The NMC Ten Tip Series

Understanding Dissociation

One of the most powerful and important mental mechanisms we have to help us regulate is 'dissociation.' The ability to disengage from the external world and retreat into your inner world - along with all of the complex physiological changes that go with that - is one of the primary ways we respond to stress, distress and trauma. The other major component of our complex stress response capabilities is the more commonly discussed 'fight or flight' (or Arousal) response, which we discuss in a separate NMC Ten Tip Series edition, *Understanding Hyperarousal: The 'Flock, Freeze, Flight and Fight' Continuum*. Both of these response patterns – dissociation and arousal – work together to help us stay in equilibrium with everyday stressors and to survive extreme experiences.

When any individual experiences extreme or prolonged distress (e.g., when physically or sexually abused) or patterns of unpredictable and uncontrollable stress (e.g., with poverty, community violence), these stress response systems can become 'sensitized.' They become overactive at baseline and overly reactive when activated. If the traumatic experiences are inescapable, unavoidable and painful the major stress response will include dissociation. This dissociative response helps to prepare the body for 'injury' by decreasing heart rate and circulation to non-essential parts of the body. A release in the body's opioids (enkephalins and endorphins) contributes to a disengaged, time-distorted, and pain-insensitive state. The mental retreat into a safer, inner world may also occur; if these inescapable traumatic experiences occur frequently, the child may create an elaborate fantasy 'place' where they may assume a persona of a more powerful character or animal. Themes of power and powerlessness, retribution and justice are common in this 'safe' inner world.

When abuse and neglect is experienced in infancy and early childhood, and when painful and inescapable abuse occurs (e.g., sexual abuse), sensitized dissociative systems are common. The manifestations of this include shy and avoidant interpersonal interactions, overly compliant or robotic interactions when directly engaged; frequent somatic symptoms (e.g., headache, abdominal pains) and frequently observed 'daydreaming', 'tuning out' and 'being in their own world.' Because these children often just 'check out' when engaged by adults, they can be among the most confusing and challenging to work with in therapy and in the home.

Here are few practical tips for those living and working with children demonstrating some forms of 'sensitized' dissociative response.

1. Quiet & shy is sometimes actually 'shut-down.' At 'baseline' these children tend to be avoidant. They tend to be overly sensitive to conflict and chaos. Raised voices, even in excitement, can push these children to shut down. Eye contact will be avoided; they may not seek adult interactions and when they do, they will often demonstrate 'overly' compliant or capitulation behavior that demonstrates submission. I have had children and youth with sensitized dissociative adaptations say that they wished they were invisible; or very small – so no one could see them. This is the first 'step' on the dissociative continuum (see below); avoidance. Adult often simply view these children as quiet, shy or 'slow.' Be present, patient and quiet when you engage these children. Over time they will feel safe enough to come to you.

2. Be prepared for misunderstandings and miscommunication. Even when they seem to understand your instructions, they may not be 'hearing' them the way you said them. There are times, of course, when it is important to give direction, re-direction, advice and commands to these children. Depending upon how sensitized they may be, the simple task of getting face to face to ask them simple questions or give simple commands "clear your place and put the dishes in the sink" will push them further down the dissociative continuum (see table below). In these situations, they will often look directly at you (studying your non-verbal cues) and act as if they are hearing, processing and ready to act on your instructions. Yet due to the inefficient processing that occurs when they are in this 'compliant' dissociative state, they may only carry out a portion of your request (e.g., they clear their place at the table but put their dishes on the counter and not in the sink). The older the child gets the more complex are our expectations and directions. Unfortunately, the dissociating child will still tune out and inefficiently process information. When confronted, they may even say, "You didn't say that." Remember that the child is not intentionally distorting or lying or manipulating. If they are dissociative, they will be physiologically incapable of efficient 'hearing'. Again, patience. Simple one-task commands are helpful. Written instructions can also help. Be prepared to communicate with an older child as if they are much younger.

