentially promote dissociation.

***Attachment and Relationships.*** The majority of abused or neglected children have a challenging time building strong, healthy attachments to caregivers. Children who experienced insecure attachments tend to be more vulnerable to stress with trouble controlling and expressing emotions. They may react violently or inappropriately. A child with a complex trauma history may experience challenges in romantic relationships, friendships and authority figures.

***Physical Health: Body and Brain.*** When a child develops in an environment that is under constant or extreme stress, the immune system and body's stress response systems may not develop normally. When in adulthood, even if exposed to ordinary levels of stress, the body's systems automatically respond as if in extreme stress. Stress in an environment can impair brain and nervous system development. Children with complex trauma may develop chronic physical complaints such as headaches or stomachaches. When these children mature to adulthood, they may engage in risky behaviors such as smoking, substance abuse and poor dietary habits that compound these conditions

***Emotional Response.*** Often times, children who experienced complex trauma have difficulty identifying and expressing emotions. They may have limited language to express their feelings. They may internalize and/or externalize stress reactions. As a result, they may undergo significant depression, anxiety or anger. The emotional responses may be unpredictable or

explosive. Having never learned how to self-soothe and calm themselves down when upset, many children who experienced complex trauma become easily overwhelmed.

***Behavior.*** A child with a complex trauma history may struggle with self-regulation, lack impulse control or the ability to think through consequences before acting. As a result, their behavior may be perceived as unpredictable, oppositional, volatile and extreme. They may engage in more high-risk and illegal activities such as self-harm, unsafe sexual practices, substance use, stealing or prostitution.

***Cognition: Thinking and Learning.*** Children who experience complex trauma may have problems thinking clearly, reasoning or problem solving. Planning ahead, anticipating the future and acting accordingly may be a challenge. They may show deficits in language development and abstract reasoning skills and may require additional academic support. This is primarily due to their internal resource to survive and their body's chronic stress response. This cascade of biological occurrences hinders thinking through problems calmly and considering multiple alternatives.

***Self-Concept and Future Orientation.*** Children learn self-worth in relation to others, especially those close to them such as caregivers. When caregivers are abusive or neglectful towards children, the children may feel worthless and despondent. A child who has been abused may blame themselves. Feelings of powerlessness, shame, guilt, low self-esteem and poor self-image are common among children with complex trauma histories.

***Long Term Health Consequences.*** The Adverse Childhood Experiences (ACE) Study is a longitudinal study that explored the long lasting impact of childhood trauma into adulthood. It was concluded that over time, childhood exposure to abuse, violence and impaired caregivers

correlated to high risk behaviors as adults. The high risk behaviors consisted of smoking, unprotected sex, chronic illness, heart disease and cancer. The traumatic childhood experiences are linked to increased medical conditions throughout their lives.

***Dissociation.*** Dissociation is common in children with complex trauma history. It can sometimes be used as an automatic defense mechanism. When these children come across an overwhelming or scary experience, they may mentally separate themselves from the experience. They see themselves as separate from their bodies, watching what happens to their bodies. It may feel like a dream or an altered state that is not real; it may even feel as if the experience is happening to someone else. Sometimes, children may lose a sense that the experience happened to them, resulting in gaps in time or personal history. Dissociation can affect a child's ability to be fully present in daily life activities resulting in a fracture of the child's sense of time and continuity, particularly in school and social interactions.

**The Impact of Neglect.** The effects of neglect can be harmful and long lasting for children. According to the U.S. Department of Social Services, young children who are neglected can be at risk for many physical problems such as a failure to thrive, severe skin infections, recurrent infections, malnourishment and impaired brain development. This can be due to inadequate medical care, leading to poor physical health and improper brain formation. The brain of a child who has been maltreated may develop in a way that is adaptive to the negative environment of the child, however, maladapted for a functional or positive environment. It may also hinder healthy cognitive and social skills. Children who were neglected may remain in a state of hyper-arousal, constantly anticipating threats, even if they are not in imminent danger. It can impair functioning later in life, promoting anxiety, aggression or being withdrawn. Also, due to this state of hyper-arousal, neglected children may be hindered in

learning academically since a child's brain needs to be in a state of "attentive calm" to learn.  
(Child Neglect, 2006)

### **The Effects of Trauma on Children in Foster Care**

According to The Adoption and Foster care Analysis and Reporting System (AFCARS) Report, 427,910 children were in foster care as of September 30, 2015. Over 670,000 children spent time in U.S. foster care and on average, children remain in state care for nearly two years and 6% of children in foster care were there for five or more years (U.S. Department of Health and Human Services, 2016).

The child welfare system, although with good intentions, may perpetuate attachment disturbances in some instances. The effects of inconsistent foster families, lengthy delays in court proceedings, and short-term or multiple mental health care providers further harm attachments and present additional hindrances for treatment. Inconsistent environments created in foster care, in conjunction with traumatic experiences, increases the vulnerability of an already fragile population of children. Maltreatment and removal from parents are traumatic events that can affect the immediate and future developmental and mental health of the neglected children (Bruskas, 2008; Lovett, 2007).

Traumatized children are at a greater risk of developing emotional and behavioral difficulties such as: anxiety, depression, attention-deficit/hyperactivity disorder, oppositional defiant disorder and separation anxiety disorder. In comparison to a non-traumatized control group, children with PTSD scored significantly higher on the Child Behavior Checklist (CBCL) internalizing, externalizing and total scales (Briggs-Gowan et.al, 2010; De Young et. al, 2011).

“Numerous children in foster care have poor developmental, mental, and educational outcomes. Many of them will struggle in their transition from foster care to young adulthood and will succumb to poor choices that will prevent them from obtaining an optimal level of health... Children with a history of maltreatment, such as neglect, who additionally endure the trauma of being separated from parents and experience feelings, for example, of fear and confusion, are vulnerable and susceptible to post-traumatic stress disorders (PTSD). Some studies show that over half of children in foster care may experience at least one or more mental disorder, and many are victims of neglect.”

(Bruskas,2008)

**Educational Outcomes.** Since children in foster care frequently move, they face many educational obstacles, rendering them vulnerable educationally. Often times they miss school days while transitioning from home to home and sometime switch schools. School credits may not always transfer between schools and school records could be lost as a result of the frequent school changes. This affects their attendance, comfort level and ultimately their long-term performance outcomes.

**Powerlessness.** Bruskas (2008), defined powerlessness as a lack of authority or control over one’s life. The powerless must obey and are unable to make any decisions themselves. Decisions tend to be made regarding a child’s placement in foster care. Although there will be lifelong implications of those decisions, the children do not participate in the decision making process. That sentiment breeds a lack of control over one’s life.

“Although it may not be practical to include small children in the decision-making process, they can still be included in this process through the provision of explanations of care. The

powerlessness of children in foster care is dramatically increased when knowledge and information about their future is withheld. It is crucial that a child experiences a sense of control and have an understanding of their life's course in order to experience a positive childhood ensuring a healthy and successful adulthood.” (Bruskas,2008).

**Transition from Foster Care to Adulthood.** If children are in foster care as adolescents, they will age out when they turn 18 years old. Some then find themselves with little financial, medical or social support. Many of whom experience difficult transitions from foster care to adulthood resulting in mental illness, criminality, and an inability to function productively and independently in society.

### **What is Attachment**

“An attachment is a reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver. A healthy attachment relationship therefore promotes physical and psychological growth for the child whose needs take priority over those of the caregiver(s).” (Lovett, 2007). A psychiatrist, John Bowlby researched the way in which babies attach to their mothers. He observed that as an almost instinctual process, human babies wanted to be close to their mothers or primary caregivers. This evolutionary act of attachment behaviors, unconsciously served as a tactic for vulnerable babies to be protected from their environment by their caregiver. As soon as babies could crawl, they tried to follow their mothers and became upset when they were separated from them (Crain, 2005). This paradigm is the basis of attachment theory.

A psychologist, Mary Ainsworth, also studied the attachment behaviors toddlers (12-24 months) demonstrated with their mothers. Through her assessment technique called the Strange



Situation, she was able to investigate and classify the quality of varying attachment behavior patterns observed between children and their mothers. While children explored their environment, Ainsworth observed how the children responded to two brief separations from their mothers. Simultaneously, she observed whether or not the children used their primary attachment (mother) as a safe, comforting, secure base (Crain, 2005).

The Strange Situation assessment technique was a procedure where toddlers were observed playing for 20 minutes while their mothers and strangers entered and left the room. The purpose was to recreate the flow of familiar and unfamiliar encounters in most children's lives. The children's responses to varied stress induced interactions were observed. Brodie (N.D.) recounted Mary Ainsworth's process of observed interactions between mothers and their child as follows:

1. Mother and child were introduced to the room where the experiment was conducted
2. Mother and child were left alone; mother allows the child to explore their environment without her participation.
3. A stranger enters the room, interacts with the mother then approaches the child while the mother leaves the room.
4. For the first separation episode: the stranger's behaviors were geared towards the child.
5. For the first reunion episode: the mother greets and comforts her child then leaves again
6. For the second separation episode: the child was left alone.
7. As a continuation of the second separation episode: the stranger entered and geared their behavior to the infant.
8. The second reunion episode: the mother entered, greeted the child, picked up the child while the stranger left.

