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Not "Bad Boys": Psychosocial Implications Of Aggression In Boys With PTSD

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Abstract

This thesis explores different facets of childhood trauma, specifically focusing on aggressive behaviors. The impact of trauma can leave individuals, especially children, in a state of constant fight. Oftentimes, symptoms appear as tantrums, irritability, and defiance, which are perceived as "bad" behaviors by society. It is crucial that social workers, educators, doctors, policymakers, and parents alike learn to understand that a symptom is a piece of a larger puzzle. If we do not acknowledge the events that lead to certain behaviors in children, there will be serious socioemotional and societal consequences. In an attempt to highlight the complex nature of trauma and aggression, I will review relevant literature and present three clinical cases to discuss symptomology, treatment, and the societal implications of aggression. The three cases describe boys ages 15, 13, and 5, to illustrate developmentally appropriate treatment.

Keyterms: **childhood trauma, chronic trauma, PTSD, child development, aggressive behavior**

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Introduction

A plethora of trauma research has recently emerged in the psychological literature. It has also become a well-known topic in other fields of study like sociology and neurology. Trauma most often occurs when an individual encounters a threat to their life, livelihood, security, or well-being, or if they have witnessed another experience a threat. However, one does not necessarily experience Posttraumatic Stress Disorder (PTSD) after a traumatic event. According to the DSM-5, an individual receives a PTSD diagnosis if six of the following criteria have been met:

> (1) exposure to actual or threatened death, serious injury, or sexual violence… (2) recurrent and involuntary presence of intrusive symptoms (memories of traumatic event, distressing dreams related to event, dissociative episodes, psychological distress, or physiological reactions)... (3) persistent avoidance of stimuli associated with trauma… (4) negative alterations in cognitions and mood due to trauma event… (5) marked alterations in arousal and reactivity associated with the traumatic event (irritability, self-destructive behavior, hypervigilance, exaggerated startle response, and sleep disturbance)... (6) duration of disturbance is more than a month (American Psychiatric Association, 2013, p. 143-145).

It should be noted that trauma does not automatically occur due to a singular event; but it can be prolonged and/or repeated; for instance, chronic trauma symptoms can occur in those who witnessed domestic violence.

As trauma research continues to grow, the subfields do as well, specifically childhood trauma. It is necessary that psychological and scientific researchers continue to analyze the effects of trauma, as the rates of traumatic events remain high in American society. In the National Survey of Children's Exposure to Violence, Hamby, Finkelhorn, Turner, & Ormord (2011) reported that 1 in 15 children witness intimate partner violence, and one 1 in 4 children are exposed to some form of family violence in their lifetime. These rates emphasize the need to

discuss prevention and treatment. Oftentimes, parents do not recognize that their child could be susceptible to trauma because of age or their whereabouts during the traumatic events. Research suggests that the impact of trauma lingers in different ways for children, in comparison to adults who have more developed linguistic and cognitive capacities (Liberman, Ippen, & Van Horn, 2015). Childhood trauma may cause more intense and more prolonged symptoms. Children with PTSD can demonstrate behaviors such as temper tantrums, sleep concerns, hypervigilance, and lack of attention.

In response to a threat, it is common knowledge that humans, among many other species, react in one of three ways: fight, flight, or freeze. Van Der Kolk (2014), author of the popular book, *The Body Keeps the Score,* argues that "when the brain's alarm system is turned on, it automatically triggers preprogrammed physical escape plans in the oldest parts of the brain" and shuts down higher functioning parts of the brain (p. 54). If mechanisms for survival work properly, then homeostasis returns to reduce the fight, flight or freeze. However, if an individual is halted from escape or defense, the brain continues to helplessly secrete stress chemicals, causing the brain and body to perceive itself in a constant state of being under attack (van der Kolk, 2014). And who is more likely to be stuck than a child, who, comparatively, has limited mobility, language, and power?

Fight is perhaps the most jarring and intense response as it involves aggression and anger. Physical expressions of anger warn people to retreat and avoid, which further instigates society's fear of anger (van der Kolk, 2014). Fighting, tantrums, yelling (all potential PTSD symptoms) can easily be identified as 'bad behaviors' in our society, and in turn, we label those who exhibit these symptoms as 'bad kids.' These 'bad kids' may have a difficult time integrating in schools or making friends. They may be referred to guidance counselors, psychiatrists, or even

institutions for behavioral reform. Or maybe they won't be referred to any rehabilitative institution; they may be put in detention, suspension, or in jail depending on the severity of symptoms. If society (and adults) simply see the behavior as behavior and not ask why, we are doing a disservice to traumatized children and may be instilling more fear instead.

For my social work field placement, I interned at a community outpatient mental health clinic in a large city where I provided psychotherapeutic services to a diverse set of adults, adolescents, and children. In an effort to protect the privacy of my clients and their families, I will not be identifying the name of this agency. These three clients are under the age of eighteen, currently diagnosed with PTSD, and demonstrate intense aggressive symptoms due to past experiences. This thesis aims to describe these three boys' backgrounds, trauma history, their current symptoms, and the therapeutic treatment we have conducted together. These case studies will be explored and analyzed in conjunction with the trauma literature reviewed. Societal issues and cultural differences will be explored. Please be advised that I do not intend to argue that female youth cannot illustrate aggressive symptoms if diagnosed with PTSD. Since my clients are male, it seems appropriate to limit my analysis to this specific population as it allows for a more in-depth discussion of published literature, treatment, and societal considerations.

Literature Review

Trauma literature is extensive and broad, as there are many lenses to examine this popular topic. For the purpose of this thesis, we will examine different psychological theories and areas of science that can aid in the analysis of aggression in traumatized boys.

Prenatal Trauma Effects

By analyzing the effects that prenatal trauma has on an infant, mental health professionals are better able to serve and understand their clients through a holistic lens. It allows us to remove the stigmatization of a behavior and understand the cause of a behavior. Trauma can have roots as early as pregnancy. Prenatal stress, specifically anxiety, correlates to negative delays in infant development (Cozolino, 2014). Anxiety during pregnancy can occur for many reasons: lack of social support, financial deficit, health concerns, and partner abuse. Cozolino (2014) argues that anxiety leads to increased norepinephrine and agitation, and lower levels of dopamine. These skewed neurochemical levels correlate to a mother's negative mood and decrease reward systems. These symptoms affect the fetus, causing it? to experience neural and physical growth delays, emotional dysregulation, and attachment difficulties when born (Diego & Field, 2008). This puts anxious and traumatized mothers at-risk for birthing children who come into the world already at an emotional deficit. There is a higher likelihood that these infants will demonstrate more aggressive behaviors than their non-traumatized counterparts.

Neurologyof the brain

The brain is a developed system, designed to further mammalian survival, and although it has evolved for humans to utilize cognitive functions, these cognitive areas are much newer and can be easily "turned off" if an individual encounters a threat. Perry & Szalavitz (2006) argue that "the lowest, most primitive region - the brainstem - completes much of its development in

utero and early infancy. The midbrain and limbic systems develop next, elaborating themselves exuberantly over the first three years of life" (p. 68). The brain itself grows in the best order to promote survival. This underscores how crucial these older regions are, since they contain motor and regulatory functions. The amygdala, located in the older limbic center, is a more primitive area in the brain, and regulates the experience of emotions. Van der Kolk (2014) asserts that humans "depend on the amygdala to warn us of impending danger and to activate the body's stress response" (p. 43). Stress hormones, like adrenaline, are released into the body to activate fight responses. For individuals who have an overactive amygdala, perhaps due to increased amounts of stress during formative years in utero or toddlerhood, stress hormones overactivate in response to mild stimuli, or take much longer to return to baseline. This explains why traumatized children react to stressful experiences, no matter how minor, with prolonged tantrums, throwing objects, and fighting.

The reaction to a threatening event, or events, also emphasizes the importance of traumatic memory. The hippocampus is the neurological memory center; it acts as a region for categorization and aids people in avoiding certain triggers that overwhelm the brain and could potentially put a person back in harm's way (van der Kolk, 2014). The brain aims to maintain vigilance and protect, but if we have experienced chronic trauma, too much external stimuli can set our brain back into a state of panic and fear. When the hippocampus, and the amygdala, becomes overridden with triggers, the sensory and 'thinking' regions of the brain shut down. For instance, the thalamus integrates sensory input (i.e., smell, sight, sounds, touch, taste) from the external world, and it helps individuals stay in the present (van der Kolk, 2014). If overwhelmed by stressful stimuli, the brain reduces blood flow to the thalamus and hinders one's ability to remain present and logical. This on-off function is automatic, and takes effort and practice to

control. Full grown adults with trauma histories struggle with these trauma symptoms, which emphasizes the intensity and difficulty experienced in developing children.

The newer areas of the brain are in essence what make us human. The prefrontal cortex focuses on cognitive capacities, like decision making, and is a much younger part in comparison to the amygdala and hippocampus. The lack of equilibrium in these regions highlights a lack of connection and creates a fragmented experience based on sensation and emotion rather than narrative coherence (van der Kolk, 2014). These newer parts cannot function if the limbic system is overwhelmed, which also explains body-based PTSD symptoms. The prefrontal cortex develops later and continues to grow into early adulthood. If childhood trauma occurs, it can inhibit one's cognitive development, which makes for a seemingly "unruly, difficult, or bad" child. By understanding trauma's impact on the brain, it provides the opportunity for parents and other adults to better handle and work with a child's symptoms.

Biologyof the body-brain connection

The reactive neurological component that induces aggression associated with PTSD necessitates researchers to study the link between mind and body. The previous section emphasized how neurological functions aim to maintain survival, which in turn, can force the body to respond in certain ways. Dr. Stephen Porges created the Polyvagal Theory to further the research on trauma body-brain connection. Polyvagal refers to the multiple branches of the vagus nerve, which runs along the human spine from brain to colon (van der Kolk, 2014). This nerve serves to promote positive social interactions and reduce potential threats by activating the two autonomic nervous systems. The sympathetic nervous system activates arousal responses and "moves blood to muscles for quick action," while the parasympathetic promotes self-preservation functions that "put a brake on arousal" (van der Kolk, 2014, p. 79). Feelings of

safety regulate which part of the system will be utilized, all of which are unconscious. One can think of the Vagus nerve as a top-down system to promote safety; first using social engagement, then fight or flight, and then collapse or freeze. Since humans are social creatures that need engagement, we enter the first level with modified facial expressions and tonal changes that signal defense to others (e.g., a frown). If the threat still remains, the body's sympathetic nervous system activates and prepares the body for fight or flight. Most of my clients, dealing with aggression, seem to be stuck in this phase. Their bodies remain on the fight defense. Polyvagal theory underscores the need for social engagement, especially for children. If a child cannot receive help in a time of crisis, then they may become stuck in a mode of fight. For example, someone without a trauma history may view a raised hand as a wave or a potential high-five. To a child with trauma, it can signal potential assault. This would in turn activate behaviors that promote distance and aggression, like a frown or a punch. In the moment, it may serve the child's immediate sense of safety, but in the long run, it can damage a child's sense of acceptance by his peers. Hindered social engagement can prevent emotional regulation and social skills.