3. Watch out for "false" compliance. It is easy to misinterpret their attentive and apparently, compliant interactions. As mentioned above, the processing of interactions is often slower, less efficient and distorting. When the child nods as if they understand you, ask them to repeat what they heard. Ensure that the child has fully understood what you are saying. Even then expect only 'partial' follow-through. Try to remember they are doing the best they can. They just process and interpret interactions differently than we do. Over time this will improve; especially if the misunderstandings and miscommunications don't lead to frustrated, angry and confused interactions which will keep they child dysregulated, disengaged and dissociated – basically incapable of learning or healing. Dissociation can lead to a vicious cycle of misunderstanding, confusion, frustration and then further withdrawal.

4. Take advantage of healthy forms of dissociation. There are many healthy ways to 'dissociate'. In fact, mind-wandering and daydreaming are very healthy forms of dissociation and are related to creativity and memory consolidation. Reading, watching a film (or TV), drawing (and other creative arts), and, yes, even playing video games are all relatively healthy forms of dissociation. These can be very positive regulating tools for neurotypical and dissociating children. Children and youth who dissociate often have gravitated to one or more of these activities to self-regulate. A key to using these tools is moderation. By offering times and places for predictable and moderate 'doses' of these activities (e.g., 20-30 minutes of reading or video game 3 to 4 times a day) you can help the child slowly move from a 'sensitized' dissociative system to one that is more typically sensitive. Slowly begin to introduce other forms of healthy self-regulation – especially somatosensory – taking walks, dance, music. As the child begins to experience and master these alternate forms of regulation, the pressure to use 'deep' dissociation to regulate can ease.

5. Be prepared to repeat yourself – consider using visual aids for transitions, household chores and school work. Due to their processing inefficiencies and other 'head in the clouds' qualities these children need external supports for organization. Visual calendars, watches with alarms, notebooks with 'tasks' and check boxes – and a variety of other visual reminders can be helpful. In general, these children want to do well; by teaching them some of these organizational strategies you and the child will find more time for enjoyable interactions – which will be bonding - all of which can help with the healing process.