Four aspects of the child's behavior throughout the process were explored:

1. The level of exploration the child engaged in throughout the experiment
2. The child's reactions when their mother left the room
3. The child's perceived anxiety when left alone with a stranger
4. The observed behavior when the child was reunited with her/his mother.

From this experiment, the patterns of attachment observed in children consisted of (1) Securely Attached (2) Insecure-Avoidant Infants, (3) Insecure-Ambivalent Infants and through later research, (4) Disorganized/Disoriented Infants was included (Crain, 2005).

Essentially, parent/child attachment is the bond shared between child and parent. That connection plays a pivotal role in stress regulation, anxiety or illness. Human beings have an innate bias to become attached to a protective caregiver even though the quality of the attachment may differ based on the parent's capacity to provide a secure, safe base and the social environment of the child (Ijzendoorn, 2007). Attachment styles are understood as varying in subtypes, stemming from a range of experiences. Included in these early experiences are hostile-abusive environments, psychologically traumatic experiences, loss, inconsistent and unstable environments, and trauma bonds. These family dynamics are referred to as "vulnerable dyads", indicating concerns that children in at risk families and environments will have a challenge developing a secure, internal working model needed for healthy attachment experiences (Lovett, 2007). As a result of these varying external factors, children range from being securely attached to being insecurely attached to their primary caregiver.

### **The Different Types of Attachment**

**Securely Attached Infants.** Through observations made via the Strange Situation experiment, Ainsworth discovered varying attachment behavior patterns. The healthiest

classification of behaviors was deemed a secure attachment. During the experiment, children with secure attachments used their mothers as a base from which to explore. When the mother left the room, their exploratory play lessened and they may become upset. When the mother returned to the room they actively engaged with one another while the mother stayed close. Once the child was reassured, she/he eagerly returned to playing and exploring the environment. The child's response to the departure and return of their mother indicated the child's need for proximity to mother to feel safe. The mother was able to be available, creating a healthy responsiveness to the child on a daily basis. That level of predictability created the foundation for the child to feel safe while exploring unfamiliar territory (Crain, 2005).

**Insecure-Avoidant Infants.** Children who presented with an insecure-avoidant attachment pattern appeared to be very independent during the Strange Situation experiment. When the children entered the room, they immediately went to play with the toys without the need to utilize their mother as a secure base; they tended to ignore their mother's existence. When the mother left the room the children were unfazed and did not seek proximity when their mother re-entered the room. When the mother attempted to engage with her child, the child would actively avoid interactions by averting their eyes and bodies.

Upon further investigations, the relationship between the mother and child with this attachment pattern stemmed from the mother's rejecting, insensitive, interfering behaviors at home. The child became accustomed to this style of interactions. The child's behaviors manifested because of an inability to rely on their primary caregiver for support and therefore they reacted in a defensive manner. They adopted an indifferent, self-contained posture to protect themselves. They blocked out their need for their mother to avoid any potential disappointments. For that reason, the children did not even look at their mothers during the

Strange Situation experiment; they avoided interactions in an attempt to deny their feelings for her.

**Insecure-Ambivalent Infants.** Children who presented with an insecure-ambivalent attachment pattern were extremely clingy and overly preoccupied with their mother's whereabouts. Due to this preoccupation, the children were unable to explore their environment. When the mothers left the room, these children were inconsolable however when the mother returned they were ambivalent towards them. The children reached out for their mothers in one moment but angrily pushed her away the next moment.

Through observations made at home, the mothers in this category tended to interact with their children in an inconsistent manner. They were warm and responsive on some occasions but not on other occasions. Cycling through this ambivalence rendered the children uncertain of their mothers' ability to be reliable. The children desperately seek contact with their mothers when apart yet display anger towards them when they return.

**Disorganized/Disoriented Infants.** With the Strange Situation as its premise, further studies were done regarding attachment styles. Researchers found that some children did not fit perfectly into the three attachment patterns Ainsworth proposed. Some children displayed behaviors where they averted their faces or froze in a trance like state when their mothers re-entered the room. The children seemed to be at a loss about how to act with their mother; they wanted to approach their mother but they were afraid to do so. The implied cause of such fearful behavior between the child and the primary caregiver was the possibility of abusive experiences (Crain, 2005).

The importance of attachment theory stems beyond the early caregiver-child interactions and impacts children as they mature into adulthood. Attachment patterns become internalized

and become a framework for future interactions with others. For example, a child who has a secure model of attachment has an internal representation of a sensitively attuned and secure caregiver. The caregiver allowed the child to feel worthy of care and have the capacity to depend on significant others. However, the child with an internalized model of an attachment figure who is dismissing, unpredictable or frightening develops an insecure working model of attachment. Early attachment molds infant brain development which impacts affect regulation as well as shapes a child's sense of self, influencing their quality of relating in adulthood (Bennett, 2008). These attachment patterns can also impact the therapeutic relationship between therapist and client.

### **The Impact Insecure Attachment has on Children Who Experienced Trauma**

The impact of trauma in young children must be considered within the parent-child relationship. While a secure attachment with a primary caregiver is associated with optimum social, emotional, cognitive and behavioral outcomes, a child who experienced trauma may be hindered in their ability to trust a parent's competence of being a protector. Conversely, the quality of the child's attachments is important in predicting how a child may respond to a traumatic event.

During the first years of life, very young children do not have the coping capacities to regulate strong emotions. They become reliant on their primary caregivers to help with affect regulation during times of distress. Securely attached children develop neurobiological systems that help them effectively regulate emotional arousal. During times of trauma, securely attached children more likely seek protection, creating a buffer from the negative repercussions of trauma. Conversely, children with insecure or disorganized attachments are at even greater risk of negative outcomes during traumatic events. They are less likely to engage in emotionally

supportive relationships that can help them process and cope with the overwhelming emotions they experience (Lieberman, 2004). Therefore, a child's capacity to cope with a traumatic event is correlated to the quality of the parent-child attachment and a parent's ability to help their child with affect regulation, minimizing physiological and psychological distress.

Secure attachment, parental psychological functioning, effective parenting skills and cohesive family functioning are protective factors against negative effects of trauma. Conversely, witnessing threat to a caregiver, direct exposure to trauma, interpersonal trauma, parental psychopathology, insecure attachment, poor parenting skills and poor family functioning place young children at greater risk of poor outcomes following trauma. Additionally, parents who were traumatized themselves may not be physically or emotionally available to comfort and protect their children (De Young et. al, 2011; Lieberman, 2004; Lieberman & Knorr, 2007; Lieberman & Van Horn, 2009).

Changes in brain development can put young children at risk of maladaptive responses post trauma. Such changes can lead to the derailment of appropriate developmental activities such as toileting, sleeping, eating patterns etc., or the emergence of emotional, social, cognitive and behavioral difficulties that may persist into later childhood and adulthood (Lieberman & Van Horn 2009).

**The Biological Impact of Attachment.** The quality of the parent-child relationship and life stressors can affect brain development. Exposure to trauma during "critical" or "sensitive" periods of brain development can have irreversible consequences (De Young et.al, 2011; Lieberman & Van Horn, 2009). Lovett (2007), highlighted the research done in neuroscience regarding attachment theory. Studies demonstrate that the quality of early

attachment influences the limbic system in the brain which regulates affect. Relational inadequacies create a neurological response to abusive experiences, rendering children experiencing challenges in attachment, memory problems and an inability to read others' emotional states. In addition, affect regulation is theorized to pass down from one generation to another. "Children who grow up in these families are seen as at risk for such problems as: inability to self sooth, the inability to modulate intense emotional arousal, and an inability to regulate sexual and aggressive impulses" (Lovett, 2007). As a result, the biological changes that coexist in such an environment promote the over use of the fight or flight response, hyper-vigilance and an elevated heart rate. Other physiological changes associated within this highly activated system may interfere with a child's ability to form attachments. These neurobiological alterations are associated with Freud's idea of signal anxiety in the ego. "When a person senses stimuli in the environment reminiscent of previously experienced danger, the amygdala activates the body to respond to this fear. When healthy development of signal anxiety is impacted by a stressful environment, the anxiety can override other ego functions and leave the person in a state of fearfulness. Consequently, the molding of the neurological system in this manner predisposes a child to be in a state of hyper-vigilance and to aggressive behavior" (Lovett, 2007).