The human body not only holds responses to trauma and stressful events, but it holds memories of past experiences as well. Our physiological reactions to trauma highlight the intensity of such events, even from a small age. Sander (1995) argues that infants can register external stress at seven days old, as infants demonstrated restlessness and spitting up in response to witnessing their caregivers hide their faces under ski masks throughout crucial attachment moments (cited by Gaensbauer, 2002). Although infants may not be able to express memories of stressful events, their bodies illustrate recollection of these experiences. There are reports that infant medical intrusions can instill physical sensations that last throughout childhood and even

into early adulthood. Gaensbauer (2002) described work with a young adult who experienced a high amount of heel pricks as an infant and throughout his development would describe pain in his heels when stressed. A four year old client of Gaensbauer (2002) had a similar experience as an infant and would pound her heels against her mattress to relieve irritable sensations. These examples highlight that bodies hold memories that may not be able to be expressed or fully remembered later in life. If our bodies can register and hold experiences of medical intrusions, then one could argue that they can most definitely recall trauma experiences. For instance, imagine a caregiver being the one to implement pain onto an infant. The implications are twofold; not only would the infant demonstrate symptoms similar to that of the Sander's (1995) ski mask experiment, but infants would also develop symptoms of physical distress and pain.

Moving past regional recollection, the human body is capable of remembering past trauma on the cellular level as well. According van der Kolk (2014), chronic trauma survivors, in this case incest survivors, have an imbalanced CD45 RA-RO ratio. He reports:

> CD45 cells are the 'memory cells of the immune system. Some of them, called RA cells, have been activated by past exposure to toxins; they quickly respond to environmental threats they have encountered before. The RO cells, in contrast, are kept in reserve for new challenges; they are tuned in to deal with new threats the body has not met previously. The RA-to-RO ratio is the balance between cells that recognize known toxins and cells that wait for new information to activate. In patients with history of incest, the proportion of RA cells that are ready to pounce is larger than normal (van der Kolk, 2014, p. 129).

With an imbalanced immune cell ratio, the system overly defends itself in preparation for a potential threat. Although the immune system directly deals with disease and toxins, on a metaphorical level, this correlates to "fight-based" trauma symptoms. Chronic trauma on multiple levels leads to this constant state of attack in moments when it is unnecessary. It not

only affects the cognitive level, but even on a physical level. This is an area of research that needs continued funding and exploration to deepen knowledge and further clinical intervention.

Gender

Another subsect of trauma research that has been gaining attention is how gender correlates to stress management. Oxytocin, a pituitary hormone, is released in both men and women, but is primarily modulated by estrogen levels and has a significant impact on breastfeeding and giving birth (McCarthy, 1995). It helps to reduce sympathetic activation and fearfulness, while increasing relaxation. According to van Horn (2011), male sex hormones inhibit oxytocin release, making males more susceptible to stress symptoms. Understanding how biological sex differences impact the intensity of symptomology is a crucial aspect in creating clinical case formulations.

It is also imperative to understand how oxytocin is used in the attachment process. Although attachment will be examined with a psychological lens in a later section, it is helpful to understand attachment through a biological one as well. For infants and young children, oxytocin is released when a caregiver accurately responds to an infant's proximity seeking behaviors (e.g., crying for food). By providing an infant with the regulation he needs, his body continues to produce this stress-relieving hormone. Weinberg, Beeghly, Olson, & Tronick (2008) argued that male and female toddlers utilize different self-regulatory strategies with their caregivers. They found that "boys need more regulatory support from their caregivers" (p. 2) while girls utilized object-based exploration to deal with stress, for instance, playing with toys instead of playing with a caregiver. Males need more interpersonal support to increase oxytocin in comparison to girls, putting them at a greater risk for mis-attunement. This is not to claim that girls are impervious to mis-attunement, but boys are at higher risk for trauma symptoms if not

supported properly. The significance of interpersonal necessity in boys could correlate to aggressive symptoms in boys with trauma. Aggression can act as a behavior to promote proximity to others. Although it can function as a mechanism to maintain distance, it can also operate as a way to control a threatening situation and maintain a sense of security in relation to others (Mikulincer & Shaver, 2011). It also suggests the negative impact of witnessing domestic violence. If a parent is being abused by another, there is almost no way for the non-offending parent to regulate and provide comfort to a boy at that moment. It thus exacerbates dysregulation in the child and creates a never ending cycle. It is important to consider the ways aggression serves an individual, but also how it hinders coping mechanisms.

Attachment Theory + Trauma

In the previous section, aggressive behaviors were examined through an interpersonal lens. Proximity-seeking behavior is a term in attachment theory that describes infants' attempts to maintain closeness to their caregiver, in an effort to have their needs met (Ainsworth & Bell, 1970). A primary caregiver's responses to these proximity seeking behaviors (e.g., crying) teaches the infant that the external world can provide him with resources for survival, "particularly in moments when… is frightened or in danger" (Slade, 2007, p. 228). Through repeated experiences, infants develop different styles of attachment to their caregivers. Ainsworth & Bell (1970) created the "Strange Situation" experiment, testing different styles of attachment. A mother and their child, typically one year-old, play in an unfamiliar playroom, and at some point, the mother leaves without notifying her child, leaving the child with a stranger. It is not how the child reacts in the moment with the stranger that is worth noting, but how the child handles the reunion with the mother once she returns. Ainsworth & Bell (1970) identified three types of attachment styles in the studied infants: secure, anxious, and avoidant. Secure infants

may cry and fuss, but could be consoled by the caregiver and return to play. Anxious infants could not be consoled and may display temper tantrums. Avoidant infants would illustrate distance from their mothers and would continue with their independent play. Anxious and avoidant styles would be considered insecure attachment since these "babies would alter these states to fit the needs of the caregiver" (Slade, 2007, p. 227). These styles are not deterministic of one's later interpersonal relationships and can adapt, but they should be understood as patterns and techniques to maintain safety and return to homeostasis.

Trauma adds another layer of intensity in the attachment relationship between child and primary caregiver. As mentioned earlier, trauma responses in children can appear as temper tantrums, restlessness, and lack of attention. Young children specifically are more prone to these behaviors as they do not have the adequate language or cognitive capacities to "recount the internalized feeling of detachment or estrangement of others" (Scheeringa, 2006, p. 169). A child cannot say 'I'm triggered', or sometimes even 'I'm scared.' Instead, they react with their bodies and return to earlier developmental proximity-seeking behaviors to unconsciously ask for soothing. Fraiberg (1982) argues that trauma responses vary by developmental stage, but can be particularly difficult to recognize as a child gains motor abilities. With advanced movement and independence, traumatized toddlers can be seen as "little monsters by day and terrified children at night, who wakened in acute anxiety and could not fall back asleep to be comforted" (Fraiberg, 1982, p. 194). Parents and caregivers may be confused or disturbed by these behaviors, which may affect their ability to soothe a child in moments of need. It is not uncommon for parents to underestimate the extent to which their children can remember or understand traumatic events, often claiming that they were not in the room or would be too young to remember (Liberman, Ippen, & van Horn, 2015). As described throughout this review,

the body remembers more than we expect it to. With proper guidance and understanding, a parent can learn to identify possible triggers and alleviate the child's trauma symptoms; this can be done by removing the stimuli and thus decreasing the response. Liberman (2004) suggests that "when this is not feasible, adults can use gradual desensitization by exposing the child to the traumatic reminder in a modulated away while engaging in protective and soothing behavior such as holding, rocking, and singing" (p. 342), which acts as a developmentally appropriate version of exposure therapy.

Since the primary caregiver acts as the main resource for security and safety for the infant, it is easy to argue that the adult's safety also plays an essential role in protecting the infant. Although we have already reviewed literature on child-centered trauma (Gaensbauer, 2005), it is crucial to understand how a parent's trauma can impact the child. Even environmental stressors, like socioeconomic strain or cultural dislocation, can impair a parent's ability to emotionally attune themselves to their child, and parents "may perceive their children's bid for attention as one more source of strain on their depleted personal resources" (Liberman, Ippen, & van Horn, 2015, p. 20). One could only imagine that these feelings may be exacerbated when traumatic life events occur in a family system. Trauma can occur on many different levels and affects family members differently, based on recurring triggers, secondary stressors, social support, alterations in family composition, and shifts in caregiving routines (Liberman, Ippen, & van Horn, 2015; Liberman, 2004). Adult PTSD symptoms can look like "avoidance, numbness, or hyperarousal," all of which can "interfere with their ability to notice or respond to the child's distress" (Liberman, 2004, p. 342). This lack of parental attunement, although understandable, can further impair a child's ability to recover and heal from the traumatic event. Mental health treatment for both child and parent would be ideal for a traumatized dyad.

As attachment theory continues to grow and gain popularity, researchers found another style outside of the three mentioned earlier (secure, anxious, and avoidant). Unlike its predecessors, disorganized attachment has no identifiable pattern or technique to maintain self-regulation in the infant. Truthfully, it is rather uncomfortable to watch a child have a disorganized attachment as he may demonstrate contradictory behaviors, incoherent movements, and moments of prolonged stillness (Main, Hesse, & Kaplan, 2005). Van Der Kolk (2014) provides examples of disorganized behaviors: rocking on hands and knees, going into a "trance-like state with their arms raised, or get up to greet their parent and then fall to the ground" (p. 119). Although these symptoms lack a pattern and appear as "disorganized," these behaviors derive from cues received by their primary caregiver. These distress responses mirror their primary caregiver's responses to their infants' proximity seeking-behaviors. For instance, if an infant cries, a securely attached mother would pick up their child and try to soothe him. With a disorganized mother, "the parent might exhibit any of the 'classic' responses to fear - including freezing (trance), attack (as in quasi-predatory movements), and flight (including subtle indications of propensities to increase distance from the infant, suggesting that the infant is experienced as alarming or dangerous" (Main, Hesse, & Kaplan, 2005, p. 282). The stress the mother experiences when caring for the dysregulated baby is internalized by the baby as well. He also becomes dysregulated and unsure of what the external world can provide for his safety. As the mother flips between states to 'protect' herself from the baby, he cannot find a mechanism for regulation. Thus, he is left in a constant state of threat. A disorganized attachment can be classified as traumatic, as it also connects to the growing research on intergenerational trauma as professionals continue to inquire how "parents' unresolved traumatic experiences are transmitted to the child through intersubjective and behavioral channels" (Liberman, 2004, p. 338). Trauma

responses are mitigated by a parent's ability to regulate a child, but how can a parent soothe the child if unable to soothe themselves?

Now, what happens if the child views a caregiver or parent as the threat? This adds another level of confusion and dysregulation in the child, since the "secure base" provides support and comfort, but can also be the source of danger and fear (Fusco, Jung, & Newhill, 2016). Depending on the stage of the child, this can seriously impact his personality and social development. A child in the unfortunate position of witness to intimate partner violence (IPV) is caught between "seeking comfort and fighting off danger, while being flooded by the painful sensory stimulation inflicted by the attacking parent" (Liberman, 2004, p. 343). One of the most dysregulating parts of IPV is its spontaneity. The abused parent may not be able to protect the child from the effects of the abuse, or may not even be able to determine when the violence could occur themselves. This inherent lack of consistency and preparation leaves the child with an onslaught of traumatizing stimuli, and it additionally leaves the parent unable to attune themselves to their child. This returns back to the importance of oxytocin and caregiving to relieve stress in children.

Even if the primary caregiver is not the abuser, the nonoffending parent's hurt and helplessness confuses the child's perception of safety and security, as the effects tend to linger past the time of the traumatic event. Lyons-Ruth & Block (1996) identified two types of primary caregivers, specifically mothers in this research, under the disorganized attachment label: hostile mothers and helpless mothers. Hostile mothers appeared as intrusive and more focused on their own immediate needs; oftentimes, these mothers experienced physical abuse or witnessed IPV in their own homes. Helpless mothers appeared as fearful and almost incapable of being the adult in the child-parent relationship; this subsect of mother tended to have a history of child sexual

abuse or parental loss. Violence within the family can retrigger parents and negatively impact their ability to care for their children. This illustrates how unresolved trauma lingers and turns into intergenerational trauma, with "ghosts taking up residence in the nursery" (Fraiberg, Adelson, & Shapiro, 1975). When working with traumatized children, it is imperative to also understand the traumas and stressors that the caregiver has experienced to see what has been subconsciously cycled into the youngster.