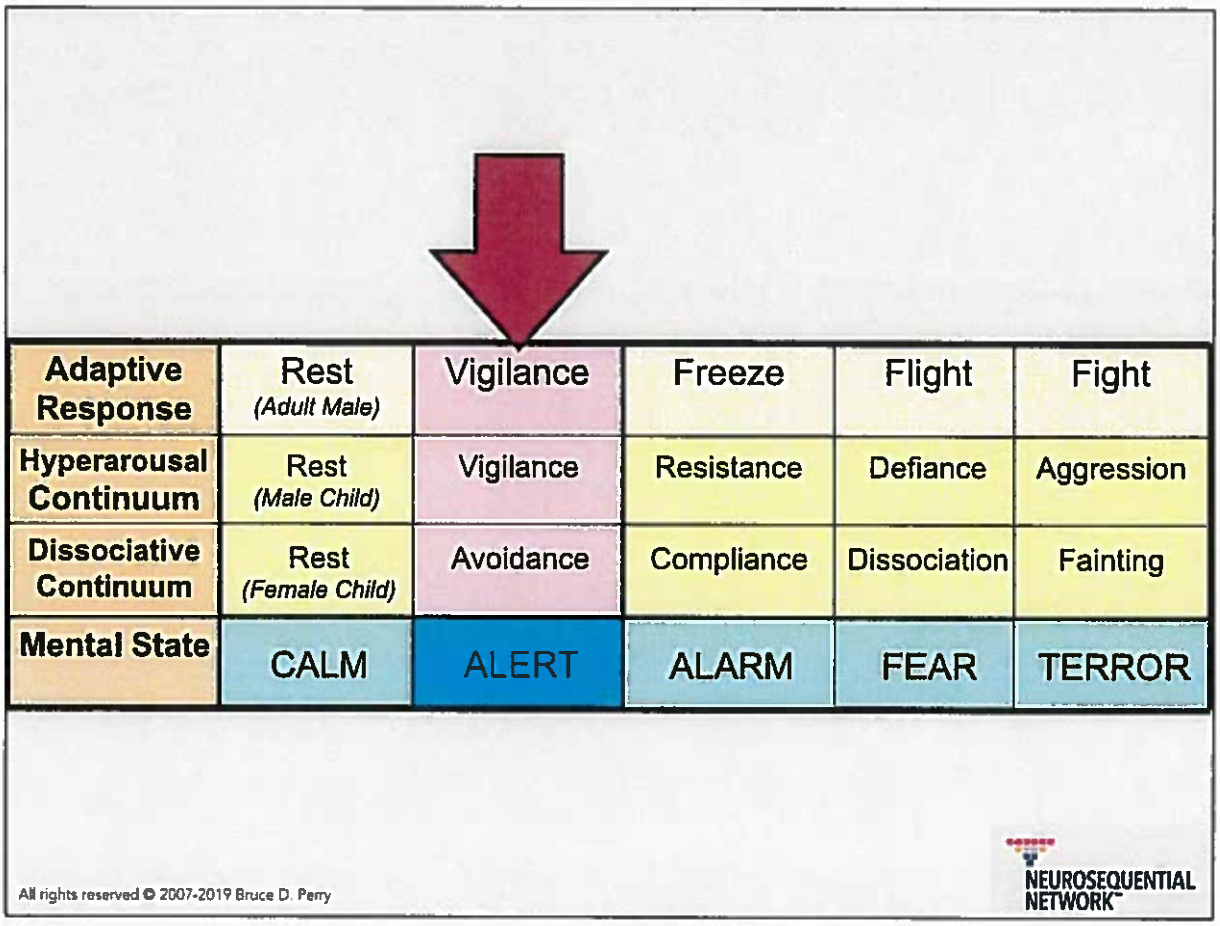
6. Anticipate that their sense of time can get distorted – leading to a whole set of problems. These children are often late, slow in transitions such as getting ready for school or finishing a task. One of the major areas of struggle is with math and other sequentially-mastered academic topics. It can be confusing how the same child who does well in English and gets A's can struggle with math and get D's. But this is common with these children. It is not because they are not trying. They just process differently; one on one tutoring can help. But the way we pay attention is not the way they pay attention; be ready to be frustrated. But remember – these children are extremely sensitive to emotional shifts; they sense and dissociate with the slightest hint of frustration or anger. Regulate, relate then reason.

7. Cutting, picking, excessive scratching, head-banging and other odd or painful-appearing behaviors are often seen. Due to their 'sensitized' dissociative neurobiology, when they experience 'painful' input it causes an exaggerated release of their body's own painkiller – enkephalins and endorphins. This is rewarding and regulating for them. Many of these children have found that cutting, scratching until they bleed and other painful behaviors actually regulate them. They will use these maladaptive behaviors when they feel more distressed or overwhelmed. The best strategy to minimize these behaviors is to find replacement (e.g., video games) but healthier dissociative strategies and somatosensory regulation choices (e.g., rocking, walking, music).

8. Somatic 'symptoms' such as headaches, stomach-aches, light-headedness and even fainting are common. The changes in the stress response systems throughout the brain and rest of the body will frequently result in real physical symptoms such as headaches and gastrointestinal problems such as constipation alternating with diarrhea – or just abdominal cramping. These are real symptoms and likely related to overly reactive opioid systems. Due to the low heart rate, a number of cardiovascular symptoms are also seen including light headedness or even fainting (called syncope). These symptoms should all be worked up by a physician but don't be surprised if the work up doesn't find anything. Another common issue is apparent seizures (staring spells). These are common and are usually not due to an actual seizure disorder (but again this needs to be evaluated); in the United Kingdom, this is called non-epileptic attack disorder (NEAD: see nonepilepticdisorderattackdisorder.org.uk). Don't be surprised if the doctor has not heard of this. These trauma-related problems are very slowly being integrated into mainstream medicine.