### **Coping & Resilience**

Coping is a child's way of balancing his/her natural developmental abilities and individual makeup while facing the external and internal challenges of trauma. To further explain, it is distinguished by the focus on how children respond emotionally, cognitively and behaviorally while dealing with the difficulties of real life contexts and the way in which these occurrences both unfold and accumulate over time. Coping also links with regulation of basic

psychological and physiological processes such as emotion, behavior, attention, cognition and regulatory effects on social partners and the environment.

Coping is important in developing a full understanding of the effects stress and trauma have on children and adolescents. Coping not only depicts the child's active role of navigating the demands that trauma brings into a child's life but it has the potential to consider the impact of how it will continue to shape development. There are many coping strategies that children utilize when experiencing stress. The most frequent strategies are: support-seeking, escape, distraction, problem solving, instructional action, accommodation, opposition, denial, self-reliance, aggression, social isolation, negotiation and helplessness (Skinner & Zimmer-Gembeck, 2007). Of those coping strategies, four tend to be most common: Support seeking, problem solving, distraction and escape.

Support seeking / help seeking is the most commonly used strategy across all ages when supported in a healthy environment. At a very early age, children seek help from their attachment figures when distressed. Problem Solving in younger children showed modest or low levels as a coping strategy, however improved with age. For adolescents, problem solving was used as often or more often as support seeking and distraction. Distraction can also be used to cope with stress. Behavioral distraction tactics can be keeping busy or playing games. Cognitive distraction can be a form of diversionary thinking, such as thinking about other things like something fun or trying to forget the stressor. Escape is an attempt to leave a distressing environment or avoid direct action. Other coping tactics that are present in less supportive environments can be: rumination, aggression in response to problems, opposition such as blaming others, denial and self-reliance (Skinner & Zimmer-Gembeck, 2007)



**The Effects of Attachment on Coping.** Lieberman & Knorr, (2007), postulated that the quality of attachments ranged along a continuum that relied on the availability and responsiveness of the caregiver, and the child's sense of security. The attachment impacts the child's coping skills. The milder end of the spectrum incorporated the developmentally appropriate stresses that occur naturally through childhood when there is a mismatch between the needs and wants of the child vs parent. Although unpleasant, the mismatches create an opportunity to teach a child that the parent has their own individuality and not an extension of the child's inner workings.

In the moderate range of the continuum, the parent consistently fails to effectively respond to their child's needs leading to developmental impairment. The child may resort to rigid and habitual self-protective mechanisms that thwart emotional closeness and readiness to learn. The behaviors range from emotional expressiveness to avoidance, withdrawal, controlling behavior, anger and aggression.

In the extreme end of the spectrum, the child's trust in their caregiver as a protector is completely shattered by intense or repeated traumatic experiences. This creates a collapse in the child's coping strategies, stunting their ability to love and learn.

**Resilience.** Resilience can be defined as the development of competence despite severe or pervasive adversity. It promotes successful adaptation, positive functioning and competence despite high risk status or chronic stress following prolonged or severe trauma. It is not something that is considered innate, rather it offers the capacity to develop over time in the context of person in environment interactions (Egeland, Carlson & Sroufe, 1993).

## **Trauma Treatment**

There are many evidence-based treatment options for children exposed to trauma. When possible, parental contributions to treatment can be beneficial. Treatment with parental input offers an opportunity to develop a coherent narrative of the trauma. It offers meaning and perspective for the child, helping them to make sense of the trauma. In doing so, the child's misunderstandings and distortions about the event can be corrected; the child's feelings of guilt or self-blame alleviate, becoming able to repair trust in the parent's ability to provide protection.

**Play Therapy.** Play therapy creates a rich forum for children to express and integrate the vast feelings they have regarding their trauma. Through supportive, stable play therapy, the therapist offers the child an opportunity to internalize healthier mental representations of themselves and others. Lovett (2007), proposed that repeated opportunities of expressing feelings and engaging in socially acceptable ways may help neurologically reconstruct methods for coping with stress and anxiety.

**Child-Parent Psychotherapy (CPP).** CPP is a manualized, dyadic intervention which can be used with impoverished and traumatized families with young children. CPP sessions include both the parent and the child at the same time and occur either in their home or in an office playroom. Sessions are generally unstructured and follow the natural unfolding between the parent and child. CPP emphasizes the emotional connection between the child and parent while utilizing attachment theory to better understand their dynamics. Often times the parent's early childhood is explored as a lens to view their interactions with their children. CPP also focuses on the parent's current stressful life circumstances and culturally derived values.

## Reflections on Clinical Work

### Case 1: Beth

**Background Information.** My experiences as a clinician in a foster care setting exposed me to varying interactions with children who experienced traumatic events. My first case was Beth. When I began therapy with Beth, she was five years old and already in foster care for three years. She was an African American girl who experienced trauma in the form of parental neglect. At 2.9 years old, Beth was removed from her mother's care due to unsuitable living conditions. It was reported that Beth did not have a stable living environment; she was found living illegally in an apartment whose prior tenants were evicted. Beth's mother (Susan) tested positive for substance use and did not pursue treatment due to the cost of treatment. Susan had an extensive criminal history with an outstanding warrant for her arrest. It was reported that Beth's father (Tom) intentionally hit the car Beth and Susan were in, which led to an order of protection against him. The ultimate goal for Beth was to be reunified with her biological family however, Tom was not a participant in the parental reunification process due to the order of protection. Initially Beth had weekly supervised visits with her mother which transitioned to biweekly visits. Beth saw her mother weekly during supervised visits and parenting sessions.

Once in care, Beth presented with varying non-age appropriate behaviors. At 2.9 years old Beth was demonstrating sexual behaviors, inappropriate touching, aggression, swearing, pulling her hair, tormenting animals and experienced toiling accidents even though she was already fully potty trained. When assessed for sexual abuse, the results were inconclusive. She had no physical trauma at the time and when probed she discussed events like a fantasy i.e. flying on a magic carpet. One hypothesis for her sexualized behavior is that she was either

inappropriately touched or exposed to sexual activity at a preverbal age. Due to her young age, she may not be able to verbally articulate what she experienced however her experiences laid dormant within her memories and manifested in her behaviors.

While in foster care, Beth lived in two separate homes. Initially, she lived with a foster family that was simultaneously caring for a newborn baby. The responsibilities of caring for a newborn and Beth's sexualized and aggressive behaviors became overwhelming for the foster mother so Beth was transitioned to a new home. While in her second placement, the foster mother reported the same concerns regarding Beth, however her approach was authoritative. It was reported that the new foster mother (Ms. Mack) addressed Beth's behaviors immediately so she could learn from them.

Ms. Mack offered a home environment for Beth and was dutiful in her responsibilities towards Beth. She was attentive to her academic needs and communicated her concerns for Beth with previous clinicians and myself. Ms. Mack adopted two other children after being a foster parent for them but did not want to adopt Beth due to her perceived uncontrollable behaviors and Susan's influences on Beth during visitations. Ms. Mack was a religious woman, attended church with the children and believed Beth's sexualized behaviors were "vulgar". She attempted to teach her the difference between "good" and "bad" and reinforced that God was always watching.

**A Depiction of Beth's Behaviors.** Beth was a beautiful little girl. Her hair was usually in corn rows or braids. Her school uniform was usually neat, although her undershirt was sometimes dingy. When she smiled her welcoming eyes lit up; she had a curious mind that seemed to always be working. At times Beth attached easily with adults and peers yet also became distant and shy at other times. Prior to sessions, she engaged with her peers, playing

UNO or Connect 4 in the waiting room. She sometimes colored with them. The adults in the room were impressed by her memory and her precocious ways.

Her records from her previous clinician indicated that Beth had a limited understanding of boundaries, engaged in non-age appropriate sexual behaviors and had some concerns regarding impulsivity, following directives and listening. These concerns were maintained during our interactions.

Throughout our work together, I received concerns from her school, daycare and her foster mother. It was reported that Beth was inappropriately touching her peers. Her daycare provider found her on a cot, touching the private areas of another girl. Her school teacher also found her touching other students. It was reported that she was heard saying she wanted to have sex with the other children. Beth's teacher stated that Beth would run out of the room and run throughout the halls of her school. Security guards had to chase her to redirect her to the classroom. Her behaviors were reported as disruptive to her class. When explored during therapy, Beth presented as if she was unfamiliar with all accusations and reaffirmed she did not touch any one. During the course of treatment, exercises regarding boundaries, personal space and touching were explored. We had discussions regarding whether the behaviors spurred from more recent encounters or latent memories from her past. The explorations did not reveal any new information regarding the origin of her sexualized behaviors. Regardless of the origin, her behaviors indicated some sign of sexual trauma.