IPV also has the negative ability to teach children of all ages to use aggression. It also appears as a riskier indicator of PTSD symptoms in comparison to the child actually experiencing the harm (Scheeringa, 2006). In high-intensity situations involving family violence, a child may run towards the parent despite being harmed, or may try to attack and stop the abusing parent (Liberman, Ippen, & van Horn, 2015). In an attempt to defend, these children are on the offensive and use aggression as a form of protection. It is essential to remember that fight is a normal response to a perceived threat. What is less normal and socially acceptable is the continued hypervigilance and use of "fight" in non-threatening situations. This is where mental health treatment comes into play, as the aim of trauma-informed care is to help clients, regardless of their age, remain in the present. Effective treatment is only achieved when parents, teachers, and mental health professionals learn that these responses are "self protective [attempts] designed to fend off a repetition of the fear and emotional disorganization triggered by the accident rather than an effort at manipulation or control unrelated to the trauma" (Liberman, 2004, p. 343). It again brings us back to the notion that the behaviors are more than that, but are seeking to be understood.

Family violence can extend beyond IPV, and moves towards the direction of directly impacting children. Although the rates have shown substantial declines in the past few years,

child abuse rates should still be considered alarming to the public. According to the Administration for Children & Families (2018), 678,000 children experienced some form of child abuse in a single year. In the previous section, it was argued that a child witnessing IPV can be more harmful than experiencing it himself. However, this does not negate the psychologically damaging effects it has on children. Children view abuse not only as pain and fear, but as a form of parental rejection (Savage & Wozniak, 2016). Aske (2004) argues this sense of rejection leads to externalizing behaviors, specifically in boys (cited in Savage & Wozniak, 2016). Externalizing behaviors can appear as tantrums, peer conflicts, running away, etc. If abuse is perceived as a rejection, it teaches children mixed signals about where to find comfort and support in stressful situations. On the other hand, physical child abuse at least gives boys some of that interaction that is necessary for their self-regulation development. A neglectful parent may cause more damage to a boy than an intrusive one. This returns back to Weinberg et al. 's (2011) findings that suggest boys need more interpersonal stimulation, which physical abuse could be perceived as in the moment. This is not to claim that one form of maltreatment is more acceptable than the other, but it does argue that some forms are more harmful than others, depending on gender.

By understanding the multifaceted nature of trauma through the lens of biology, neurology, and attachment theory, mental health professionals can develop a comprehensive model to help their clients and family provide trauma-informed treatment. A comprehensive approach aids in case formulation, resource referrals, and psychodynamic interventions to help the child and his family understand and manage his own behaviors and feelings.

Case Studies

Overview: I will briefly summarize the three clients I will be discussing in this thesis, aiming to provide background information and context. The sources for this material were process notes taken as part of my internship experience as well as discussions with my clinical supervisor. Pseudonyms are used to protect patient privacy.

Jason

Jason is a fifteen year-old Peruvian-American freshman at his local high school. He enjoys video games like Fortnite and MindCraft, working out, and hanging out with his friends and girlfriend, Nadia. He has a young face with chubby cheeks, unruly hair, and a large build, which he developed for his passion for wrestling. He has a soft vocal tone and seems rather lethargic in sessions, but loves the amusement park and riding on ATVs. He likes relaxing hip-hop music that he "can vibe to in a car," and prefers to be alone with his pet chameleon, Flame. Recently, he has developed an interest in cooking; his most recent kitchen experiments include baking muffins and grilling steak. Truthfully, it would be hard to guess or even comprehend the trauma Jason has experienced just by his outward appearance.

Jason's immediate family was referred to therapy by ACS, after the removal of his father. When Jason's older sister, Stephanie, attended her annual check-up, the pediatrician noticed severe bruises on her body, mandating him to report the findings. Jason's mother, Claire, exhibited signs of relief, as the call finally meant that she would receive help in protecting her family and herself from Jason's father. Jason's father is someone who demonstrates sociopathic tendencies. In the past year working with Jason, I have heard numerous tales from Jason and his mother about the horrors they endured. Jason reported physical abuse since Kindergarten, with weapons varying based on age: bare fists, hangers, cement bricks in pillow cases, and a staff made of plaster. The father would tie up Claire in front of the children so that she would not

leave the house, or if she did something not to his liking. Jason recounted one Thanksgiving that the father brought home two buckets of KFC, assuming that his father would share it with all of them. But the father only allowed Jason to eat the chicken, not Claire or his sister. Jason's father would leave porn on his son's tablet for him to watch. When the father was away, there was no respite for the family as he set up cameras inside the house that streamed to his phone to ensure no one acted "out of line." Jason's father handled punishments in cruel and sadistic ways: when Stephanie struggled with her grades, he threatened her to do better "or else." When Stephanie's grades did not improve, Jason's father had them both watch as he took Stephanie's fish from the tank and burned it alive. Even though I have been working with Jason for more than a year by the time that thesis is published, I still feel that I only know pieces of his family's extensive trauma history.

Although Jason's father was removed, the aggression and trauma remained in the home. Without the father, Jason and his sister demonstrated signs of adjustment disorder with their main authority figure gone. Jason exhibited signs of hypervigilance, aggression towards his peers and his sister, and outward defiance of authority figures.

Brian

Brian is a thirteen year-old Puerto-Rican male who started attending individual sessions along with his twin brother Curtis and his mother Ally. He is the smaller of the fraternal twins with big eyes and short hair. In the year that I have been working with Brian, I have witnessed many sides of him. In the beginning, he used one-syllable sentences and would barely look me in the eyes. As he became more comfortable with me, I found that Brian is quite the jokester with a competitive streak, especially during games like *UNO* and *Sorry*. He enjoys sports like basketball and soccer, and trying new tricks. He seems like a happy child in the playroom, but has faced many difficulties in the real world that have caused him much anguish.

Ally described Brian's prenatal life starting with violence, as their biological father used to physically abuse her during pregnancy. Brian and Curtis were born at 29-weeks and were in NICU for 2 months. Brian's father was absent for most of his life and did not keep most promises, leaving Brian with feelings of abandonment. Brian's seventeen year old brother, Damien, is described as a chaotic force in the home, whom Ally has difficulty managing due to physical and psychological limitations. Ally describes the older brother as rebellious, rude, and abusive, and worries about what Brian is learning from him. During one of their conflicts, when Brian was nine, Damien called the police on Ally for abuse, causing her late night arrest. This left Brian and Curtis in tears and without physical or emotional protection from the sight they had just witnessed. When the family is not in conflict, it is hard for any individuals to receive space and privacy due to the restricted setting. Brian, Curtis, and Ally share a room; Damien, his girlfriend, and their baby Aiden share the living room, while Ally's mother and step-father share the master bedroom. The lack of space in this home incites conflict and irritability.

Brian's home life may be cramped and intimidating, but school life has also been uncomfortable for him. Since Brian entered school, he has been placed in special education classrooms due to learning disabilities, most notably Dyslexia. Ally recounted that his elementary school often neglected Brian's needs and did not provide him with the educational services he needed to thrive. School also creates other difficulties for Brian since he has demonstrated symptoms that fall under the ADHD diagnosis (Attention Deficeit/Hyperactive Diagnosis). He reports trouble concentrating, often jokes around and disrupts the classroom, or will just walk out, which lands him in detention or getting a call home. Brian gets bullied in class for his learning disabilities, which causes him to act out or fight with other students. School incites feelings of inadequacy and overstimulation, but also fear. When Brian was in the

5th grade, he had his pants pulled down by another boy in the bathroom. Brian refuses to talk about this incident with anyone -- it took him a year to even tell Ally that the incident had occurred. She suspects that there may have been some sexual misconduct involved as Brian used to tie his pants so tightly that his pediatrician warned him of potential organ damage if he did not loosen them. Brian will not speak about any details of this incident, but has loosened his pants since the doctor's warning. Brian's refusal to discuss this incident, or any incidents that involve high intensity of emotions, highlight the intensity of his symptoms. When upset, Brian tends to shut down or lash out. His mother notices a major change in affect when he is confronted with situations that make him uncomfortable. He will throw household objects, break pieces of furniture, or curse at anyone in his path. In the past, Brian has cut his arm twice. When asked why by his previous therapist, Brian reported uncertainty, but knew he was angry. This aggression combined with his dissociation illustrates the two sided nature of Brian's trauma.

Charlie

Charlie Marcus is a five year-old African-American boy, who is the third of four siblings. He has round eyes, an infectious laugh, and always wears his favorite Spiderman slides. His family refers to him as Marcus, while others (teachers, peers, and myself) call him Charlie, which he prefers. He has met all of his developmental milestones and seems like a cheerful and playful child. He especially likes to dance, play basketball, and follow around his older brother. For a child his age, Charlie demonstrates above-average cognitive skills and patience: he took down a Jenga set and put it back together, twice. He has a clear understanding of people's positions in his life and will correct someone if they are wrong. He made it very clear to the psychiatric staff that his mother's current boyfriend is not his father, but "just Daniel (pseudonym)." Charlie is quite an interesting child to work with since his behaviors and

circumstances all stem from intense experiences of trauma and emotional abandonment.

Even though Charlie has exceptional cognitive skills, he demonstrates serious delays surrounding his emotional regulation and communicative capacities. Charlie has difficulties with transitions and regularly throws tantrums. He will hit, kick, and throw himself to the ground. In one instance, he stabbed another child with a pencil when the child would not give him the color he wanted. This is the reason why his mother, Jane, brought him to the agency, since she felt that she has never dealt with a child like this and does not know how to handle him when he enters these highly aroused states.

When conducting the intake with the mother, as with any parent, we go through a series of questions. This process helps clinicians get a sense of the child and how we can best support them. We went through Charlie's history, starting from pre-conception to his present day life. At first, Jane claimed that Charlie's life was rather ordinary as nothing major happened to him (e.g., no broken bones, no physical abuse, etc.). When I began to pick apart these answers, trying to pull for more clarification, I decided to ask Jane about her experience as a mother, starting with "Was Charlie planned?" This question led to a long history about her life before Charlie.

Jane met Charlie's father (also named Marcus), and they quickly fell into a romantic relationship. About a month in, she found out that she was pregnant. Initially, she considered termination since she was already raising a twelve year old daughter and seven year old son on a safety instructor's salary. But Marcus advised against it, with promises of familial support and care. She decided to take a chance and continue with her pregnancy. About seven months in, Jane began to notice a disconnect from Marcus as he showed up less and began to bail on their dates more frequently. In an attempt to find answers, Jane arrived at his mother's house and

found that Marcus was the father to seven other children from seven other women. Jane, feeling betrayed and confused, cut off ties with Marcus, but received help from his mother. Marcus' mother admitted that she does not know why her son does this, but she tries at least to help the other children, and their families, when they need support. Jane swears that this is a sign of genetic mental disorder, and worries that Charlie may be afflicted with the same condition as his father. Charlie's trauma highlights the power of invisible scars from intergenerational trauma.

