Inside out and back to front

Alan Burnell introduces a neurosequential approach to working with adopted children experiencing Developmental Trauma Disorder

For most counsellors and therapists working with children and families, adopted children are a small but significant minority. These children can often pose a challenge and be something of an enigma. Their sometimes extreme and challenging behaviours don't appear to fit with the well-meaning and nurturing home in which they now live. To understand and make sense of adopted children, we have to go beyond their present context and see them in the context of their past.

A Hadley Centre study[1] of non-baby adoption placements showed that a third broke down, and a third seriously struggled. Over 60 per cent of adopted children in the study were found to have more than four 'risk factors' in their background: neglect, physical and sexual abuse, multiple placements and carers, and birth parents with a history of substance misuse and/or mental health problems. The study also found that adopted children continued to have behavioural and relationship problems in their new adoptive families. A Government review of adoption services at the start of the new millennium[2] recognised that children adopted today had complex needs, and that placing children for adoption was not a solution in itself – post-adoption support and therapeutic intervention needed to be part of the contemporary adoption package. Though many local authorities and voluntary adoption agencies now have post-adoption support services, they are still rather tokenistic because of resource limitations. Adoption UK[3], the national association of adoptive parents, is constantly campaigning for more post-adoption services, and for the recognition of the need for a genuinely comprehensive multidisciplinary approach.

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From attachment difficulties to developmental trauma

Family Futures has been at the forefront of innovation and service provision for adoptive families for over a decade. Initially, we drew heavily on Attachment Theory to make sense of adoptive children and their behaviour. However, as our service progressed, we realised that whilst adopted children often do have attachment difficulties, these difficulties were not the *cause* but a *symptom* of a more complex set of developmental difficulties. These difficulties had their roots in trauma: possibly even beginning pre birth.

There is a now a well-established link between maternal use of alcohol and other toxic insults to foetal development. More recently, the myth of the protective qualities of the womb has been challenged by research[4] that shows that high levels of cortisol caused by stress in the birth mother pre delivery permeate the embryo and its environment, causing developmental harm. Post birth, the effect of neglect, poor parenting and abuse become compounded and predispose children to impaired development. Trauma in infancy is now recognised to impact all aspects of a child's development – not just their psychological attachments but their neurophysiological and cognitive development as well. The main casualties of infant trauma are the development of the brain and the central nervous system. For this reason, and alongside other forward-thinking therapists and counsellors, we at Family Futures now look to neuroscience to make sense of adopted children today.

There is currently a strong lobby in America and in the UK for a new diagnostic category to better describe the impact of trauma in infancy on child development: that of Developmental Trauma Disorder (DTD). The evidence base for this new diagnosis comes from a working party of eminent clinicians who have amassed a great deal of persuasive research data from work with thousands of children worldwide, and neuroscientific theory[5]. Developmental trauma is distinctly different from PTSD. The primary distinction is that in PTSD, the child has usually experienced one or two specific traumatic events, whereas DTD describes a state in children who have experienced all-pervasive trauma, including the trauma of deprivation and neglect.

'The diagnosis of PTSD is not developmentally sensitive and does not adequately describe the effect of exposure to childhood trauma on the developing child... because infants and children who experience multiple forms of abuse often experience developmental delays across a broad spectrum, including: cognitive skills, language skills, motor skills and socialisation skills.[5]

DTD has been defined as a child having multiple or chronic exposure to *'one or more forms of developmentally adverse interpersonal trauma – eg abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence and death'*[6]. The subjective experience of these events includes rage, betrayal, fear, resignation, defeat and shame.

In our view, this definition of DTD clearly describes the history and experience of children in the Hadley Centre research project, and children being placed for adoption today. It greatly informs Family Futures'

IMAGEZOO/GETTY

work with children who are fostered and adopted, whose histories very much mirror the definition.

Developing a neurosequential approach

Quite early on, we realised that we couldn't just talk to children about their past, which is a frontal lobe activity. Nor could we simply help a child form more secure attachments without dealing in some way with the residue of trauma that had been somatically ingrained into the child's system. Van der Kolk, one of the leading clinicians in this area, famously described the problem as 'the body keeps the score'[7]. Another pioneer in this field, Bruce Perry, defined the need for a neurosequential approach to helping children[8] – that is, starting with the primitive brain and its instinctual responses to stress, which are hard-wired into all mammalian brains, and working forward from there. This is the model we have developed.

Stage 1a Developmental re-parenting – learning to regulate stress response

In terms of therapeutic intervention, we first focus on helping parents to help their children to feel safe, and to begin to learn how to regulate their feeling states. This requires parents to understand the physiology of stress, and how the brain and central nervous system respond to stress.