*I spoke with the foster mother about Beth's behaviors in school. The foster mother told Beth that I would be speaking with her about school. I met Beth in the waiting room and she seemed distant. We go to the therapy room.*

*Beth: My stomach hurts, I have to use the bathroom*

*Me: Sure, you can use the bathroom (she stayed in the bathroom for a while, I could hear her defecating. I think she was nervous. She returns to session)*

*Me: How's your tummy feeling Beth?*

*Beth: I don't feel good*

*Me: Awww, I'm sorry you don't feel well. Sometimes our tummies bother us when we get really nervous...or if we eat something that doesn't agree with us. (I make a silly face, she smiles)*

*Me: You know there is something really important I want to talk to you about. Can you guess what it is?*

*Beth: No*

*Me: Hmmm, well I spoke with Ms. Mack about what has been going on in school. She said that you were touching other children on their private parts and we just want to make sure you are safe and your friends in school and daycare are safe.*

*Beth: I don't know why they said that*

*Me: No? Hmmm, I wonder why they would say that? Can you think of anything?*

*Beth: No!*

*Me: Hmmm, I'm a little confused because your teachers are saying that you touched other children on their private parts and they heard you say you wanted to have sex with them and you are saying that you didn't. I'm just curious, what is sex anyway?*

*Beth: (Looking and smiling) You knooooow.*

*Me: Me?! I know? Well I know what I think it is for adults but I'm curious if you know what it is.*

*Beth: (Smiles coyly, starts to put her fingers in her mouth almost as if she is regressing. We go back and forth trying to get additional information but Beth insists nothing is happening. We continue session talking about personal space and being safe with ourselves and others.)*

Beth demonstrated various limitations in impulse control and imposed limit setting.

Transitioning from the end of session to the waiting room was typically a challenge. I believe partially, Beth had a hard time with a set limit and also the waiting room became overstimulating because it became packed with other children either waiting to be seen by their clinician or waiting to get on the bus to return home. I theorized that the waiting room became overwhelming for Beth, leading to a meltdown in anticipation of returning to the waiting room.

*Prior to ending each session with Beth I give her a ten-minute window to begin cleaning up. I counted down to when we had five more minutes and ultimately let her know when it was time to go home. This was an attempt to transition her to the waiting room. The week prior, Beth had a complete meltdown when it was time to leave, she screamed and threw toys throughout the room. She would not leave the therapy room and insisted on calling her foster mother to pick her up. Eventually she transitioned to waiting just outside the waiting room while peeking in.*

*Me: Ok Beth, it's time to clean up the toys.*

*Beth: (begins walking over to the sink to play with the water)*

*Me: Beth, I understand that sometimes it can be so hard to leave but now is not the time to play with water. When I see you next week we can play.*

*Beth: (Beth pouts and stomps to the water and turns on the faucet on full blast)*

*Me: (I walk over, take off the water and kneel down to get to her eye level)*

*Beth, No. It is time to go.*

*Beth: ( Beth begins to pout and folds her arm tightly, she walks over and knocks down a chair and starts to scream)*

*Me: ( I wait until she calms a bit) Beth, you know I thought about you a lot and last time I saw you it seemed like you really did not want to go to the waiting room. It can be really hard for some kids. We have so much fun playing and then we have to stop. I was wondering what you feel when you go to the waiting room*

*Beth: (Doesn't make eye contact or speak, still huffing)*

*Me: I noticed that when you first come here, the waiting room is kind of quiet but when you go back it gets really busy and loud. There are so many kids in there. Did you notice that?*

*Beth: (Makes some eye contact)*

*Me: How about we do this, let's clean up and when it's time to leave I can hold your hand and we can wait in the hallway, right outside the waiting room and ask the bus lady to meet us there. That way it could be a little quieter for you. How does that sound?*

*Beth: (quietly)Okay...*

Beth presented as a very bright child who was eager to learn, I was impressed by her understanding of sequencing, math and patterns. When we played games like Connect 4, she was able to quickly identify patterns. She played adding and subtracting games with her snacks. After building rapport with her, I was able to use her understanding of patterns to create a sense of scheduling stability for her. Beth typically saw her mother on Monday's and Wednesday's while she attended sessions with me on Tuesday's. There were times when her mother was inconsistent with her schedule due to holidays or transportation issues and it would reflect in Beth's behavior.

*Session begins with Beth performing her session routine of hanging up her book bag and coat. I begin by asking about her day at school and what she did with her mother on Monday during her parent visit.*

*Me: So how was your visit with mommy? What did you guys do?*

*Beth: I saw mommy yesterday*

*Me: I know, and you see her again tomorrow.*

*Beth: I do?*

*Me: Yeah, remember? You see mommy on Monday, then I see you on Tuesday and you see mommy on Wednesday.*

*Beth: And then I see mommy again?*

*Me: Well, after you see her on Wednesday then you will see her on Monday. Do you remember the days of the week?*

*Beth: (Looking up at me and nodding her head)*

*Me: (I begin to sing) Today is Tuesday, today is Tuesday all day long, all day....*

*Beth: No! No singing!*

*Me: (I smile) Ok, we don't have to sing. Have you heard the days of the week song before?*

*Beth: Seeming unresponsive, then nodding) In school...*

*Me: Ohhh okay, well I know you are not in school now and when you are here you like to play right?*

*Beth: mmhmm (as she nods her head)*

*Me: Well, you saw mommy on Monday, then you see me on Tuesday, and mommy again on Wednesday, then you see mommy again on Monday, me on Tuesday and mommy again on Wednesday*

*Beth: Oh! Like a pattern!*

*Me: Yes! Exactly! Like a pattern!*

### **Revelations of Trauma in Our Play Therapy Sessions.**

***The Impact of Beth's Insecure Attachment.*** Beth's experiences comprised of various traumatic events. In addition to being neglected by her mother, she may have had some inappropriate sexual encounters. Although she seemed to snuggle with her mother, she was not able to develop age appropriate play with her. When discussing her mother during sessions she sometimes seemed very eager to be with her yet, she sometimes presented as indifferent when talking about her. Many sessions consisted of a mother figure in her play, at times my role as therapist was used to explore her feelings about her mother. When playing a game of memory, Beth exclaimed, "Oh! I play this game with my mommy!" The previous week she said the same



thing about the Connect 4 game we played together. She said, “Ok, you can be mommy!”.

Upon further exploration, I uncovered that she did not play games with her mother, she mostly regressed to an earlier stage of development. She sat on her mother’s lap, while she sucked her finger and cuddled. The relationship she had with her foster mother also presented as an ambivalent relationship. She seemed to want a family unit; she called the foster mother mommy and the other adopted children her brother and sister. When I spoke with the foster mother she was adamant about not adopting Beth. Their interactions potentially reinforced an ambivalent relationship for Beth and her attachment figures. I believe during sessions I was able to be a vehicle that represented a mother figure. My role was to reflect a caring, supportive, maternal figure who provided healthy boundaries. At times, her experiences with me resulted in moments of closeness and connection coupled with indifference and aggression.

Beth had an ambivalent attachment with her mother and also seemed to have one with her foster mother. During one session, Isabella played with dolls which was a little different considering she usually played with Play-Doh or Connect 4 and rarely used her imagination. In her play she acted out one doll being particularly “bad” vs another doll who was always good. The caretaker of the “bad” doll said that she will not “buy” her because she was rude. She did not want to take the bad doll to the movies etc.

*Beth Look at all this doodoo! She has doodoo everywhere! Look! (gets a wipe to clean the baby.)*

*Me: Oh my goodness look at it! It’s everywhere*

*Beth: mmhmmm, I don’t know how she gets this on her like that.*

*Look it on her back! We have to clean her up*

*Me: I know right*

*Beth: She is so dirty she is just going to have to take a bath when I’m done cleaning her up*

*Me: I think so she looks like she made a mess. What did she eat!*

*Beth: (Laughing) I don’t know, what did she eat? She ate too much.*

*Look, she even has it in her eye!*

*Me: Oh no!*

*(This kind of play goes on for a while where she is highlighting how dirty the baby is and I'm reiterating her reactions. She showed some restraint in asking for a wet paper towel since she normally doesn't ask to use the sink creating a meltdown when met with resistance from me.)*

*Beth: This baby is too rude*

*Me: She is?*

*Beth: mmhmm*

*I always have to talk to her! The teacher is always calling and she is too rude.*

*Me: What did the baby do to be rude?*

*Beth: Don't you see this mess!?*

*That's why I don't want to buy this baby. See look at this baby (pointing at the other smaller doll). Do you see any mess on her?*

*Me: Noo*

*Beth: She is a good baby, she is clean and she is not rude. That's why I want to buy this baby.*

*Me: You want to buy her?*

*Beth: mmmhmm.... can we get her dressed?....please!*

*Me: Sure*

*(She goes back and forth about what the baby should wear and which baby should wear which outfit. The good baby seemed to get more things)*

*Beth: Ok, let's go to the movies*

*Me: The movies...yay!! Who is going to the movies*

*Beth: I'm only bringing this baby (takes the "good" baby)*

*Me: You are not taking the other one?*

*Beth: Look at her! She is dirty! She needs to take a bath herself*

*Me: Really?*

*Beth: You know I take a bath by myself*

*Me: Oh yeah*

*Beth: But sometimes I cry*

*Me: Really, awww why?*

*Beth: I just don't want to take a bath by myself.....come on lets go!*

*Me: Where are we going?*

*Beth: You know, to the movies*

*We can go to the movies, then the mall and then the waterpark*

*Me: Whoa that's a lot of places*

*Beth: Ok let's move this into the trunk*

*(She puts stroller etc. behind the chairs we are sitting on)*

*Me: Well I have a question. I was wondering if it was the baby's fault that she got doodoo everywhere*

*Beth: Yes it is!*

*Me: It is?*

*Beth: Well, ok, she can come, mommies are not supposed to be mean.*

It is important to note that Beth's foster mother also described Beth as "rude". It can also be interpreted that there is some link between Beth did not wanting to "buy" the rude doll and the foster mother not wanted to adopt Beth.