During the assessment, Jane denied that nothing else was of concern regarding his development. As an infant, he slept normally, ate fine, and was easy to soothe when crying. She claimed that everything started to go downhill when he turned two and could start talking. Jane stated that it was more than just the terrible two's, which she understood from her two previous children. She reported that his tantrums were inconsolable and came out of nowhere. I asked if there was anything scary occurring at this time, which she denied. We continued, and I asked if she was ever hurt in front of him, which she replied with "oh… there was a boyfriend of mine who would hit me. But he never saw." I asked how she knew if Charlie did or did not see Jane's physical abuse. She replied that he slept in the other room. Jane's at-the-time boyfriend and the father of her fourth child, was extremely violent and abusive towards Jane during their relationship. His violence was so extensive that it reached beyond the home, and he attacked an older woman on the street, landing him in prison. When I asked Jane if Charlie witnessed the arrest, she denied that and said it was during the night while he was sleeping. When Charlie woke up, he did see shards of glass and broken furniture. Later in the treatment, during an individual session with Jane, I mentioned that it may be hard for an adult to understand what a toddler may or may not experience, and how it is even harder since children lack the language to describe their fear and helplessness. For Charlie, the trauma he experienced never got spoken or

recognized, leaving it nowhere to go but inside of himself. This leads to a very confused and helpless little boy, who outwardly presents as unmanageable, difficult, and to Jane, “genetically” disturbed.

Treatment

Overview: In this portion of the paper, I aim to describe the mental health treatment provided to Jason, Brian, and Charlie. Due to the differences in developmental stages and trauma experienced, the interventions utilized varied. A repeated principle in mental health work is that it is important to meet the client where he is at, in an effort to deal with ambivalence and start building rapport to enhance the therapeutic alliance (Boyd-Franklin et al., 2015). Working with children adds another layer in the treatment as clinicians also have to work alongside the parents. Depending on the circumstances, treatment may have been mandated by child protective services or referred by the school. This creates varying levels of interest and commitment to treatment. This section will explore the multiple ways I tried to address the problematic externalizing behaviors with the clients and their families.

Jason

Jason started to attend treatment when he had just turned fourteen years old. After reading his intake assessment, I was unsure of what to expect from a fourteen year old with such an extensive trauma history, complex family system, and acute symptomatology. After I told my supervisors that I received this case, she queried whether I would be afraid to sit in the room with him, because of his aggressive behaviors. Prior to meeting him, I said I was unsure and we agreed that safety concerns (for both Jason and I) would need to be assessed after the first session. For instance, I would have to check in to see whether he would bring his pocket knife. However, after the first session, my unease dissipated since I found that his aggression was primarily reactive to the trauma he had experienced.

On day one, Jason shared multiple stories of the pain and horrors he endured through his life. He was ready to talk about the abuse, the confusion, and his self-protective nature. Here is an excerpt from the first session in which Jason describes a fight with his older sister:

> J: I came home and she was listening to my Beats pill. I told her to give it back because it's mine. She told me it wasn't. I asked her who paid for it, and she said mom. I went to get my receipts – I keep those – because I know what's mine. She expected it say to my mom's credit card, but it said cash. That's how I paid for it. So, I told her to give it back. She didn't and said that she didn't care. I told her to give it back again and we kind of went at it. I told her she didn't get me, and she said look again. On my forearm, she left a long scratch because her nails are crazy long. And I can't support that. So, I went to get my boxing glove and I punched her. Hard. She almost went flying. Close to living room. She began crying and asked what the fuck was wrong with me. My mom came in and asked what the hell was going on… She said that this is what our dad did to us, all the fighting.
> AR: It sounds like you really need to protect what's yours now too.
> J: Yeah, ever since my dad left, I made an oath to never let anyone touch me again… even if it's family…

We initially see a territorial teenager, protecting his possessions and his body. However, as we delve deeper into just this first session, we can see a dichotomy between aggressor and self-protector. After the removal of his father, if aggravated and feeling under threat, he responded with an attack and viewed it as self-defense. Now, the idea was not to prevent Jason from fighting or reacting with aggression, because truthfully, we all knew that he was not going to stop fighting because an adult said so. The idea was to get him thinking about his triggers that led to aggressive behaviors.

Aggression and protection seemed to go hand-in-hand. He described moments of his friends getting bullied and stepping in, hiding his Chameleon from his sister's assaults, and even

providing food to his sister and mother against his father's threats. Here is another piece of a conversation Jason and I had about the role as protector in his family:

> J: On Thanksgiving, my dad got KFC… buckets. Enough to feed an entire family *(first smile, albeit small).* He gave me my own bucket and said, here son. This is for you. But with my sister and mom, they expected the same thing. But… he gave them nothing. Like put it in the fridge, and then went in his own room with his own bucket. My mom and sister sat on the couch, looking depressed… so, I gave them some of mine… but I couldn't be obvious… like we had to leave some fries and stuff… so that he wouldn't know.
> AR: That's really smart of you.
> J: Yeah, but… even when my sister was in the fridge to get more food, I heard his door open. I had to yell back that it was just me in there, so that he wouldn't come out and see her….

At a young age, Jason had to learn many essential things: secrecy, defense, and pain. All of which were necessary for his survival at the time when his father dictated the household, but with his father gone, the lack of 'structure' and fear spilled out to other aspects of Jason's life that did not necessarily apply to the world of high school. This retelling highlights the confusion Jason experienced as a child, since he was parentified as a protector.

This notion of protection continues to be an integral part of Jason's treatment as it also underscores his black and white thinking. During Summer 2019, Jason began to attend wrestling camp, which he enjoyed and continued to excel in. However, he developed ambivalence about his attendance when his mother began asking him to start teaching her some of the moves. Jason, reluctant to share these moves or share in the experience of his camp, repeatedly claimed that his mother cannot defend herself. He believed his mother just was a C (his maternal surname), whom he categorizes as family members who run away and are weak. While on the other hand, he is a B (his paternal surname), whom he typifies as fighters and aggressors. Jason split this idea of powerful and weak, and could not allow himself to view his mother as powerful

or strong since she never showed those kinds of behaviors. It also demonstrated the resentment he felt about teaching her how to protect herself and eventually claimed, "it's not my job to protect my mom." Due to the persistent abuse in the house, Jason never got the chance to be the one protected and feels obligated to solely look out for himself.

This anecdote also highlights how Claire views her son's aggression. Sometimes, she views him as a protector, big and strong -- even a teacher. In other instances, she regards him to his father. In my one-on-one sessions with Claire, she expressed fears that her son would become like his father, especially in regards to his anger. More importantly, Jason scared her. Here is a short narrative of Claire describing a fight between them:

> There was one time that he was getting so angry and he said something, so I got a broom – not to hit him with, but to you know, get him to back off. And he grabs it, saying I won't do anything, and yanks it away. He ended up hitting himself in the chin. And he was so mad so I went in my room to call for help, because I thought he was going to hurt me and they sent someone over. It was ACS and these two black women came into my house trying to tell me how I hurt him! I'm scared that he's going to go after this girl, who made a bad mistake.

This is just one example, but it illustrates the defensive and helpless feelings that Claire experiences when interacting with Jason. She has also referred to herself as small in comparison to her son and worries that he could beat her up. There is a clear dichotomy as to how she perceives Jason, which seems situational and based on her own fear. The split that Claire attributes to Jason can be sensed and internalized. Liberman (1999) defines maternal attributions as "fixed beliefs that the mother has about the child's existential core, beliefs that she perceives as objective, accurate perceptions of the child's essence" (p.737) and not inherently bad. It is when these maternal attributions become negative and prophesize misfortune that they can impact a child's sense of self. Mothers with these negative, specifically violent, attributions

towards their sons can misinterpret and distort appropriate child behaviors to fit their core beliefs. They can even unconsciously provoke some of these aggressive behaviors (e.g., getting a broom) that they fear (Liberman, 1999). For Jason, his mother views him as an aggressive, angry, and unmanageable boy, like his father. In adolescence, one could argue that these negative attributions hold serious consequences surrounding his sense of identity. Erikson (1959) argues that individuals enter crises depending on their developmental stage. Teenage years bring on the conflict of identity versus role diffusion, which asks the question of who are you going to be. Claire's repeated concerns about Jason's evolution into his father plays into characteristics that Jason views as valuable. His father may have been abusive and terrifying, but Jason also viewed him as strong and effective. For someone like Jason, who has found that power equates to survival, it would seem more useful to identify with someone like his father in comparison to his mother. Again, he perceives his mother as a (C) while he is a (B) like his father. A split between surnames illustrates the acute need for Jason to maintain a powerful identity. Loss of identity leads to exposure of past trauma and crises, which would be too overwhelming with feelings of fear, mistrust, restraints, and pain (Erikson, 1959). Combining his own normal development with the confusing maternal perceptions attributed to him, Jason is stuck in a constant state of hypervigilance and power-seeking.

With Jason, I only had one crisis session, which is quite a strength in his treatment. It is not simply due to the therapeutic work we did, but perhaps also highlights how Jason learned to cope with his anger in ways that did not involve fighting. The crisis session was a month after meeting him, and I received a frantic voice message from Jason's mother, saying that "he needs to come in! You have to speak with him. He won't listen, you have to tell him he can't go after girls!" When I called back and spoke with Claire to clarify what she meant, she explained that

Jason got stabbed in the back with a pencil by a classmate. When I asked if he was okay, she almost brushed me off, but instead expressed worry for the girl that had done it in the first place. Claire believed that her son was going to beat the female classmate up. Here is the beginning of the session:

> AR: Ok, so it seems like some things happened today at school. Mom, I know you gave me a little idea of what happened.
> Jason: I'm so angry.
> Mom: Yeah, he's so angry and when J gets angry, he goes blind.
> Jason: Not blind!... I just ignore everything else until I've done something…
> Mom: Okay, whatever… but he's angry and now wants to hurt this girl… and he can't because he's so much stronger than her… you know, because boys are stronger than girls. But I'm scared that he's going to plot revenge.
> Jason: I would.
> Mom: You can't! See? This is what I'm talking about – he gets into this thinking. The girl made a mistake but he would hurt her if he goes after her.

When I wrote this process recording, I realized that this was a session that illuminated many of the fears that Jason and his mother experienced. Jason focused on revenge, while his mother focused on the other girl. One could argue that Claire identified with this girl and projected the image of her ex-husband onto Jason. However, at the same time, I truly saw how Jason thought he needed revenge. In this next section, Jason describes the incident:

> Jason: So, it was in between classes, and this girl comes up to me. She calls me "Ed" and "retard" and other stuff, which gets me angry. I said… something *really* inappropriate back. And turned away from her since we had to get to class. And then all of a sudden, I get stabbed with a pen… and I look at her, like "what have you done?" And I was about to hit her, but the SWAT team came to get me. So, I couldn't get her back… and now I'm so mad. So mad. She only got suspension – that's not punishment!
> AR: What do you think would've been an acceptable punishment?
> Jason: Suspension does nothing – reading a book in a separate classroom is letting her slip by. She needs to be taught a lesson.
> AR: Which would be?
> Jason: She can't touch me and get away with it!

Jason believed that revenge showcased power and strength, which he merged with the idea of safety and protection. As a child, Jason learned that being powerful and exerting strength over others meant being safe, which is what he saw as protective in his father. Like his father, he could not allow someone to hurt him and "get away with it." Jason described an incident when his father was still present in the household. A male classmate beat up Jason's friend, and Jason defended his friend, perhaps too well. The classmate and Jason fought until broken up by school resource officers. The classmate's parents and Jason's father were all called into a meeting. According to Jason, school officials did not appreciate when Jason's father would come since he was so scary. Jason father's shouted at officials and the parents for daring to punish his son for protecting himself and winning a fight. Jason described that the other adults were left in a state of shock, and nothing happened to Jason as a result. Jason's retelling of this story exemplifies how Jason viewed his father: terrifying, powerful, and useful. Even though Jason received an immense amount of pressure, fear and pain from his father, Jason also viewed his father as a protector too. He learned that protectors never back down from a fight.

In session, when I challenged Jason's thinking on fighting back, he often replies that if he does not fight back or "get revenge," then the others will just bully or aggravate him in the future. This implies that there is no other option than to fight. An immense part of the treatment became challenging and expanding this split thinking, which led him to consistently use aggression as a mode of communication and protection.