Stress responses are easily triggered in children with developmental trauma disorder. The release of cortisol produces the typical symptomology of hyperarousal, hypervigilance, and fight, flight or freeze responses. Such hyper-reactivity could be seen as adaptive, and as a survival response in what might have been a threatening environment during infancy.

But what children with developmental trauma disorder have had little experience of is positive hormonal surges of oxytocin, serotonin and dopamine. The latter are stimulated by touch, attuned interaction with parent figures, and positive reciprocal attachment relationships.

So our neurosequential approach starts back to front, beginning with the primitive reptilian brain, allowing the child to experience, via the parent, what happy babies experience: periods of quiet alert. During such periods, babies take in their environment and learn from their parents, wiring up their neurological systems in a developmentally adaptive way.

Because of the developmental insults the child has experienced, parents themselves have to go back developmentally in order to then go forward. This requires the parent to parent the child as if they were much younger than their chronological age, even taking them as far back as the baby stages. This requires parents to massage and play games with their child, which involve touch and close eye-to-eye contact. It is not unusual for parents to play such games as peek-a-boo, counting fingers and toes, the sorts of interactions parents would normally have with an infant. Despite the chronological age of the child, developmentally traumatised children will often engage in these interactions with relish, because at some level they themselves appear to be aware of what it was they missed out on when they were very young. Bathtimes and bedtimes are very important in establishing a predictable routine, which is nurturing and developmentally attuned. Meal times and food may have to follow a similar developmental catch-up, with the child going back to being fed for a while, to have that experience of being weaned from bottle, to mushy food, to solids.

Of course what parents discover very quickly is that their child does babyhood and infancy in a traumatised way. So yes, they are eager to regress and do regress, but remain hyperaroused, hypervigilant, controlling or dissociative. By small steps and successive approximation (shaping), parents are supported in their attempts to try and 'normalise' an appropriate infant response. In the case of feeding, often children will have the tendency to want to control the feeding process, as a result of having been left to feed themselves with bottles or food. Parents need to help the child have a good baby experience, of being fed by the parent with good eye contact, with the parent controlling the feeding process.

As part of our multidisciplinary team, a paediatric occupational therapist will have carried out an assessment of the child's sensorimotor development and will have prescribed a series of exercises that will help the child with sensorimotor coordination and development, and with moderating sensory stimulation. An example would be a child who for the first year or two of infancy spent most of the day strapped in a buggy and who never learnt to crawl before they walked, who never learnt right-

Patterns of response to trauma 'triggers'

Dysregulation (high or low, ie agitation or shut down) – changes persist and do not return to baseline; not reduced by an increase in conscious awareness of being dysregulated. Dysregulation occurs at the following levels:

- **Affective** (eg mood swings, irritability, rages and outbursts, depression etc)
- **Somatic** (eg physiological, sensorimotor, medical balance, dyspraxia, hand-eye coordination etc)
- **Behavioural** (eg re-enactments of trauma experience, hypervigilance, hyperactivity, self-harming etc)
- **Cognitive** (eg belief that trauma is happening again, confusion, dissociation, depersonalisation)
- **Relational** (eg clinginess, oppositional behaviour, distrust, over-compliance)
- **Self-attribution** (eg self-hate, blaming oneself for what happened).

left synchronisation and as a consequence has poor muscle tone and balance. The parents might, in a playful way, carry out a series of exercises with the child, which are designed to address these specific physiological developmental gaps.

Our role as workers is to set the developmental context for parents and encourage and support them not to grow their children up, but to take them back, and to give them the babyhood and the infancy they never had but desperately needed.

Stage 1b Processing the trauma

When parents and children are able to achieve moments of calm and reflection, it is possible to help the child to begin to make sense of their early experience and the effect it has had on their feeling states, behaviours and relationships. At Family Futures, we enable the child to begin to address the trauma through a form of life story work. As a precursor, one of the therapy team will have done an exhaustive and forensic search of the adoptive child's file when they were living in their birth family and in foster care. The aim of this exercise is not just to get a 'coherent narrative' of the child's life with dates, times, people and places, but also to create as vivid a picture as possible of the child's lifestyle and day-to-day experience at each developmental stage. The actual story work is usually done using a large sheet of paper, paints, crayons, and other creative media to depict, using the metaphor of a road or a river, the child's life course. The child is helped to understand their history by the therapist and parent painting, drawing and sticking pictures of significant events and relationships onto their time-line. This will be annotated by the child with their expression of feelings that they had then or that they have now, which they can represent using paint, pastels, colours and words.