Almost every session consisted of an event where Beth challenged set limits and either completely shut down or had a temper tantrum. When her melt downs were emotionally based, I was able to engage her in play to express her feelings, however when they were behaviorally based I strategically refrained from engaging with her. I noticed talking to her during those times positively reinforced those behaviors.

*Me: I think you had enough, your hands are clean.*

*Beth: (She started to pout and frown then started to scream. At first it was just screaming)*

*Me: Oh, it looks like you are upset, I will be here when you are ready to talk about it or if you do not want to talk about it we don't have to.*

*Beth: (hides under the table, kicks chair while screaming and throwing anything she can get her hands on)*

*Me: Whenever you are ready to talk Beth I will be here but I can't understand you if you are screaming.*

*Beth: NEVER, NEVER! I WILL NEVER TALK!!!*

*Me: Oh my goodness! Look at you balling up like a little turtle!*

*(I knock on the top of the table while she is in a ball under the table)*

*Hello, is Mr. Turtle home?*

*Beth: No! It's Mr. Turtleman*

*Me: Ohhh, ok, is Mr. Turtleman home*

*Beth: Yes*

*Me: Oh good, hi Mr. Turtleman, I was wondering if you can tell me what's going on with Beth, how is she feeling?*

*Beth: She is angry!*

*Me: Ohhh, she is feeling angry?*

*Beth: Yes!*

*Me: I wonder why*

*Beth: Because nobody cares about her, NOBODY! Her mommy doesn't care about her!*

*Me: Ohhh, her mommy doesn't care about her?*

*Beth: No! Nobody likes her! Do you like her?*

*Me: Do I like Beth?*

*Beth: Yes, do you like her?*

*Me: Yes, I like Beth very much.*

*(Beth screams again)*

*Beth: Call her mommy*  
*Me: Ok, Ring ring, ring ring, Hello*  
*Beth: Hello*  
*Me: Who am I speaking with?*  
*Beth: Beth's mommy*  
*Me: Oh, hi Beth's mommy*  
*Beth: I don't care! I don't care!!! Call Beth!*  
*ME: Ok, ring ring ring ring*  
*Beth: Hello*  
*Me: Hi Beth, I just wanted to see if you were ready to come play. Are you ready to come up?*  
*Beth: Ok I'm coming*  
*Beth: Can I play with this?*  
*(She picks up two red pieces of wood)*  
*Me: Sure you can use that. Beth, thank you so much for asking to play with it before you used it.*  
*Beth: (smiled) ok hold this up here, don't move, use both hands (she motions me to hold up one piece of wood)*  
*Ok now hold it here (she starts to hammer the piece of wood with another piece of wood)*  
*Me: What are you building?*  
*Beth: I'm making a gate*  
*Me: Oh, you are making a gate. Is it a gate to keep people in or keep people out?*  
*Beth: It's a gate to keep people out*  
*(eventually, she uses the other piece of wood as a magic wand)*  
*Beth: Magic door magic door let me in (the gate opens)*

**Beth's Behavioral Concerns.** Beth's observable behaviors, linked to trauma, presented in different ways. In terms of attachment, Beth was very close to her mother when in her presence however during sessions she would say that she does not miss her mother or she does not feel sad that she was not with her mother.

*Beth: Oh! I know this game!*  
*Me: You do? You played this game before?*  
*Beth: Yeah I play it with my mommy*  
*Me: You do! That's nice. Which mommy do you play it with?*  
*Beth: The one I see here.*  
*Me: Do you like playing this game with mommy?*  
*Beth: mmhmm*  
*Beth: I don't get to play with mommy any more*  
*Me: You don't? How does that make you feel?*  
*Beth: Not happy*  
*Me: Yeahhh*

*(start playing Connect 4 without any rules, just putting red and black chips in a pattern)*

*Me: I wonder if it makes you sad not to see mommy (no eye contact, just playing the game)*

*Some kids may feel sad if they don't see their mommy.*

*Beth: I don't feel sad*

*Me: No? You don't feel sad? Just not happy?*

*(continues playing connect 4 without eye contact and I play with her)*

*Me: I wonder what makes you happy*

*(no answer, just playing)*

*Me: You know what makes me happy? I feel happy when I get to see you and play with you (No verbal response from Izzy but she looked up, made brief eye contact and smiled)*

Another area where her trauma impacted her interpersonal abilities was evident in her lack of impulse control, limit setting and her inability to engage in directed activities. When asked a simple question that made her uncomfortable or if she was asked to perform a basic task she did not want to do she would completely shut down. When being mildly redirected, it seemed she took it as an imminent threat and would avert eye contact, transforming into a posture that was like a cocoon, with her arms wrapped across her body or head as she balled herself up, eliminating any form of verbal or physical interactions. Conversely, there were moments when she would do the opposite and scream, kick and tantrum.

## **Case 2 - Nicky**

**Background Information.** Nicky was a 6-year-old girl I counseled who was in foster care for approximately 2 years. She was placed in foster care due to a lack of parental supervision and inadequate guardianship. In addition, her mother (Trudy) was caught stealing with the children and resisted arrest. Her mother presented with some cognitive delays. Nicky was one of five children. All of the children were taken out of Trudy's care however, Nicky and two of her brothers were placed in the same foster home with "Ingrid", their foster parent.

Nicky was placed into two foster homes while she was in foster care. An attempt was made to reunite Nicky with her mother after one year. Nicky had to undergo surgery and her

mother was complying with the necessary requirements to regain custody of her children; as a result, Nicky was allowed to go home. Three months later after being with her mother, Nicky was re-placed into foster care because her mother got into a physical altercation with a child while Nicky was present. Nicky had some consistency with her most recent placement with Ingrid.

**Nicky's Behaviors.** Nicky was in first grade. According to records, Nicky's teacher reported there were concerns of impulsivity and ability to stay on task in class. It was also indicated that Nicky's social skills, work habits and interactions with her teacher were potential growth opportunities. Nicky was eager to learn, however academically she was barely approaching grade level in most of her academic areas and needed additional academic support.

According to a report, Nicky's foster mother had concerns regarding displays of aggressive behavior, lying, and difficulty with peer interactions. Additionally, she was referred to therapy with many sad feelings regarding her mother and had difficulty finding appropriate ways to get attention; her behaviors ranged from being overtly affectionate to reverting to negative behaviors. Nicky had weekly visitations with her mother. The ultimate goal was for Nicky to be reunified with her mother, Trudy.

**Revelations of Nicky's Trauma Through Play Therapy.** Nicky attended individual, weekly therapy sessions with me. As part of Nicky's assessment, she participated in a psychological evaluation. Her play skills were assessed through the Westby Symbolic Play Scale and were noted to be at an age expected level. The very first time I met her in the waiting room she ran up to me to give me a hug. I thought it was interesting how quickly she was willing to show affection even though she did not know me. That was a bit concerning because it seemed like a potential blurred boundary when approaching a stranger. During the first

session, she seemed to attach quickly and shared a lot of her experiences. She expressed some knowledge of kissing, “girlfriend/boyfriend” dynamics and sex.