One of the major treatment interventions provided was mentalization, or reflective functioning, an offshoot of theory of mind (TOM) and essentially promotes the notion of "holding the mind in mind" (Allen, Fonagy, & Batemnan, 2008, p. 3). The ability to be cognizant of one's own feelings and thoughts can lead to more meaningful and intentional

actions. In theory, it seems like a rather doable and simple concept, but for those who have experienced trauma or disorganized attachment, it can be quite difficult. A secure attachment teaches individuals that their needs and internal states can be read by others. However, since Jason came from a family where internal states were not met or even acknowledged, he now illustrates difficulty in being able to mentalize others' states. As discussed before, trauma history can impair this ability due to a neurological imbalance that instead promotes fight-or-flight responses (Allen, Fonagy, & Bateman, 2008). Thus, mentalization became one of the key interventions with Jason, in an attempt to reduce the aggressive behaviors that landed him in trouble at school.

Although this capacity holds intention and meaning for psychological development and growth, it is an intervention that is truly accessible for clients with split thinking. Allen, Fonagy, & Bateman (2008) describe that a clinician needs to maintain a 'mentalizing' stance that includes curiosity, interest, adaptability, and authenticity. Together, we explored interactions and self-experiences from different perspectives and challenged ideas of certainty. It is a technique that promotes the notion that the clinician, and the therapy, can be a safe space to explore options, feelings, and thoughts. The clinician also must be able to recognize and admit to mentalizing errors on her part to maintain and model rupture and repair. If I can illustrate repair in my mistakes, it can help show Jason that I am able to recognize when I am not attuned with him. At the same time, it is important I maintain a marked and regulated stance with Jason so that we can safely engage in difficult conversations. Here is a conversation Jason and I had, roughly six months into treatment, regarding his most recent detention.

> Me: You don't remember what happened.
> Jason: Nope.
> Me: Huh… okay… but you got detention?
> Jason: Yep.

Me: Well… let's think about what it could've been.
Jason: It was nothing bad though.
Me: What would be bad?
Jason: I didn't steal anything. I'm pretty sure I didn't say anything smart. I didn't throw the first punch.
Me: Huh… the first punch?
Jason: Yeah, if someone touches me it's self-defense.
Me: Right, it's hard for you to walk away if someone starts going after you.
Jason: Yeah, of course. It's dumb – teachers say that you can walk away if you get punched. But why would I walk away? That makes no sense.
Me: What makes no sense?
Jason: That you would get hit and not do something about it. No one… no one that I know will just walk away after getting hit.
Me: no one…?

Since it is the beginning of the session, I try to maintain curiosity about the situation but primarily focus on Jason's ideas of badness. Instead of trying to get him to remember the details of the incident, I try to help him hone in on the process of what occurred. The aim is to expand Jason's ability to incorporate other perspectives and ideas, which can be done by questioning concepts of "badness" and "common sense." Since this is a confusing concept for Jason, I try to promote this kind of thinking by offering imaginary scenarios where he gets to act and guess. In a way, this approach compares to play therapy. Harrison & Tronick (2004) identify that a main component to therapy for children is to expand coherence and complexity by incorporating new experiences into their sense of consciousness. By challenging Jason to take on new perspectives, he is trying out new situations on people in a safe and therapeutic environment.

Through these repeated experiences, Jason can prepare himself to enter into a world where things are not as rigid and where he can play around with ideas that do not inherently involve constant self-preservation. In therapy, repetition acts as a mode of preparation for opening up meanings to traumatic experiences (Harrison & Tronick,

2004). Since Jason's trauma extended over the course of many years and developmental phases, this took time, but gradually, I noticed a shift in language and perspective. Instead of making large black-and-white statements, he started to use terms like "or maybe that's just how I think" and "in my opinion." The subtle shift in language signifies a much larger shift in mentalization -- Jason's ability to identify that people think in other ways has expanded. The idea is that a shift in perspective-taking can also lead individuals to become more aware of their own thoughts and subsequent actions -- people who mentalize are better able to be mindful of their own processes. This came to light as Jason was more able to access the process of his anger. Here is an excerpt of one of our final sessions where he describes not wanting to get mad in front of his girlfriend:

> Jason: We laugh together, like to do the same things. We do everything
> together.
> AR: Seems like you two really can share things together.
> Jason: Yeah, anything… except when I'm mad.
> AR: Ah, that changes things?
> Jason: Yeah, I want to be alone when I get mad.
> AR: And what happens?
> Jason: I catch an attitude… Yeah, I get really mean and just try to be alone. We talked about that today actually. She was like that she doesn't mind being near me when I'm mad and wants me to come to her, but I can't do that. I don't want to have an attitude with her.
> AR: So it sounds like you're trying to protect her.
> Jason: Yeah, I get this really mad face.
> AR: And you don't want her to see?
> Jason: No she actually kind of likes it?
> AR: Oh does she?
> Jason Yeah, she thinks it can be… pretty cool when I get mad. I get the mad face from my dad.
> AR: He had it too?
> Jason: It's good in some ways. It scares off the teachers. They were always afraid of my dad. I think it's coming out in me too. Nadine was getting picked on by a teacher and she told me. So the next time we had class together, I told the teacher to stop talking to her like that and she couldn't look at me. I had to tell her to look at me.

AR: Huh. So your mad face… kind of helps her and can be useful?
Jason: Yep, sometimes.

This session marks three major changes that occurred since I had first met him. Firstly, instead of wanting to get immediate revenge when mad or angry, he described wanting to be alone, to settle himself down. This highlights a newfound sense of mindfulness as he can now connect feelings to actions. And secondly, he illustrated his ability to think about his girlfriend's thinking, even if it did not make sense to him, specifically about his "mad" face. Lastly, he was also able to hold two different ideas about the mad face: it's a sign that he wants to be alone, but it also provides usefulness in some situations. I do not commend Jason for wanting to scare teachers, but he was now able to view experiences in multiple ways. Holding two, or more, conflicting ideas about one entity demonstrates increased cohesion and complexity in cognition. In relation to his aggression, this adapted skill can aid Jason in moments of high intensity and conflict. Instead of viewing a raised hand as a slap or a frown as a sign of attack, he can mentalize alternative ideas about other's actions. A raised hand could be a high five, and a frown could be a sign of sadness. This subtle shift, when practiced in a therapeutic space over time, continues to build and can subsequently reduce aggressive trauma symptoms that land Jason in detentions and fights.

Brian

Something I have noticed while working with children and adolescents is that preadolescence, or the tween years, is maybe the most difficult age for me. Teenagers, like Jason, tend to talk or maybe mash up some theraputty while discussing things. Children use the playroom and make elaborate stories about dinosaurs and princesses.

Tweens are somewhere in the middle, and I did not know what to expect when working with a traumatized eleven year old.

The first session involved legos and silence -- occasionally, I would comment on how hard Brian was working on his truck. He would nod and not say anything past one syllable responses. At first, it was hard to imagine that this quiet boy threw furniture, slammed doors, shouted at the top of his lungs, and cursed like it was his first language. His mother, Ally, described them as "tantrums," as one would about a toddler. Ally described that they would occur when things did not go his way, or if he did not get something right away. This kind of reaction to events illustrates a surprise factor that upsets Brian's ability to cope.

Brian experienced many complications throughout the course of his short lifespan. Again, he spent the first few months of his life in NICU, experienced a shift in home environments several times, witnessed the arrest of his mother, dealt with the regular chaos from his older brother, and struggled in school academically. His mother reported fluctuation in his attention span, which led him to counseling at the age of eight. He became very attached to his first therapist, whom he worked with for a year. Ally reported that there were major improvements in behaviors when they had worked together, but unfortunately, she had suddenly passed away in the midst of their treatment. A sudden death highlights hardships for clients, due to the therapeutic alliance (Beder, 2003). One could argue that it is only exacerbated in young children, who are still developing the cognitive capacities to understand abstract concepts like death.

The massive number of small and larger traumas and complications in Brian's life built on top of one another. As mentioned throughout this thesis, trauma causes

individuals to react to everyday stressors with intensity and aggression. Liberman, Ippen, & van Horn (2015) provide an ample explanation of why therapy is so necessary for children, who are still developing the cognitive capacities for self-regulation:

> "Imagine that our bodies are like pots. When bad things happen, it's like the heat has been turned on really high, and it starts to boil inside. Most of us have learned to put a lid on our feelings… we are taught not to talk about bad things and instead hold them in… this usually works, but what we are learning is that this can affect our bodies… sometimes we get headaches, our bodies, hurt, like our backs and shoulders, we get high blood pressure or diabetes… well, with tiny bodies… it's really hard to keep that pot covered especially when the heat is turned on really high. Sometimes even though they try to cover it, they blow up… One way we help kids is by turning down the heat. Another way is that we can sometimes let them open the lid. We don't want them to blow out, but if we let them talk about and play what happened, they might release some steam" (p. 80).

It is difficult for adults to cope with the psychological and physiological aftermath of traumatic events; we can only assume that it is even more difficult when a child experiences such horrors. The inconsistencies and pain that Brian experienced needed an outlet, which Ally recognized. She wanted me to handle things with him, like the tantrums and the cursing immediately. She also said that she wanted to know what happened in the bathroom at school that caused her son to wear his pants so tightly. When conducting individual sessions with Ally, I validated her sense of urgency as a parent. But I also reminded her that therapy takes time. Something that I needed to remind Ally about continuously was the idea that Brian needed to trust me to open up to me, and that could only be done with time and consistency.

Consistency in the therapeutic relationship and environment is crucial to seeing progression. Kinniburgh, Blaustein, & Spinazzola (2005) emphasize the importance of

attachment while working with traumatized children, and one of the most effective ways to amplify sense of trust is through co-creating a space of structure, acceptance, and consistency. In the beginning, this was rather difficult with Brian as treatment began right before the winter holidays and due to Ally's busy schedule and physical limitations. However, with time, this leveled out -- Brian and I were able to meet on a regular basis.

Not only did the regular scheduling matter, but also the environment. Brian's homelife was crammed with people: a twin brother, an older brother, grandparents, and his mother. He barely had a big space to himself, which naturally led us to the playroom. Even though Brian was older than most of the children who used the playroom, he immensely enjoyed it. He quickly found agency in the idea that this was our space. Here is an excerpt of our first session together in this space:

> B:: Whoa! It's so big! So cool!
>
> *He runs in and kicks off his shoes and immediately goes for the balls and begins shooting them into the basket. He's running around.*
>
> AR: yeah, I found out that no one uses this room during this time so I figured we could try something new. How do you feel about it?
> B: It's so cool! We're on the second floor – we can see all the cars! (Goes to the window)
> AR: Which cars do you see?
> B: I see a Toyota, a Jeep, and a bunch of others I can't tell. They go all the way up there – it's a big garage.
> AR: yeah it is… I see one with a Batman logo.
> B: Where?
> AR: See the tannish car in the corner? It's a big car.
> B: Oh, I see it! Cool.