9. These children can also 'blow up'- different evocative cues can cause profound externalizing dysregulation. It is common for children with complex and pervasive histories of trauma to have BOTH a sensitized dissociative and arousal response. Different evocative cues (e.g., loud male voice, authority figures) will elicit the externalizing (i.e., hypervigilant, hyperactive, impulsive and aggressive) behaviors. The same child may find female evocative cues elicit 'dissociation' – and he will be compliant and apparently 'regulated' with the female staff or teacher but clearly dysregulated by the male staff/teacher. This results in a confusing and complex behavior picture. Remember that both of these response patterns can be addressed; and in all cases, a key is to stay as regulated as possible. This speaks to the ongoing need for self-care. ***You can help regulate your dysregulated child ONLY if you stay regulated.*** Take care of your needs. It is not selfish – it is essential if you are going to be a therapeutic presence for the child.

10. Fantasy play, drawing, reading, viewing and gaming can become extreme but don't use these activities in any "reward" or "punishment" model. Contingency based behavioral strategies dysregulate children, cannot build complex skills and are ineffective with these children. One of the major challenges in the 'trauma-sensitive' systems movement is that the most common and pervasive approach used in most schools and mental health systems with maltreated and traumatized children is traditional 'contingency' programs (points and levels with 'rewards' and 'consequences'). These approaches are effective for some basic behavior changes with neurotypical children or youth (but not with dysregulated or sensitized children or youth). The unfortunate reality is that these approaches actually escalate and further dysregulate these children leading to increased rates of critical incidents such as run away or aggressive behaviors. It is common in a contingency approach to restrict the primary regulatory tools these children use as a source of regulation (e.g., sport, recess, video games). This is a mistake. It will not build internal motivation or lead to any meaningful change in the sensitivity of children who dissociate. It will drive them further into a disengaged, 'false' compliant state. What can look like 'progress' is often simply a hollow victory – the child has simply disengaged.



Adaptive Response	Rest *(Adult Male)*	Vigilance	Freeze	Flight	Fight
Hyperarousal Continuum	Rest *(Male Child)*	Vigilance	Resistance	Defiance	Aggression
Dissociative Continuum	Rest *(Female Child)*	Avoidance	Compliance	Dissociation	Fainting
Mental State	CALM	ALERT	ALARM	FEAR	TERROR

NEUROSEQUENTIAL NETWORK™

State-dependent adaptations to threat. Different children have different styles of adaptation to threat. Some children use a primary hyperarousal response some a primary dissociative response. Most use some combination of these two adaptive styles. In the fearful child, a defiant stance is often seen. This is typically interpreted as a wilful and controlling child. Rather than understanding the behavior as related to fear, adults often respond to the 'oppositional' behavior by becoming angrier, more demanding. The child, over-reading the non-verbal cues of the frustrated and angry adult, feels more threatened and moves from alarm to fear to terror. These children may end up in a very primitive "mini-psychotic" regression or in a very combative state. The behavior of the child reflects their attempts to adapt and respond to a perceived (or misperceived) threat

From: Perry, B.D. (1999) Memories of fear: How the brain stores and retrieves physiologic states, feelings, behaviors and thoughts from traumatic events: In: Images of the Body in Trauma (JM Goodwin and R. Attias, Ed.). Basic Books. New York, pp 26-47

The NM Ten Tip Series

Understanding Hyperarousal

The 'Flock, Freeze, Flight and Fight' Continuum

The human body has some very effective and flexible ways to deal with stress, distress and trauma. A major component of our complex stress response capabilities is the *Arousal Response*, more commonly referred to as the 'fight or flight' response. A related, interacting but separate response pattern is *dissociation*. This is discussed in a separate NMC Ten Tip Series edition, *Understanding Dissociation*. Both of these response patterns – dissociation and arousal – work together to help us cope with everyday stressors and to survive extremely challenging or even traumatic experiences.