Through this process, the child's feelings and experiences are acknowledged, validated and empathised with. The child is also encouraged and empowered to express their feelings and to retrieve often unpleasant memories in the safe and accepting environment created by the parents and therapists working together. As and when the child inevitably becomes resistant, dissociative or dysregulated, the role of the therapist is to set a pace that the child can cope with, and model for the parents how best to help their child process their pain.

This process of mapping the child's life story often starts in the here and now, acknowledging the safe, nurturing environment in which they now find themselves and working backwards chronologically into less safe and more scary times. This process can take months and often needs to be revisited at different times throughout childhood as the child's ability to make sense and process their past develops. This life story work encapsulates the key principles of working with traumatised children which are:

- remaining in a safe and sensory-supportive environment
- to have their feelings acknowledged (*'You had those feelings'*) and validated *('What was happening to you was horrible; it's not surprising you had those feelings'*) in an empathic way (*'It was wrong what happened to you: I wish I'd been there to protect you and hold you'*)
- helping the child to have mastery over their feeling states and their body, so that they don't dysregulate.

Persistently altered attributions and expectancies

- Negative beliefs about self, self-attributions
- Distrust of protective caregiver
- Loss of the expectation that others will protect them
- Uncertainty about the reliability or predictability of others, expressed as distrust, suspicion, problems with intimacy
- Loss of trust in social agencies to protect
- Lack of belief in recourse to social justice/retribution
- Sense of the inevitability of future social isolation and victimisation
- Lack of a continuous sense of self, loss of 'mind-mindedness'.

Stage 2 Secure attachment formation and affect enrichment

Secure attachment behaviour and affect enrichment is only possible when a child is not living in a state of constant traumatisation all the time. Somebody once said that a traumatised child has two feet in the past, and their head looking backwards. A securely attached child has one foot in the present and one foot in the past, but they are looking through the present to the future. We support parent and child to engage in attachment-forming therapies. A good example is Theraplay, developed in the 1960s in America, a form of focused play therapy designed to enhance attachments between parents and children. Theraplay theorists have identified four essential elements for secure attachment:

1 an appropriate level of structure
2 nurture
3 engagement
4 appropriate levels of developmental challenge.

In Theraplay, the first step is an assessment of these four elements in the child-parent relationship. The outcome of this assessment will determine the sort of activities that the therapist will support the

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parent and child to engage in. Each activity will target one of the four elements, working to redress any imbalance or deficit. These activities can be part of a therapy session but also can be practised by parents at home or by classroom assistants in the classroom. Theraplay has a universal application for all children since attachments are key to all children's mental health.

These interactions are playful, fun and developmentally enhancing, and help the child's mid-brain development. They are affect-enriching in that they expand the repertoire of accessible feelings, together with the child's ability to name a wider range of feeling. This mid-brain-focused therapy is developmentally a stage on from the hard-wired survival responses of the primitive brain, which require regulation and management: this work represents a move towards the development of experience-dependent neurological and synaptic connections. It is a positive experience of infancy, free from the fear of trauma.

Stage 3 Positive identity formation

For children who experienced early trauma that left them with negative self-attribution, shame and fear, a secure attachment forms a basis for the development of a positive sense of self and optimism about other people's intentions and the future. At this stage in the therapeutic process, the child is free of pathological fear and has internalised the secure attachment with the parent figure as a positive sense of self and self-worth. From this position, with the parent and therapist, the child can begin to develop their cortical capacity for reflective, integrative, left-brain right-brain thinking, to think about themselves, their current relationships and their past, without the distorting lens of trauma.

Regrettably, this is often where therapy with adopted children starts, with life story books, chronologies and contacts that have been viewed traditionally as providing continuity with the past. For the contemporary adopted child, for whom chaos, neglect and abuse were their first experiences of life, it is arguable that such continuity can be seen more as contamination and re-traumatisation if the three steps, outlined above, have not been worked through. Conversely, the good news is that however bad or traumatising a child's early experience and history have been, if they have processed these feelings and experiences and have been helped to form secure attachments, then they can reflect upon their past and their present, and think about their future, with a greater sense of hope and optimism than would previously have been possible.

It is important to remember that the ultimate aim of therapeutic work with adopted children who have experienced early trauma is not knowledge but understanding and forgiveness. Not forgiveness in a religious sense, but as the ultimate act of resolution. Such resolution is something that develops from within, to its own natural timetable, and cannot be imposed from the outside in a formulaic way, or through guilt. Just as the child has been helped to understand themselves in the context of their history, they need to be helped to understand their birth parents' and their birth family's behaviour in the context of their history.

Following the neurosequential approach, of enabling the child to move from primitive-brain feeling states to mid-brain interpersonal affective relationships to cortical self-reflection, the result of any therapeutic intervention should be to move children from fear to feelings and to forgiveness. ■

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