The playroom shifted our sessions greatly. Brian's affect moved from flat and reserved to bright and energetic. After this first session in the playroom, Brian developed an attachment to the room and even said goodbye to it. One time, due to shifts in his

schedule, Brian came on a different day than normal, and we were not able to use the playroom. He reverted back to his quietness, flat affect, and one syllable sentences, even though we tried playing basketball games in my office. Although it was an unfortunate moment, it did provide insight into how Brian dealt with disappointment. I had asked him how it felt to be in a different room, and he replied that he didn't like it. I wondered aloud if this happened often, not liking when things did not go as planned. Brian replied with a headnod, leading me to question: "what does it feel like when this happens?" He looked at me and said, as if it were obvious, "I don't know, I have anger issues." Perhaps, since we were in a different space, Brian could not go much further with me, or maybe I felt like I couldn't push much more since I already felt bad about not providing him with his normal space. But this one moment highlighted Brian's process towards the behaviors that land him in trouble at school, with peers, and at home. Here is a section from a session with Brian as he reports his views on his aggression and its necessity:

> B: I got into a fight the other day too.
> AR: Oh yeah?
> B: Yeah, this kid thought I said something. But I didn't and told him that. So he punched me in the face. And then I punched him back.
> AR: Oh, so he thought you said something bad about him?
> B: I guess. Kids try to hit me.
> AR: Hit you like?
> B: Physical not mental.
> AR: What's the difference between a physical and mental hit?
> B: Physical is a punch or a kick… mental is more like, teasing you. Making you feel bad.
> AR: Oh, and you get more physically hit, huh?
> B: Yeah, these kids want to fight me.
> AR: What kind of kids?
> B: Kids who want to be big. I tell them I don't want to fight. But they still want to. So I have to fight back.
> AR: You have to?
> B: Yeah, it's self-defense. If someone hits you, you have to hit them back. That's what my mom told me.

AR: So… you have these kids, who want to hit you, and they want to be big… huh, I wonder what they want to you feel?
B: Like the littlest person on the planet.
AR: Wow. Not even just smaller… but the tiniest person on the planet.
B: Yep.
AR: No wonder you'd feel sad about that.
B: Uh-huh.

Much like Jason, Brian reports a need to defend himself from bullies and other kids. Instead of telling Brian not to fight and ending the conversation, the idea is to instead expand upon the experience of fighting. Not only does he view this as protection from bruises, but feeling belittled and scared.

It was not uncommon for Brian to be sideswiped by unexpected events. His father, who demonstrated alcohol and substance use concerns, would often miss times in hanging out with them. Brian's mother would often speak aloud her fantasy of visiting, and eventually moving, to Florida, but would rarely follow through. Or when he expected to go to the bathroom and was instead met with intense embarrassment, shame, and probably assault from older students. Although these examples range from minor disappointments to traumatic events, they build upon one another and essentially teach Brian that the world is untrustworthy. For a growing boy, learning that the world has so many unpredictable twists and turns leads to a lack of agency and sense of control. This turns into Brian constantly dealing with the pain that coincided with these unexpected turns, which often appeared in the form of a tantrum or impulsivity.

Aggression appears in multiple lights depending on an individual's unique circumstances. It does not necessarily involve a fist or a scream, but can come across as quieter actions. In the middle of our work together, Brian began to start stealing money

by using his mother's credit cards. He spent money for online games, like Fornite, to get more 'lives,' or would buy himself gifts on Amazon. Conway et al. (2019) describe that developmental trauma experiences can predispose "children to limitations in emotion regulation abilities [and] social adversity" (p. 214), which can appear as ADHD-symptoms and often overshadow the trauma history, since the behaviors are considered more socially disruptive. Brian's impulsivity also highlights his difficulty with being able to keep his mother's experience in mind, returning to the importance of mentalization. One could conjecture that Brian demonstrates hardship with mentalization because his inner experience was also never fully considered. Even though Ally prides herself on caring for Brian as best she could, she is still often caught up by her older son's malicious tendencies and later, her newborn.

One of the most interesting parts of this field placement is that clinicians often see members of entire families for treatment. Without violating confidentiality and emphasizing the importance of a team approach, clinicians have access to co-treat family members in a comprehensive manner. Ally's therapist reminds me that no matter how hard Ally tries to care for Brian and his twin, the older brother, Damien, always comes first, since he engages in and evokes so much resentment and hostility. In sum, Brian experienced a moderate level of maternal deprivation. John Bowlby (1944), the father of attachment theory, analyzed how different forms of maternal deprivation affect juvenile theft. Bowlby (1944) describes one boy in particular, Derrick, who began to steal as "a desire to make up to himself and partly a desire to revenge himself on his mother, who admitted herself to favoriting" (p. 122) the other brother. Now, Ally may not favor Damien, but the older brother consumes her time and attention. Working with Brian

through a lens of maternal deprivation rather than conduct disorder or ADHD allowed me to view the parts of Brian I needed to access with him -- the lost and unattended-to son. Interestingly enough, Brain could tap into what lack of attention meant to him in relation to stealing. Here is an exchange from one of our sessions together where we discuss taking money:

> AR: You know, B, we talk about things in this room. And you're not a kid-kid, so I can tell you things.
> B: *(still playing but looking at me)* Uh-huh.
> AR: A while back, your mom told me about a friend that you had that used to take his mom's CC and buy things without her knowing, like video games.
> B: Which friend?
> AR: I don't know… that's why I'm asking you.
> B: Oh… oh, that's Jared.
> AR: Ok, so Jared. Did he buy you this game?
> B: Nah, my mom did.
> AR: Ah, but Jared does buy these kinds of games without his mom knowing, huh? Seems like your mom was upset about him doing it.
> B: Yeah. He does that.
> AR: Why do you think he does it?
> B: Because his mom doesn't pay attention to him.
> AR: You think it's because he wants attention, no matter what kind?
> Brian: Yup.
> AR: Yeah, that's one way to get it… I wonder, have you ever taken or bought something without Mom knowing?
> Brian: No. Wait, yes. Once. No twice. Twice.
> AR: Oh, you have?
> B: Yeah, and I regretted it.
> AR: Oh really? Why's that?
> B: Well… my mom worked hard for that money. And I took it.
> AR: Well, why did you take it?
> B: Because I wanted those things. I didn't want to wait for Christmas.
> AR: So, you really wanted something and took it. I'm wondering if your mom said anything to you after she found out?
> B: Yeah, she yelled at me.
> AR: Oh yeah, and how'd that make you feel?
> B: Sad.
> AR: You felt sad because she yelled at you?
> B: Yep.
> AR: What's it like when you're sad?
> B: I cry.

For most child clients, it is imperative to bring in updates from the parent sessions. I often remind my child clients when I meet with their parents, and I will tell the child what I know from the parent. It re-emphasizes the alliance that I have with the child. Here, I tie in my knowledge of the events gradually with the use of "Jared," and together, we expand the thinking to himself. Through this conversation, Brian was able to access different ideas about what caused his sadness. Not only was it the yelling that made him sad, but it was the idea that he had hurt his mother and "taken money that she worked hard for." Brian and I did not get into his own sense of maternal deprivation, but it is interesting that he was able to access another's experience of it. It suggests an increased capacity to mentalize.

As I mentioned, throughout the treatment process the consistency in our games became the most prominent intervention in building a sense of trust and alliance. Brian's usual arsenal of games involved basketball, made-up versions of volleyball and soccer, *UNO,* and *Sorry!* These four games were essential in creating our routine, and subsequently, our alliance. With the ball-based games, Brian got to try out new moves and practice old techniques. I often used my announcer-NBA voice to narrate his moves, cheered him on when he would get a dunk, and quietly whispered ideas like "you could try again" or "oh, so close." When he showed off enhanced techniques, I would ask if he had been practicing, which would prompt a smile in reply. One time I stole the ball from him, quite stealthily, to which he replied with pride, "Looks like someone has been practicing." Through these games, he was able to mirror sportsmanship and appreciation for growth. With *Uno* and *Sorry!,* he learned how to utilize strategy, patience, and mentalization. These kinds of games force individuals to keep the other players' choices and techniques in mind. For instance, if he moved too quickly in *Sorry!,* sometimes I

would ask, “is that going to help you, or me, towards Home?” With subtle prompting with a focus on the game’s objectives, Brian began to mentalize my thought process. It also sparked conversation on patience and learning coping mechanisms; Brian and I created finger-tapping rhythms to help pass time while the other player strategized.

The repetition of these games helped Brian build a sense of competency and industry. Erikson (1959) argues that children in the late childhood and preteen stage confront the crisis of industry versus inferiority. This stage underscores the importance of mastery, which leads to increased self-efficacy and self-esteem; it teaches children that they are capable. However, trauma and consistent chaos can impact one’s ability to thrive and feel capable. Structuring the games and the playroom in a way that Brian could expect certain things lead to feelings of safety and comfort.

While playing these games, Brian and I could find a rhythm in our conversations and themes that spoke to the concerns woven throughout his life. Brian’s older brother had a baby midway through treatment. Although Brian reported excitement about being an uncle, at the mere age of 13, he demonstrated ambivalence about it in his symbolic play. His use of imaginary play was limited and rare, but it often illuminated Brian’s inner experience, filled with fantasies of grandeur, laughter, and sometimes rage. Here is a brief description of Brian’s play, involving a baby, after we discussed his sister-in-law’s experience with pregnancy:

> *Brian goes to sit down by the other window. He is sitting next to a baby doll and the dollhouse furniture. He takes the babydoll and begins moving its legs and banging them together, hanging the baby up side down. He then slaps the baby upside his head and says “Behave!” He looks at me and chuckles lightly… He then tells the baby to sit in a chair and stay. And gives him a pineapple before returning to basketball.*

Although Brian laughs and plays, he is also working through the ambivalent feelings of becoming an uncle and no longer being considered a child. He disciplines the baby doll aggressively, illustrating some of the unconscious hatred and negativity Brian may be holding. Utilizing the play therapy room, Brian can work on and release these feelings with me in a nonjudgmental environment. I wish, at the time, that I was more able to think aloud with Brian about his subconscious hatred, disappointment, and anger. However, it highlights some of the relational concerns I experience with Brian as a client.

The countertransference in a therapeutic relationship acts as an essential element in understanding the undertones of sessions and therapeutic growth. Franklin et al. (2015) asserts that it is a normal reaction and integral part of the alliance; clinicians react to the client's transference. Understanding this as not a bad or good thing, but just a part of the overall process, aided me in reflecting on some of my own resistance to discussing certain topics with Brian. Like with the situation with the baby doll, I found that there were other topics (e.g., taking money, Damien, sex, etc.) where I found myself stuck in bringing up certain topics. I noticed that I would feel nervous or guilty if I were to discuss these topics, which I expressed to my supervisors. With research, I found that this kind of countertransference commonly occurred with clients with abuse history. Davies & Frawley (1994) identify 8 relational positions that are reenacted in the relationship. The one that I found myself experiencing with Brian is "sadistic abuser/helpless victim." Throughout my sessions with Brian, I often thought of him as soft and puppy-like, and by me bringing up anything negative, it would retraumatize and hurt him again. I did not want to be another adult that sideswipes, neglects, or disappoints him. One could hypothesize that I did not want to be another aggressor towards Brian. I worried that if I challenged him, it would appear as aggressive and would cause him to aggress back, not to just

me but his family and peers. Once I recognized and understood this position, I was more able to identify when I started to fall into this thought process. My supervisor suggested that I view the relationship as a form of care, that I wanted to protect Brian from future pain. However, reflecting and talking with him about these "negative" topics is actually going to help him in the long run. It will protect his brain and give him knowledge and ways to think in the future.

Charlie

Play therapy acts as an umbrella term for the multiple interventions a clinician may use when working with children. The interventions stem from evidence-based research, training, and individual client factors. (Scheeringa, 2015; Boyd-Franklin et al., 2015). As we have seen in the past two cases presented, safety, attunement, and parental involvement are crucial aspects of child psychotherapy. When working with a client as young as Charlie, it is imperative to involve the parent in the therapeutic process. After the intake described in his case study, it was decided amongst the agency's child team, my supervisors, and myself that dyadic play therapy would provide Charlie with the most therapeutic outcomes. As mentioned earlier, Charlie was unwanted, emotionally unattended to, and labeled as his absent genetically-disturbed father since the moment he came into the world. For a four-year old boy who already experienced that much trauma and emotional neglect, it is necessary to include his attachment figure in the room.