When exposed to extreme or prolonged distress (e.g., physical or sexual abuse), or unpredictable and uncontrollable stress (e.g., with poverty, community violence), these stress response systems can become 'sensitized.' This means they become overactive at baseline and overly (and inappropriately) reactive (see the NMC Ten Tip Series edition, *Understanding Sensitized Stress Responses*). A classic example of this is when a child dramatically over-reacts to a caregiver's simple request or direction; a child with a sensitized arousal response will be prone to meltdowns and extreme reactions to simple transitions, the disappointment of "no" or "not now", and simple correction or re-direction. Many adoptive and foster parents are very familiar with these reactions.

The basic mechanisms of the arousal response are intended to help us cope with various challenges including serious threat. Our arousal response is graded – starting with an initial 'flock' response (also known as 'social referencing') – basically the process of looking to others to help you figure out how to interpret and act on the potential challenge or threat (*think of how you might look at a co-worker when your supervisor introduces some new policy; or how a young child looks to a parent when he scrapes his knee on the playground; you are looking to see if your co-worker thinks the policy is as stupid as you do; the boy is looking to mom to gauge how to react to the pain – minimize or over-react*). As the perceived threat increases, the body shifts both mental state and physiology to prepare to 'flee or fight' (see Figure 1).

As the arousal response is activated some areas in the brain will be 'deactivated' and others activated. In general, the more threatened (or sensitized) one becomes, the more the cortex (the 'smartest' area of the brain) is deactivated; the simpler, more primitive systems in our brain take

over (see Figure 2 below). A sensitized threat response – so common in foster and adopted children – then can result in decreased rational thinking and planning capabilities, impaired capacity to anticipate the consequences of behaviors, increased distorted information processing, alterations in attention and increases in impulsivity and related behavioral problems. From more information on this topic see the CTA Press Caregiver Series document on *Effects of Traumatic Events on Children: An Introduction*.

Here are few practical tips for those living and working with children with a 'sensitized' arousal response.

1. Anticipate transitions and provide visual and auditory transitional aides. At 'baseline' these children tend to be 'tuned up' and very 'reactive' – or what is sometimes called labile. When asked to disengage from one task and move to another (e.g., wake up, wash up, get dressed, eat breakfast, prepare for school) they often struggle. This is because, to their body and brain, that series of changes is overwhelming the capacity of their poorly regulated stress response systems to smoothly manage these (even tiny shifts) in attention, motor activity, internal processing – and the thousands of other internal physiological changes that go with any change in body posture, mental focus, and external stimuli (e.g., the visual and auditory cues of the playground vs the classroom).

Think about how ***you*** feel at the end of a busy day when there are so many 'moving parts' – finishing up at work, getting through traffic, coming home, checking on homework activities, thinking about dinner, getting Sally to soccer practice (and don't forget her shin guards) while you make sure Tommy is working on his homework and not playing videogames, and you are getting cold calls from someone wanting you to switch your phone service, and your neighbor rings the doorbell...AAHHH. Too much, all at once overwhelms anyone. It is helpful to understand that what we feel are simple transitions are often this kind of overwhelming experience for our children. To make this easier a) give the child more time to transition; b) give multiple visual and simple auditory reminders (e.g., a visual clock counting down 2 minutes to disengage from one activity to move to another), c) integrate some form of regulating activity (music, marching, singing) into common routine transitions and d) create transition 'routines' where the same cues and expectations are used again and again. More on transitions is available in the upcoming NMC Ten Tip Series edition, *Managing Transitions.*

2. Create external structure to build internal structure: sleep rituals. Sleep is one of the major transitions traumatized and maltreated children struggle with (see the upcoming NMC Ten Tip Series edition on *Sleep)*. This transition will go more smoothly by creating a set of regulating and predictable bedtime rituals. This illustrates the importance of a broader principle – if you create external routines, rituals and 'structure', the brain will respond, over time, by creating internal structure. The human brain has some very important and powerful systems that create 'anticipation' of what should be 'coming next' based upon what has happened in similar situations in the past. For many of our children, the chaos and *unpredictability in their earlier lives created 'false' and inaccurate capacity for anticipation. For* example, a child's brain may anticipate physical assault if he hears a tiny rise in level of frustration in an adult's voice. In order to overcome these inaccurate

'anticipations' and create new and healthier ones, we adults must provide lots of consistent, predictable interactions. For sleep creating routine is key; screen time off at least an hour before bedtime; bath, jammies, quiet play, reading, snuggling – transitional lighting. Depending upon the age of the child and their preferences, there are many ways to create these rituals and routine. The key is to be consistent, predictable, nurturing and regulating.