*Nicky: Do you see my brother?*

*Me: No, I don't see him. What's his name?*

*Nicky: Daniel, he is a great guy*

*Me: How old is he?*

*Nicky: He is twelve.*

*Me: Does he live with you?*

*Nicky: Yes, he stays in the room with me. And I have another brother who is 3 and another one who is 13*

*Me: Ohh*

*Nicky: He has a girlfriend*

*Me: He does?*

*Nicky: They talk a lot on the phone. He has a girlfriend and I have a boyfriend*

*Me: You do!? What's his name?*

*Nicky: I don't know*

*Me: Is he in your school?*

*Nicky: No, he is on the van. (another child who comes for therapy)*

*He wanted me to k-i-s-s*

*Me: Kiss! He did! Where?*

*Nicky: guess*

*Me: on your hand?*

*Nicky: No*

*Me: On your head? (we go back and forth about where he kissed her but she would not say until I said where) He kissed you on the lips?*

*Nicky: Yes (smiling) And he has another girlfriend.*

*Me: Really?!*

*Nicky: He kissed her too, he called us over by the wall (She shows what he did, he was pointing at his lips)*

*Me: Oh wow!*

*Nicky: (Smiling)*

*Me: So then what happened?*

*Nicky: You know my brother has a girlfriend*

*Me: Do they k-i-s-s?*

*Nicky: (Whispering as she gets closer) I think s-i-x*

*Me: s-i-x, what's that*

*Nicky: (Gave me a “come on” kind of look. She walks over and starts whispering in my ear) It's.... you can't tell Ingrid.... ok, you can't tell Ingrid...*

*Me: Ok... (In that moment I wanted to go over confidentiality so I hesitated) Well...*

*Nicky: (slightly stepped back) Guess*

*Me: Guess?! I don't know, I need a clue*

*Nicky: (starts making a T sound)*

*Me: touch?*

*Nicky: shakes head (we go back and forth with guessing)*

*Me: I can't guess; I think you can tell me.*

*Nicky: Take off clothes*

*KB: Ohhhh, take off clothes (Nicky starts to look uncomfortable) You know what Nicky, if you do not feel comfortable talking about that right now we can stop and talk about it later. I want you to know that whatever we talk about stays between us but if it is something that's a really big deal like someone in hurting you then we will talk about what to say to Ms Ingrid ok?*

*NH: ok*

During that session Nicky shared a lot of information quickly, considering it was our first encounter.

Throughout our play sessions, Nicky engaged in challenging play scenarios that reflected her past trauma experiences and her emotions. Although she seemed older than her age she was willing to play age appropriate games. Despite our seemingly positive initial interactions, there were times throughout our encounters where she became aggressive and indifferent. On multiple occasions she became emotionally charged when re-enacting the scene where her mother was arrested. She presented as very angry, aggressive and emotionally confused.

*During session she was playing with a toy dog, making it bark loudly and aggressively.*

*Nicky: Bark! Bark! Bark! Bark! Bark*

*Me: Oh wow! Puppy is barking really loud.*

*Nicky: Yes! Bark! Bark! Bark! (She looks up at feelings chart on the wall)*

*Me: I wonder what puppy is feeling? Can you show me on the feelings chart?*

*Nicky: She is angry!*

*Me: She is angry? I wonder why she is so angry?*

*Nicky: Because you hit her!*

*Me: Because I hit her?*

*Nicky: Yes! (She keeps barking and brings the dog closer to my body)*

*Me: Oh no, she is mad because I hit her? What can I do to keep the dog safe?*

*Nicky: Bark! Bark! Bark! (getting louder)*

*Me: Can I say I'm sorry to the dog? Would she feel better then?*

*Nicky: No!!! You lie! You are not sorry!*

*Me: Ohhhh, I'm not sorry? The puppy looks like she has a lot of really big feelings and I wonder how we can make puppy calm down and feel safe?*

*Nicky: (Barking gets louder and she gets closer to my face)*

*She ate your face off!*

*Me: Oh no! She ate my face off?!? How does puppy feel now?*



*Nicky: She feels better*

*Me: So puppy feels better after eating my face? And where am I with puppy now?*

*Nicky: You are in puppy belly*

*Me: Oh, so I'm close with puppy, in her belly, and now she feels better?*

*Nicky: (Shakes her head yes)*

During sessions Nicky actively used her imagination to work through her emotions.

Although she was able to express her feelings through play she rarely took ownership of them.

During one session we used finger puppets to play. Through play Nicky was able to act out a scene of her mother aggressively hitting and bullying another child. When asked if she ever experienced anything like that she said no. There seemed to be a disconnect between the scenes she acted out and her connection to them as reality. When her feelings about them were explored they seemed confusing. She engaged in conflictual feelings of anger, sadness and happiness. Her treatment plan was to continue navigating the varying emotions she felt and enhance her ability to identify them within herself.

*Nicky and I were pretending to call one another on the phone. We were talking about different cartoons and Sponge Bob.*

*Nicky: Call me again*

*Me: OK, ring ring, Hey Nicky what are you doing?*

*Nicky: Watching a movie*

*Me: Oh, what movie are you watching?*

*Nicky: guess*

*Me: Is it sponge bob?*

*Nicky: No*

*Me: (go back and forth about different cartoons)*

*Nicky: It's an adult movie*

*Me: Oh ok, hmmm, can I get a clue*

*Nicky: It has CPS*

*Me: Hmmm, CPS, what is CPS*

*Nicky: (Gives a funny look)*

*You know, cps is when you do something bad and the cops come and arrest your mommy.*

*Me: ohhhh*

*Nicky: (Laughing) Can I do my homework?*

*Using four finger puppets Nicky reenacted some aspects of events that led to her mother going to jail.*

Nicky: *Ok you be this one (handing me the hippopotamus)*

Me: *Ok*

Nicky: *What are their names?*

Me: *I don't know, what should we call them? You tell me.*

Nicky: *(looking at her fingers) This one name is Nicky, this one is Ms. Ingrid and this one is Daniel*

Me: *Ok, and what should we call this one? (the one on my finger)*

Nicky: *Ummm we can call her Hip.*

Me: *Ok, Hip*

Nicky: *(holds four puppets and starts whispering to them.)*

Me: *(in Hip voice) It looks like they are whispering.*

Nicky: *(whispering sounds) Ha Haaa!*

Me: *It looks like they are whispering and laughing*

Nicky: *(motions over to Hip with the other puppets and hits Hip)*

Me: *Ouch!*

Nicky: *Ha haha!!!*

Me: *That hurt! Why did you hit me?!*

Nicky: *Remember, that time is school?... You hit me*

Me: *I hit you in school?*

Nicky: *Yes! (continues whispering and laughing viciously.)*

*(The conversation goes back and forth about hitting, fighting and feelings of being hit. She continues to hit Hip repeatedly and laughs about it.)*

Nicky: *Now you have to go over there! (Pointing to a chair, away from the table we were playing on)*

Me: *I have to go over there? (In Hip voice)*

Nicky: *Yes!*

Me: *What is this place?*

Nicky: *It's jail! Bad people go there. No one can ever find you. Ha Haa!*

*(Nicky continues to play. We start using the feeling chart and exploring feelings and the difference between things that happen in our imagination and in real life.)*

Me: *Oh my goodness. There were so many big feelings when we played today.*

*Can I ask you a question? (She looks at me nodding) Did any of these things happen with you or anyone you know?*

Nicky: *(Nodding her head no)*

Me: *Oh I was just curious because if they did we can definitely talk about it. (She looks at the feelings chart) Hmmm.... I wonder what Hip was feeling?*

*(No response)*

Me: *She had people talk about her, people called her names and said she pooped in her pants.... she had to go to jail....I wonder what she felt*

Nicky: *She felt happy!*

Me: *She felt happy?! I wonder what made her happy?*

Nicky: *She feel sad*

Me: *Now she feels sad? I'm so confused she has so many feelings. I wonder what made her sad?*

Nicky: *Well she sad because she in jail and stuff*

Me: *Oh, and why was she happy*

*Nicky: Well she has her family (showing the other puppets that were being mean to her)*

*Me: So even though the others were mean to her and she feels sad she should feel happy because they are part of her family?*

*Nicky: mmhmmm*

When explored, Nicky seemed to express conflicting feelings such as an object being both happy, sad and angry. Play proved a vital outlet for conversations regarding her experiences, especially regarding her mother. Although she was not able to say those experiences were hers, she was able to engage in working through her trauma via play therapy.

### **Case 3: Rosalind**

**Background Information.** Rosalind was a fifteen-year-old, Latina girl in foster care who was mandated to have no direct interactions with her biological family. Rosalind was a beautiful young lady. She had a pleasant smile with an endearing presence. She was fully developed physically with a mature figure. I perceived her as bright, sweet and engaging however she had streaks of feeling down. She was one of five children. Her two older siblings, now in their 20's, both lived in foster homes growing up. She was abandoned by her mother (Tina) when she was a baby and raised by her paternal aunt (Marie). Although Rosalind's father was present at times, he was constantly in and out of her life. He was addicted to drugs and attended various drug rehab programs. Marie was the legal guardian of Rosalind's younger brother and sister, however, she never adopted Rosalind. Tina lost her parental rights over Rosalind's younger siblings yet retained her parental rights over Rosalind. Although Tina had legal custody over Rosalind she had limited interactions with her. The majority of Rosalind's care was with Marie.

The relationship between Rosalind and Marie was interesting. Rosalind was raised in a neighborhood that had gang activities and she enjoyed hanging out with limited restrictions,

despite Marie's discomfort and warnings. Rosalind later described that Marie was concerned about her being a negative influence on her younger siblings. Through therapy it was later discovered that Rosalind internalized that perception and strived to create a more positive identity. Throughout Rosalind's therapy sessions, she held Marie in high regard and yearned for a connection with her biological family. Although Rosalind described Marie as mirroring her sentiment, it was unrequited. Marie never followed through on allowing visitation rights with Rosalind.