Dyadic therapy involves the mother, the child, and the therapist all in the room together. Similarly to couple's therapy, it is imperative to remember that the identified patient is not the mother or the child, but the relationship. In essence, the therapist acts as translator between the two, utilizing play as the language for attunement; the ultimate goal is for the therapist to no longer act as that conduit (Liberman et al., 2016). In the case of Charlie, "child-parent psychotherapy is designed to repair the behavioral and mental health problems" stemming from

"experiences of maltreatment, violence, and other forms of trauma that shatter [Charlie's] trust in the safety of his attachments" (Liberman, Ghosh-Ippen, & Van Horn, 2015, p. 1). The goal of treatment was to help Jane make her son feel safe in the world.

Jane's desperation for someone to help manage her child's behavior was a major strength in the treatment. As many know, seeking mental health services can come with serious stigmatization. Although she had two other children, Jane viewed Charlie as different, with more intense and disruptive needs and behaviors. Jane's newness as a mother to Charlie may have recapitulated fears she may have experienced with her other children. Many first-time mothers experience hypervigilance after bringing their newborn from the hospital, which Stern (2004) adds as a normal experience in the "Motherhood Constellation." Jane's hypervigilance took the form of outward desperation.

However, despite her pleas for help, Jane also demonstrated ambivalence about the effectiveness of treatment. I often found myself claiming that "she'll try anything, but believes in nothing." Jane was open to many of the suggestions and interventions, but she never reported faith or progress in it. One could question whether or not the clinical staff was prepared to take on a child like Charlie, but if one continues to examine Jane's reactions, it'll become clearer that this case was more than just about Charlie's "bad" behaviors. Oftentimes, I would receive a shrug or a raised brow when I offered suggestions. In a sense, her lack of faith stemmed from her powerful negative maternal attributions towards Charlie. This kind of thinking sets in motion a self-fulfilling prophecy that essentially proves that her son will never get "better." On a much deeper level, it shows how much despair and pain Jane sees in her own child because of all the ghosts in her own nursery, which appear clearly in dyadic therapy (Fraiberg, 1973). Jane had difficulty recognizing the psychological impact of her negative perceptions of Charlie, in

coordination with his father. She also had difficulty understanding that Charlie could remember the times when she would be physically abused. This denial was pronounced and took time for Jane to even recognize as a possibility.

Part of the dyadic intervention involves video feedback to microanalyze parent-child interactions. Although video does add a layer of strangeness in the room, at the same time, it does show clinicians frame by frame moments that one would not be able to refer back to without it. It can focus on specific moments of an interaction, by reviewing "gaze, face, orientation, touch, and vocalization" (Beebe, 2003, p.28), which subsequently illuminates the emotional co-regulation of both mother and child. Identifying specific contingencies can highlight patterns and can predict behavioral outcomes in the dyad. It is important for the clinician to film and remain out of the "scene" and use developmentally appropriate language to describe the filming situation to the child. I told Charlie that I would be making a movie of the story that he and Mommy would tell. With that, he nodded and went on about his play business. For Jane, I explained that in video, there might be important things that Charlie is trying to say that we are both missing. In this next example, I will do my best to describe a video feedback interaction of Charlie and Jane:

> *Charlie and Jane are on the play mat together. He takes out the different animals from the animal box: bunny, puppy, alligator, lion, and dinosaur.*
> Jane: Looks like we have a zoo here.
> Charlie: Yeah the Zoo!
> *He puts bunny into a circle, made by an upside down miniature basketball hoop. Jane takes the puppy.*
> Jane: (play voice) Can I come too?
> Charlie: Yes!
> *Jane hands the puppy over to Charlie. She then tries to put the alligator inside the circle with the bunn and puppy.*
> Jane: You forgot him.
> Charlie: No! Not in there!
> *Charlie smacks the alligator away. Jane's eyes widen.*
> Jane: Okay, why not?

Charlie: No, he'll eat the bunny and puppy.
Jane: Oh, so he has to stay out here.
Charlie: Yeah.
Jane: He's out here all alone though.
Charlie looks around for the dinosaur.
Charlie: They can be together. They'll fight together out here.
Jane: They're about to fight?
Charlie takes the alligator and dinosaur and begins to fight as both animals. He bumps them into one another and makes noises. Jane averts her gaze and looks for other things to interact with. She picks up *Aladdin* and starts fidgeting with *Aladdin's ?* and interacts with other figurines.
Jane: *Aladdin* is going to play over here.
Charlie: No, they're going to fight.
Jane: I don't want to fight. I'm not doing that.
Charlie: No… *Charlie's voice becomes smaller here*
Jane: I'm going to have Aladdin play over here.
Charlie: I want to go home… I want to play on my tablet.
Jane: You're not playing on your tablet when you get home.
Charlie. Nooo…. *Voice becomes more desperate*
Jane: You didn't listen to me earlier.
Charlie throws the animals down and turns his body away from Jane.
Jane: Hey, stop throwing things!
Charlie stops but turns away.
Jane: Now you're pouting… come on. What do you want to play? Come on. Stop that.
Charlie begins banging bigger animals together again.

Although this interaction lasted less than three minutes, it speaks volumes to the cycle that Charlie and Jane find themselves in.

Let's start by examining Charlie's symbolic play. By separating the bunny and puppy from the alligator and dinosaur, he demonstrates a sense of protection. The little animals need protection in a "sacred" circle, away from the fighting that ensues outside of the circle by alligator and dinosaur. Perhaps this signifies a wish for protection from all the fighting he witnessed as an infant and toddler. It also could indicate a wish to protect his mother, who was originally casted as the "puppy." He wished for his mother to stay inside the circle with him, safe and protected. However, the play shifts when Jane witnesses slight bits of aggression from Charlie. He smacks the alligator away, and then uses it to battle a large dinosaur.

As the battle ensues, Jane looks away and finds something else to do, perhaps unable to tolerate her son's aggressive themes. This notion continues to return throughout the sessions. Charlie will want to play basketball or dinosaurs, while Jane suggests to play something calmer like "drawing or building." The shift away from the more stimulating play highlights her inability to contain and be with her son's physical drives. It may be too triggering for her, or it may reinforce her negative maternal attributions about her son's "genetic defects." It leads her to rejecting his play, and ultimately him, and starting her own play. The rejection becomes too much for Charlie, triggering the negative self-perceptions he has of himself, and causes him to want to "go home and play on his tablet." The continued talk of tablets and past memories of his not listening incites shame and rage in Charlie, causing him to throw things and fight his way out of those intense feelings. This in-depth analysis would not have been possible without video feedback since it gave us a clear picture of the behavioral cycle of Charlie and his mother.

The next part of video feedback is conducting a microanalysis with the parent, which is ultimately rather complex. Beebe (2003) suggests that clinicians using this intervention comment on richness and strength in moments. We watched this scene together without any of my commentary, and at the end, I asked about what she thought. Jane replied, "Everything needs to go his way." I took the opportunity to comment on the fact that she has many good play ideas (the Zoo) and commended her for the puppy idea, to which she laughed light heartedly. We returned back to the scene, and I narrated the interaction step-by-step ("Oh, you're giving him the puppy") and paused it when Charlie refused the alligator to enter into the circle. I clarified with her if this was the moment she considered that everything needs to go his way. She agreed. I offered the alternative that maybe he was trying to protect her smaller animals away from the big ones. Jane seemed unconvinced as I continued, "This is a boy with so many fears, and I

think by keeping all of those cute little animals in that circle, he's telling us that he wants to be protected. But it's so hard when big animals, big people, are fighting outside." Jane considered this and nodded her head, not adding or reflecting on it. This is more than acceptable in psychotherapy as silence allows for processing. Jane continued to watch, but still voiced complaints of Charlie's rigidity and inability to cope with unexpected changes.

Throughout the treatment, it became clear that Jane experienced a need for people to understand the difficulties that she went through with Charlie. Returning to Stern's (1994) Motherhood Constellation, there is an aspect that "consists of the representations of how the… mother sees [herself] as [a] parent, and how [she] sees [Charlie], taking the form of memories and other past influences" (p. 31). One could argue that Jane views herself as a victim in her relationship with Charlie, paralleling her romantic relationship with Charlie's father. With the father, he attacked Jane with lies, manipulation, and loneliness, leaving her with a boy she was unable to manage alone, financially or emotionally. Now, she may be replaying herself as a victim to Charlie, who attacks her with financial burdens, emotional expenditure, and pains of the past. In sum, "the line between past and present becomes blurred," which alters the fact that Charlie is no longer just a four year-old boy, but "a current representation in the series of males who have caused mother pain" (Trout, 1985, p.36). All of these unspoken pressures on Charlie hinder his ability to effectively communicate with others and self-regulate himself. In some ways, Charlie was not only on the receiving end of negative maternal attributions, but also deprived of developmentally appropriate care.

In moments of frustration, I would try to alleviate some of the pressure from both Charlie and Jane that triggered his tantrums and subsequently, her irritation and impatience. At leaving time, I would help tie shoes and provide reminders about when it would be time to leave. These

little moments were my attempt to show my allegiance with both of them, as I would say things like “Oh, I know it’s so hard to leave. Charlie was playing and having such a good time with Mommy,” or “You can be mad, Charlie, but you can’t hit our bodies. It’s not safe.” It was my job to hold the two during moments of conflict and work out these moments. There was one moment when I walked to the waiting room that may have been the most profound and useful work that I’ve done with this dyad, which I will describe below.

> *I walked to the waiting room to pick up Jane and Charlie, but before I can even reach the door, I hear screaming and yelling. I recognized both voices and took a deep breath to prepare myself for them. Jane had Charlie on her lap, but it was clear that he had no interest in being held there. He was squirming around and slid out of her arms. When I saw what happened, Jane let him go. Charlie ran to hide behind the waiting room kitchen set. He was not crying but made a keening? sound. I sat beside Jane and say nothing.*
>
> *Jane: See? This is what I deal with everyday. Everyday! I can’t do this -- this is what makes me want to call ACS on myself. What am I supposed to do with him? He can’t freak out all the time. It’s not how life works.*

With that moment being nearly eight months ago, I now realize the weight of that final statement. Jane speaks not only of Charlie but of all the painful and disappointing memories that he represents. She conveys a wish that Charlie was not supposed to happen this way, and that she was not supposed to be left alone with him. Trout (1985) argues that part of the mental health treatment of toddlers is to reduce the parental perception of the child as a symbol of the past. In this next part of this interaction, I try to reduce the globalization of this conflict and try to align Charlie and Jane together.

> *After Jane stopped speaking, I remained silent with her, sitting with her frustration and pain for a while. It also gave me time to think of how to handle this situation most aptly, and most of all, out of the eyes and ears of the receptionist and fellow clients.*
>
> AR: It seems like today was hard, not that everyday doesn’t feel hard with him.
>
> *Jane scoffed in agreement*

Jane: He wanted the window rolled down, and when I said, no, he's been freaking out ever since.
AR: Let's see if I can help get us inside. Take some of the load off your back.
I approached Charlie slowly and bent down. He told me to go away, so I did not approach any further.
AR: It seems like you really don't want to be here today. You just want to stay behind this counter, huh?
Charlie makes another moaning noise and attempts to throw a fake wooden utensil at me.
AR: Don't throw that at her!
Charlie replied with another moaning noise.
AR: Maybe you feel so bad inside that you just want to run away and push everyone too.
C: (soft) I don't want to go.
AR: I hear you. You just want to hide and be mad.
Jane approaches from her seat and leans against the wall. She has her arms folded and coughs into her arm.
AR: You okay?
Jane: I think I'm getting sick.
AR: Oh… so you're both having it pretty rough today.
Jane: (soft) I guess.
AR: (back to Charlie) So, Mommy isn't feeling so well either. And you aren't feeling so well. I wonder if we can all feel bad together in the playroom. There's more room to feel bad there.
Charlie looks away for a long time
AR: You can throw things in there. There are the balls. You can show me how bad you feel in there as long as you don't throw them at me and Mommy.
C: Fine…
Charlie comes out from behind the counter. We move the counter back. He walks to Jane and holds her jeans while she grabs their things. She pats his head and tells him to follow me.