3. Walk and talk. When we move, especially when we move in a repetitive, synchronous way – like walk, run, ride a bike – our body is sending regulating feedback to the stress-response systems in the brain. This helps us stay regulated. We all have some patterned, repetitive somatosensory activity that can calm us down when we get stirred up (*somato* – means coming from the body and *sensory* means coming through our five senses; together – *somatosensory* – refers to the collective input the brain receives from our body and the environment). This may be chewing gum, doodling, knitting, whittling, walking, going for a run, swimming, sitting in a rocking chair – all of these activities provide regulating input. So one of the most useful ways to keep your child – and you - regulated is to walk together. When you are in parallel – and regulated – it makes it easier for the cortex (the top and 'smart' part of our brain) to be engaged (see Figures below). Emotionally charged topics will be easier to discuss; constructive feedback will be easier to 'hear.' Intimacy will be easier for the child to tolerate. Walk and talk is a great way to bond.

4. Regulate yourself before you try to regulate your child. This tip is going to be part of almost every one of our Ten Tip Series. Humans are very social creatures; we are contagious to the emotions of others. If we are upset, frustrated and dysregulated we will dysregulate those around us – especially our children. A key is to stay as regulated as possible. This speaks to the ongoing need for self-care. ***You can help regulate your dysregulated child ONLY if you stay regulated.*** Take care of your needs. It is not selfish – it is essential if you are going to be a therapeutic presence for your child (see the NMC Ten Tip Series edition on *Self Care).*

5. Proactive regulatory activities decrease the need for reactive regulatory actions. Over time, we begin to see which activities and interactions help regulate our dysregulated child. It may be that she responds to being held and rocked, or he will seek solitude and some 'dissociating' activity such as videogames or reading to regulate. In schools, it is common to remove a dysregulated child from a classroom and give them some space and one-one time with an aide to calm down. The point is that we frequently use known regulating activities in a 'reactive' way. We give them the space, personal attention and rhythmic somatosensory activity to 'calm them down'. There is nothing wrong with this; however, if we want to start to change their dysregulated baseline, we need to put in place proactive, frequent 'doses' of these regulating interactions. If, for example, the day at school starts with five minutes of regulating activity and there are scheduled, predictable brief times during the day when the child gets to have one-on-one regulating interactions (such as a five-minute walk) with a trusted aide, it is likely that you will avoid longer and more severe episodes. Starting the after-school routine with a snack and a five-minute mutual hand massage will make it easier to slow down, regulate, reconnect and *then* ask about homework. Spacing proactive, planned five to seven-minute regulating activities throughout a day will start to help keep

your child more regulated, thereby allowing him to better benefit from the other positive cognitive and emotional learning opportunities he is exposed to during the day.

6. Expect to see wide variability in your child's functioning. All of our brain-mediated capabilities – thinking, feeling, behaving – are influenced by our 'state' (see Figures below). This means that in one moment you child may be capable of sitting quietly in your lap, respectfully listening to your advice and ten minutes later screaming obscenities, throwing toys and saying he hates you. At home a child may demonstrate mastery of a concept in math and then when tested at school get a zero. This 'lability' in cognitive, emotional and behavioral functioning is a classic (and predictable) issue with children exposed to developmental trauma. But it confuses teachers, parents and, often, professionals. In one moment, the child can demonstrate compassion and thoughtfulness – and the next his behavior looks anti-social or cruel. Because, in some moments and some contexts, the child can demonstrate healthy interactions and behaviors, the adult assumption is that when he is not 'behaving' he is *choosing* to act in these impulsive, thoughtless or cruel ways. This is a mistake in interpretation – and all too often it leads to the creation of ineffective or even destructive efforts to shape the child's behaviors. In truth, these inconsistencies are very predictably part of the trauma-related changes in the child's brain. The inconsistency is related to the sensitization of their stress-response systems – and the 'state-dependence' of brain-mediated capabilities (see the Figures below and the NMC Ten Tip Series on *State-dependent Functioning).*