*Rosalind was engaging. She smiled and talked freely about school but did not overshare regarding her family life and the reasons she was in therapy. She had a positive outlook on moving forward with her life, believing doing good things bring good things. She did not think too much about her "situation" and focused on the future. Rosalind is very resilient, positive and upbeat.*

*(After talking about a girl no one wanted to sit next to in class because she was a "nerd")*

*Rosalind: But I don't care about stuff like that because I think you should be nice to everyone because you never know. they could be something one day and you could be something now but be nothing later.*

*Me: Wow, that's really insightful. Where did you learn to think like that?*

*Rosalind I don't know, I just do. Like I don't tell people about, you know, my situation. I just try to be positive and not look at the past. You just never know what someone else can be going through. Like this girl in my class, she kinda, you know, goth. And people tease her and I know she like cut herself and stuff like that and this other boy says she's crazy but to me she just going through a lot. And she likes this boy who is older than she is and I don't think that's a good idea.*

*Me: Really, why don't you think it's a good idea?*

*Rosalind: Because he's like older and I don't think it's good. These kids out here just don't be knowing!*

*Me: How old is she?*

*Rosalind: Like 13!*

*Me: ohhh*

*Rosalind: I try to help her out and stuff and try to tell her but she doesn't listen.*

*Me: It sounds like you look out for people who are younger than you. That's nice. Is there anyone else you look out for like that?*

*Rosalind: Yeah, my little sister. She has it so good and doesn't even know it! I try to tell her. These kids don't listen.*

*Me: (Smiling) Well in what way do you try to help her but she doesn't listen?*

*Rosalind: Ok, so, I was kind of, you know, a bad influence on Michelle, my sister.*

*Me: How?*

*Rosalind: So, I used to hang out with a lot of older guys in my area, who were not good g and she used to be with me hanging out with their like little brothers and stuff. But I could handle it because I'm you know, more mature but she has a really bad attitude. Like she doesn't know how to be positive and be a good person. I try to tell her but she just has a bad attitude. I don't think she is going to get far in life.... but like me! I'm gonna do something with my life. Like go to school and stuff. I can go to NYU because it's close.... or maybe University of California...I heard it's nice out there.*

Growing up, the dynamic between Rosalind and Marie seemed to become a bit tumultuous and Rosalind insisted on living with her mother. She was always curious about being with her mother and wanted to opportunity to live with her. At approximately age 13, Marie agreed and Rosalind lived with her mother for approximately one year. Within that time frame, Rosalind assumed a somewhat parentified role with her mother. Rosalind described her living arrangement; she said she slept in the hallway of a basement on a make-shift bed with no mattress. The conditions were deplorable. She described Tina as irresponsible. Tina shared non-age appropriate information with Rosalind such as her financial plight, and sex life. Rosalind lived with days of limited amounts of food while her mother made getting food Rosalind's responsibility. While living with her mother, Rosalind experienced inappropriate sexual advances from her mother's boyfriend. He made sexual comments and one day asked to touch her breasts. When Rosalind told her mother, she did not believe her. When she told her Aunt Marie, she did believe Rosalind. After the incident, Rosalind was returned to living with her Aunt Marie.

While in Marie's care, Rosalind decided to have sex. It was her first sexual interaction. She was curious and stated that she wanted to have sex; she was not forced. In addition to continuing to hang out late, Marie believed Rosalind was smoking marijuana, although Rosalind

denied ever smoking. When Marie found out Rosalind had sex she kicked her out of the house immediately.

At this point, Rosalind was placed into a group home. Within the time frame of six months, Rosalind was placed into five different foster care settings. Her frequent transitions did not seem to be due to her behavior. She was slipping through the cracks within the Department of Social Services. In this regard even the system in place to protect her, failed her. By the sixth month she was placed in a more permanent foster home setting.

**Observations of attachment style in Therapy Sessions.** Within her most recent foster placement, the foster mother (Dawn) tried to be attentive towards Rosalind's needs but Rosalind seemed to have an ambivalent attachment pattern. Rosalind's attachment with me was also ambivalent. When she showed up for sessions we had good rapport, but when we had intimate conversations she avoided coming to her follow up sessions. Meyer (2001) thought "an individual with severe impairments of object relations is often unable to muster or retain hopeful expectations and a predominantly positive image of the therapist." Although my client did not have severe impairments of object relations I believe it played a role in our therapeutic interactions. I am not certain if she was able to internalize my image as a therapist, nor what that image represented.

If I were to assess her earlier holding environments, I can see a pattern; people let her down consistently which limited her capacity for basic trust with others. On a couple occasions, I was not able to see her during our session due to a holiday schedule or training. When I spoke with Rosalind about not seeing her, she quickly pushed me away and said, "If you don't want to see me then I don't want to see you." I was taken aback and tried to explain that it was not meant to be a rejection, but I believe she felt too vulnerable and afraid of being abandoned again

by another adult figure. The challenge for Rosalind was being constantly abandoned and the challenge for me was being another representation of her abandonment.

*(During another session, discussing her aunt feeling proud of Rosalind because of a good report card)*

*Me: How did it make you feel that she was proud of you?*

*Rosalind: It was good. I would never do anything to disrespect my aunt or Dawn because they spent millions on me...well maybe not Dawn yet because I just got there but they really look out for me.*

*Me: Yeah, I'm sure. Was there ever a time you think your aunt was not proud of you?*

*Rosalind: Well maybe she was not happy when I, you know, had sex. It was just that one time. I mean he did not force me or anything like that but I just wasn't ready. I mean I can't take care of a baby or anything like that now. I have to pay my own bills before I can do that!*

*Me: (laughing) I hear you...that sounds like something you heard before. Well I am really impressed with your mature perspective. You know last week you mentioned you felt like you had to be cautious because of your situation. Do you feel like because of what happened and now you are living with Dawn that you have to be perfect or behave a certain way?*

*Rosalind: No, I feel comfortable with Dawn.*

*Me: Do you feel like there is a difference between how you act now and how other 15-year-old girls act?*

*Rosalind: (Opens her eyes big and rolls them a little) Yes! Oh my goodness, I wish I could tell these kids out here that they have it good. Because see, I was the spoiled one in my family. I was like the baby. These kids out here just don't have to worry but like me I'm in my situation.*

*Me: Oh yeah that's right you have two older sisters with your mom and dad but then two younger siblings with just your mom right?*

*Rosalind: yeah...and I look just like my dad, I love my dad!*

*Me: When was the last time you saw him.*

*Rosalind: He used to call me every day in the group home. I saw him like December and he looks better now.*

*Me: Oh, where is he?*

*Rosalind: He is getting himself together, he's in a rehab facility in Manhattan. But he doesn't call anymore. I love him though, I don't think I ever loved my mom, she's a bum. Not like she's homeless or anything she just looks like she needs to take a shower and get some clothes and stuff. You know I saw my step dad at Dunkin Donuts and he shouted that he loves me!*

*Me: Oh, how did that make you feel?*

*Rosalind: I don't like...at all*

**Therapy Sessions.** During therapy, Rosalind completed a Trauma Symptom Checklist for Children; her scores reflected clinical significance in the areas of sexual concerns. Rosalind stated she felt terribly guilty for having sex because she “sinned”. She seemed conflicted between her natural urges/desires and the role she is supposed to play as a mature 15-year-old. There were other times Rosalind discussed the difference between being a typical 15-year-old and her experiences. Often times she presented as very mature, however, the drive for being mature seemed to be rooted in being accepted by her elders, to “present” well. Part of our work was deciphering between her perceptions of self-versus the way she wanted to portray as herself. She presented as a very mature person who could handle her feelings and emotions without help; a person who had it all together with no worries, however her behavior reflected otherwise. According to her foster mother, she had bouts of feeling deeply sad. During sessions, she expressed her only outlet as church where she cried profusely but did not know why.

*When talking about a boy that liked her, she said he just wasn't on her "level". She felt that she was too mature for him and that they could not develop a deeper connection. During session she would express a positive attitude such as, "I just try to stay positive. I mean, like, I don't like thinking about the past. I believe when you do good things then good things happen. I mean I'm not saying like I'm God but I see everything."*

Rosalind said she sometimes felt that the pastor was talking directly to her about her burdens and the need to let them go. She mentioned that going to church helped her to be good and felt like a release. When asked about why she cried in church, she attributed it to everything she went through for the past year.