Even though it was just a moment, Jane and Charlie were able to mentalize each other's perspectives. Together, they found common ground that they both have bad days and can still be with each other through it. Initially, Jane and others view this running away and him throwing as mere tantrum and a reaction to him not getting his way. However, it speaks to the global issue of Charlie's inability to cope with change, stress, and triggers.

Charlie's tantrums were frequent and considered "unmanageable," even by school staff and other parents. About eight months into the treatment, I received a voice message from Jane,

reporting that she would be unable to attend the session. This was a common occurrence for this dyad, which perhaps speaks to Jane's subconscious denial about her son's chances of getting better. Jane often provided multiple reasons for their lack of attendance (e.g., appointments for other children, forgetting, illness, etc.), which Liberman (1990) cites as a cultural difference and a desire not to appear as rude or disrespectful. However, what was different about this session was that Jane was very forthcoming about why she would not be attending today: she was currently driving to a Psychiatric Hospital for Children and Adolescents. In her message, she said, "I can't do this anymore. It's nonstop. He needs help, he needs medication, and more than I can give him. He's old enough to go, so he's going." The message suggests that Jane had been waiting to bring Charlie to a psychiatric facility, perhaps to prove his recklessness and unruliness. When I met with Jane, I validated her need for help and how Four Winds can finally give her the help she needs. Jane reported that people, including her own parents, stigmatized her for making this decision, so it was crucial to demonstrate my alliance with her in the moment of need. It would have been too rejecting to disagree with her decision, even though Charlie's hospitalization elicited sadness and fear in me.

After a week-long inpatient stay, Charlie was diagnosed with Major Depressive Disorder with Z-code - contextual factors that impact a clinician's diagnostic choices - of unspecified trauma. It seemed like an inaccurate diagnosis that did not take into account the witnessing of interpersonal trauma. When he met with my agency's pediatric psychiatric nurse practitioner, she believed that most of his symptoms stem from trauma or possibly autism, due to his inability to cope with transitions A month later, his school called the Hospital to take him into treatment again for an inpatient stay. During the second hospitalization, he was diagnosed with ADHD. All of these diagnoses negate the fact that this young boy witnessed extreme interpersonal

trauma and was now being funneled through different mental health services. D'Andrea et al. (2012) argue that "the application of nonspecific diagnoses to maltreated children reduces the likelihood of positive treatment outcomes," (p.188) due to the utilization of incomplete therapeutic interventions. Diagnosing him with Depression, Autism, or ADHD only considers a portion of the symptoms and fails to address the underlying trauma. Focusing on the diagnosis, and its subsequent recommended interventions, rather than the trauma itself pushes mental health and school staff away from utilizing best practices. Multiple incorrect diagnoses can cause stigmatization and skewed expectations regarding Charlie's behavior.

Also, it is vital to focus on the fact that Charlie experienced two hospitalizations within a month. Although necessary at times, psychiatric hospitalizations for children can be exceptionally scary and confusing since the patients are without their parents and exposed to a range of other children's difficulties. Charlie benefitted from his stays at Four Winds as the staff provided him with structure and consistency, something he sorely lacked at home. After both hospitalizations, Jane described that it was a miracle cure since the tantrums decreased while the communication increased. However, this only worked for a week before the return of aggressive behaviors. It was told to Jane by me and the agency's psychiatric staff that the hospitalization worked because of the structure, not because of the medication necessarily. Jane continued to express frustration that nothing would work for him, that he was unfixable.

However, it was not only Jane who found Charlie to be unmanageable. This idea that Charlie was a lost cause at the age of five spread like wildfire. Institutions stopped wanting to help him, and Jane. Upon his second hospitalization, Charlie's school subtly told Jane not to bring him back, emphasizing that he needed a more therapeutic school. I helped Jane to try to find another school to take him in after his hospitalization, but most were at capacity or were not

taking mid-year students. When my supervisor and I called the hospital to report the riskiness of his discharge, we were met with more resistance. I explained that Jane was overworked at her new job with the three other children, his former school would not allow for his return, and that Charlie would primarily be watched by his 17 year-old sister. The clinicians at Four Wind essentially claimed that Jane would have to figure it out on her own, and it was not their problem. Even discussing his return to the agency, there were questions about whether we had the optimal services for Charlie and Jane, and whether or not we should even take them back. It was acknowledged that we needed to, but questions continued to rise, highlighting the global problem that no one wanted this child and his unmanageable and disruptive symptoms.

This theme is a clinical example of how negatively our society treats children experiencing trauma. Aggression is viewed as unacceptable and unmanageable, which causes children to be expelled from school. Additionally, there is a higher rate of Black children being expelled than their White peers. The National Association for the Education of Young Children (2017) reported that Black children only represent 18% of the preschool population, but 48% of them have received more than one out-of-school suspension. In comparison, White students represent 46% of the preschool population, but only 23% have received out-of-school suspensions. The disparity between these two statistics is glaring, and highlights the beginning of the school-to-prison pipeline, which is the institutionalized system that funnels children from schools into the criminal justice system and further perpetuates America's mass incarceration rates. This pipeline specifically targets minority children with policies that actively disregard appropriate child development (Alexander, 2012).

Children Charlie's age are prone to aggressive behaviors, but our school systems and social norms do not allow for this reality. Erikson (1959) advocates that children in this age

bracket experience a crisis of initiative v. guilt, which promotes the idea that childhood experimentation and socialization will lead to conflicts with peers and adults but ultimately teach the child to believe in himself. If they are not supported to take initiative, they are left with intense feelings of guilt that will arise in later stages. Charlie already reports guilt and immense shame about his own existence. Not only does he demonstrate aggressive physical behaviors, like pushing people away or fighting, but expresses it also in his language regarding himself. It was terribly painful to watch him say things like, "I'm going to bang my head" or "I want to die." Jane brushed them off, claiming he says these things all the time, but I attempted to help her realize that he was not saying these things to be funny, but to show how much he is in pain, all the time. The lack of limit setting in his external world with Jane, causes him to be filled with an internal world of strife and aggression. Part of this is projective identification as he subconsciously showcases aggression to develop individuality and illustrate that his inner experience is much different from what his mother expects (Braucher, 2000).

With multiple systems and his family-life working against him, my work with Charlie was exceptionally difficult, disheartening, and tiresome. I found myself often in a stalemate with Jane, his school, and his other mental health professionals. Sometimes, I found myself stuck and unable to move, scared to share my opinion on what this child best needed to thrive. I only realized after the treatment came to an end that I identified with Charlie. In some ways, much like Charlie was afraid of disappointing and upsetting Jane, I became the same way. Projective identification does not just occur in children with their parents, but also in clinicians. Braucher (2000) describes this phenomenon as an attempt to communicate internal experiences onto another. In this case, I found myself identifying with Charlie, finding hardship in trying to relay my expertise and clinical skills. Although I did not illustrate or identify with Charlie's sense of

aggression, I perhaps received the underlying message of this boy's oppositionality: he experienced greater fear than most others.

After his second discharge from the hospital, Charlie no longer stayed with Jane. She thought it would be better to send Charlie up to Albany, to live with his paternal grandparents. Jane could not adequately find a school, and she stopped answering my calls. After a couple of weeks, the director of my agency instructed me to call ACS since there was a lack of communication and concerns regarding Jane's ability to comply with Charlie's medication and treatment regimen. With reasonable anger, Jane insisted that she never wanted to see me again, saying that I got her in trouble and did nothing to help. Oftentimes, people associate ACS with trouble with different systems, which is not an inherently wrong assumption as it has torn apart families. However, ACS can also provide resources to families that need extra support. Jane, unconvinced by this idea, shrugged it off and said that Charlie would be staying in Albany and they could give him help there. I offered continued support to Jane, if needed, and she never took me up on it. Interestingly enough, when ACS returned their findings report, they found nothing on Charlie's investigation. Once again, this leaves him without resources and the needed support to deal with his aggression and pain. This emphasizes the parallel process between clinical treatment and current societal issues that cyclically impact one another. It is imperative for a clinician to recognize the parallels to provide comprehensive trauma treatment as involved systems can further exacerbate one's individual symptoms.

Concluding Discussion

This thesis connected the developmental trauma literature with relevant case studies to specifically examine the symptomatic expression of aggression. Through the lens of the neurological and psychological literature, we were better able to understand and recognize Jason's, Brian's, and Charlie's aggression as a symptom of the painful experiences they had as children. Without providing context for the aggression, these three boys, and many others, would be simply labelled as "bad kids" and fall into systems that would typify and vilify their development. The job of the clinician is to help reduce the intensity of these aggressive symptoms that no longer serve a survival function. With proper coping mechanisms and psychoeducation surrounding trauma symptoms, boys who witness interpersonal trauma can be better able to manage their physiological and learned responses. Parental education can also assist in the consistency and maintenance of these skills.

The other intervention that I did not personally use but should be considered when working with children with trauma is trauma-focused cognitive behavioral therapy (TF-CBT). Ramierz de Arellano et al. (2014) define this intervention as a way "to provide a process in which the child and his… nonoffending caregivers learn about trauma and develop strategies to reduce related stress and modulate and control associated feelings and thoughts" (p 592). TF-CBT provides concrete solutions and interventions for children and their families. Another approach is to expand the use of trauma-informed classrooms and school environments. Working with a clinician is important, but the therapeutic change does not occur in an environmental vacuum. If the clinician cannot work in tandem with parents and teachers, then much clinical work can become undone. The optimal intervention is comprehensive and has the adults working together as a united front. Trauma-informed classrooms and therapeutic

residential schools promote this as teachers and school staff are trained in interventions to best handle behavioral concerns that other school environments are not equipped to handle. McInerney & McKlindon (2015) provide an example of what trauma-informed learning looks like: instead of reprimanding two students for getting into a fight and giving them overdue suspensions, the teachers and principal provide space for down-regulation, breathing and reflection. This kind of approach prevents continued escalation of trauma symptoms and unnecessary out-of-school suspensions that penalize children for reactions. Trauma-informed learning environments also integrate parental involvement, which again speaks to the importance of consistency in the child's life. Other forms of interventions are support and art therapy groups that allow children to feel heard and connected with others.

A final crucial suggestion is to continue spreading awareness of trauma and aggression. As mentioned throughout this thesis, aggression is a form of defense that is subconsciously designed to intimidate and scare others. Witnessing aggression activates our own fear responses causing us even as adults to react in ways that we would not typically do with a child. It is important that mental health professionals seek their own treatment, appropriate supervision, and social support to avoid the descent into burnout or compassion fatigue (Boyd-Franklin et al., 2015). As awareness surrounding trauma continues to grow, the hope is that more will view aggression as a symptom and not a cause for penalization. Along with the overdiagnosis of ADHD, there are also targeted diagnoses that are often trauma-based but have labels that come with negative implications, for instance, Oppositional Defiant Disorder. Jason, Brian, or Charlie could have been easily diagnosed with this disorder because all of them demonstrate reactive aggression. Although there are privacy laws aimed to provide protection regarding mental health, a mental health diagnosis can still unintentionally cause stigmatization, which can further

instigate aggressive and defensive behavior. It is crucial that we examine all the ways in which trauma can impact a child's ability to thrive and overall well-being.

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