**Rosalind's Trauma Manifestation.** Although unconscious, Rosalind was triggered by anyone talking about her family. Rosalind presented as very calm during sessions, however she described different situations where she got into fights because different people spoke about members of her family in general, without knowing the specifics of her life story. She fought a



boy five times in her group home because he teased her about her family. Another incident happened in school where a girl said she wanted to spit on Rosalind and her mother. The impression I got was that the girl knew nothing of Rosalind's situation but made general comments about her mother. They were asked to go to the school counselor. Rosalind's recount of the story placed her in a very mature stance, even her counselor was impressed. Rosalind said she informed the girl about being in foster care and about how insensitive she was being. She stated her perspective and moved on. Rosalind said she left the girl in tears but did not care because she started the problem.

## Discussion

When working with children in foster care who experienced trauma, I discovered that being a therapist was a relational process. In as much as I wanted to help them learn to express and work through their feelings of trauma in a tangible way, a major part of our dynamic rested on intangible underpinnings. Within the underbelly of our interactions was my countertransference and the quality of attachment they had with their first relational object, their mothers. Attachment theory hypothesizes that the most fundamental layer of attachment with primary caregivers impacts people biologically, emotionally, cognitively and relationally. With this concept at the epicenter of my interactions with my clients, it offered a lens to better understand their behaviors. In hindsight, I am able to look at the impact insecure attachments had on our therapeutic process and their relational interactions with their environment. All three of my cases, Beth, Nicky and Rosalind, experienced trauma and I believe they also developed insecure attachments with their mothers. That insecure attachment affected their interactions both internally and externally.

Beth may have been exposed to some sexual activity at a preverbal age and it manifested in her behaviors even at an older age. When assessed at a younger age, she may have dissociated since she described her experiences as if in a fantasy i.e. floating on a carpet. The research supports that very young children can develop and retain memories of traumatic events and are functionally able to present with the emotional and behavioral presentations of trauma. Beth's implicit memories resurfaced in her sexualized behaviors with her peers; her behaviors stemming from neglect were present in therapy. Her trauma as well as her insecure attachment to her mother may have contributed to her impulsive behaviors. It was challenging for her to self-

regulate which was perceived as oppositional or volatile. Research would suggest, that biologically, her body could have been in a constant fight or flight mode and relationally she did not have a secure base to create healthy coping mechanisms. At times she had an insecure-avoidant relationship towards her mother, she cuddled with her yet avoided admitting to having feelings for her. She also seemed to have an insecure attachment with her foster mother. As a result, she also presented with an insecure relationship with me during our sessions. Through her play, she seemed to display feelings of rejection; she appeared to feel that the foster placement was not permanent although she lived there for years. The coping skills she relied on were opposition and aggression.

Nicky also had an insecure-ambivalent attachment with her mother. Nicky's prior process notes reflected her strong desires to be with her mother. It was so strong, the child welfare department deemed it was worth her going home. Unfortunately, that experience was short lived. In addition to neglect, Nicky's mother may have had her own challenges cognitively which added another layer of possibly being unavailable to effectively care for Nicky and provide a secure foundation.

During therapy, Nicky expressed her aggression and well as her feelings of abandonment by her mother. In Nicky's case, research may suggest that she was possibly re-experiencing her trauma through post-traumatic play. She repeatedly incorporated her mother being arrested during different play scenarios. Due to her trauma, she may have had some difficulty academically and emotionally. Children who experience complex trauma may have limited language to express their feelings. Nicky often seemed to merge many different conflicting feelings together when sorting through and expressing different feelings. As a possible means of coping, Nicky may have expressed aggression.

Although Rosalind experienced a more or less consistent caregiver for most of her life she developed an insecure attachment with her mother which trickled into our therapeutic interactions. Rosalind demonstrated effective coping skills. She was able to seek help and problem solve when her step father was inappropriate. However, she also seemed to use distraction and escape as coping mechanisms. She did not want to face her challenges. She preferred to ignore them as if they never happened. Due to her ambivalent attachment she had a hard time connecting with her foster mother. During sessions she would draw close to me, sharing vulnerable aspects of herself then avoid returning to session for weeks at a time.

### **Concluding Remarks**

Both trauma and insecure attachments are pervasive with children who are in foster care. Often times, neglect is the catalyst that prompts entry into foster care and neglect breeds insecure attachments, impacting a lifetime of relationships. The research from the literature review supports the understanding that experiences during childhood have a long lasting effect into adulthood, both within the individual as well as the way in which the individual interacts with others. The repercussions of neglect prove to be long lasting and generalizable to varying aspects of development such as biological, cognitive, emotional and psychological. Ultimately, the relational quality experienced during childhood foreshadows adult interactions as a whole.

An important aspect of children who experience trauma and insecure attachment concerns the ideas of self-concept and future orientation. Essentially, childhood experiences serve as the seeds that blossom in adulthood. When adequately nurtured, children with a secure attachment more or less develop coping skills that equip them for future endeavors. However, when neglected, children with insecure attachments have a higher probability of developing a sense of powerlessness, low self-esteem and a poor self-image.

Continued research investigating trauma during early childhood can potentially offer insight into ways to promote healthy transitions into adulthood. An increased awareness of trauma and insecure attachments in children fosters an understanding of best practices to help facilitate healthy long term relationships into adulthood. It can offer a lens to develop a supportive environment for growth. Treatments such as play and psychodynamic therapy can begin to chip away the foundation of trauma and insecure attachments, creating a light at the end of a dark tunnel.

## BIBLIOGRAPHY

- Bennett, C. S. (2008). Attachment-informed supervision for social work field education. *Clinical Social Work Journal*, 36(1), 97-107.
- Briggs-Gowan, M. J., Carter, A. S., Clark, R., Augustyn, M., McCarthy, K. J. and Ford, J. D. (2010). Exposure to potentially traumatic events in early childhood: differential links to emergent psychopathology. *Journal of Child Psychology and Psychiatry*, 51(10), 1132-1140.
- Bruskas, D. (2008). Children in foster care: A vulnerable population at risk. *Journal of Child and Adolescent Psychiatric Nursing*, 21(2), 70-77.
- Brodie, R. (n.d.). Mary Ainsworth and Attachment Theory. Retrieved from <http://www.childdevelopmentmedia.com/articles/mary-ainsworth-and-attachment-theory/>
- Chu, A. T., & Lieberman, A. F. (2010). Clinical implications of traumatic stress from birth to age five. *Annual Review of Clinical Psychology*, 6, 469-494.
- Crain, W. C. (2005). *Theories of development: Concepts and applications*. Upper Saddle River, N.J: Pearson/Prentice Hall.
- De Young, A. C., Kenardy, J. A., & Cobham, V. E. (2011). Trauma in early childhood: A neglected population. *Clinical child and family psychology review*, 14(3), 231.
- Egeland, B., Carlson, E., & Sroufe, L. A. (1993). Resilience as process. *Development and Psychopathology*, 5, 517-528.
- Greeson, J. K., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake III, G. S., Ko, S. J., ... & Fairbank, J. A. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network. *Child welfare*, 90(6), 91.
- IJzendoorn MH, topic ed. *Encyclopedia on Early Childhood Development* [online]. <http://www.child-encyclopedia.com/attachment/according-experts/attachment-early-age-0-5-and-its-impact-childrens-development>. Updated March 2007. Accessed July 2, 2017.)
- Impact of Complex Trauma - NCTSN - Child Trauma Home  
[www.nctsn.org/.../files/assets/pdfs/impact\\_of\\_complex\\_trauma\\_final.pdf](http://www.nctsn.org/.../files/assets/pdfs/impact_of_complex_trauma_final.pdf)
- Kaplow, B. J., Saxe, N. G., Putnam, W. F., Pynoos, S. R., & Lieberman, F. A. (2006). The long term consequences of early childhood trauma: A case study and discussion. *Psychiatry: Interpersonal and Biological Processes*, 69, 362-375.

- Lieberman, A. F. (2004). Traumatic stress and quality of attachment: Reality and internalization in disorders of infant mental health. *Infant Mental Health Journal*, 25(4), 336–351.
- Lieberman, A. F., & Van Horn, P. (2009). Giving voice to the unsayable: Repairing the effects of trauma in infancy and early childhood. *Child and Adolescent Psychiatric Clinics of North America*, 18(3), 707–720.
- Lieberman, F. A., & Knorr, K. (2007) The impact of trauma: A development framework for infancy and early childhood. *Psychiatric Annals*, 37, 416-422.
- Lovett, B. B. (2007). Sexual abuse in the preschool years: Blending ideas from object relations theory, ego psychology, and biology. *Child & Adolescent Social Work*, 24, 579- 589.
- Meyer, W. S. (2001). Why they don't come back: A clinical perspective on the no-show client. *Clinical Social Work Journal*, 29(4), 325-339.
- Office on Child Abuse and Neglect, Children's Bureau, (2006). Child Neglect: A Guide for Prevention, Assessment and Intervention. Retrieved from <https://www.childwelfare.gov/pubs/usermanuals/neglect/>
- Skinner, E. A., & Zimmer-Gembeck, M. J. (2007). The development of coping. *Annual Review of Psychology*, 58, 119-144.
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, (2016) <https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport23.pdf>