7. Consistency and predictability at home and school will be helpful. As mentioned above, the brain has very important 'anticipatory' networks that help us make sense out of the world. The more the day is consistent and predictable, the less 'vigilant' the brain needs to be. And the less vigilant a 'sensitized' brain is, the less likely there will be meltdowns. Try to develop some daily routines that can help anchor the child's day. Consistency around meals, chores, predictable 'down time' – all can help. A key to this is to look first at how consistent and predictable *your* day is; start small. Can our family develop a very predictable routine for evening meals (sometimes really hard with busy engaged families and all of the after-school activities)? Can we develop simple rules – no phones or screen-time during meals? It is often very sobering to realize that we – the grown-ups – have minimal consistency or predictability in our lives. We bring our busyness – and chaos – to our families. Children who have experienced trauma or maltreatment are very sensitive to this. Look at number 4 again; the regulation of our children starts with our regulation.

8. Use simple, calm and clear instructions for tasks at home and in school. Reinforce these with visual or written reminders. Children with a history of trauma frequently have inefficient access to their cortex – the thinking part of their brain. This means that when we give them complex, multi-step commands, they will frequently not process these instructions accurately or completely. To help them we should give them simple instructions. Do not assume they actually processed these instructions accurately even if they say they understand. Repeat the directions; ask them to tell you what they heard. Give them written or visual reminders (e.g., a calendar with reminders written on specific days). You may tell them to make their bed – they hear you and understand. They make the bed today. Tomorrow, the concept that you want them to make the bed *every* day

is simply gone from their head. Some aspects of memory are effected by developmental trauma. Be patient. Be prepared to repeat instructions, rules, expectations again and again. And if you stay calm and regulated when you do, they will ultimately 'get it.' It takes time. Visual and written reminders can be very helpful.

9. These children can also 'shut down' - different evocative cues can cause profound avoidance, 'false compliance' and dissociation. It is common for children with complex and pervasive histories of trauma to have BOTH a sensitized dissociative and arousal response. Different evocative cues (e.g., loud male voice, authority figures) will elicit the externalizing (i.e., hypervigilant, hyperactive, impulsive and aggressive) behaviors. The same child may find female evocative cues elicit 'dissociation' – and he will be compliant and apparently 'regulated' with the female staff or teacher but clearly dysregulated by the male staff/teacher. This results in a confusing and complex behavior picture. Remember that both of these response patterns can be addressed; and in all cases, a calm, patient and confident approach by adults will help the child become better regulated.

10. If you use reward and consequence, understand that immediate relational rewards are more effective than punitive consequences. The most common approach used in schools and mental health systems with maltreated and traumatized children is a traditional 'contingency' model (points and levels with 'rewards' and 'consequences'). These approaches are effective for some basic behavior changes with neurotypical children or youth (but not with dysregulated or sensitized children or youth). These approaches escalate and further dysregulate children with a sensitized 'arousal' system, leading to increased rates of critical incidents such as run away or aggressive behaviors, often requiring extreme interventions such as restraint.

Your time and attention are the most powerful rewards. Finding time to be present, parallel, and patient with these dysregulated children will pay off. In future Ten Tip Series we will discuss reward and consequence in more detail (see *NMC Ten Tip Series Understanding Reward and Consequence)* – but for now, remember that what is rewarding – and what is a consequence – for a child who is calm and regulated is very different from what is a rewarding or a consequence for a dysregulated child. Often what we think will be a motivating consequence (e.g., withholding recess from an acting out child) is often a dysregulating act – it makes things worse. And what we think should be a reward, has no pull.

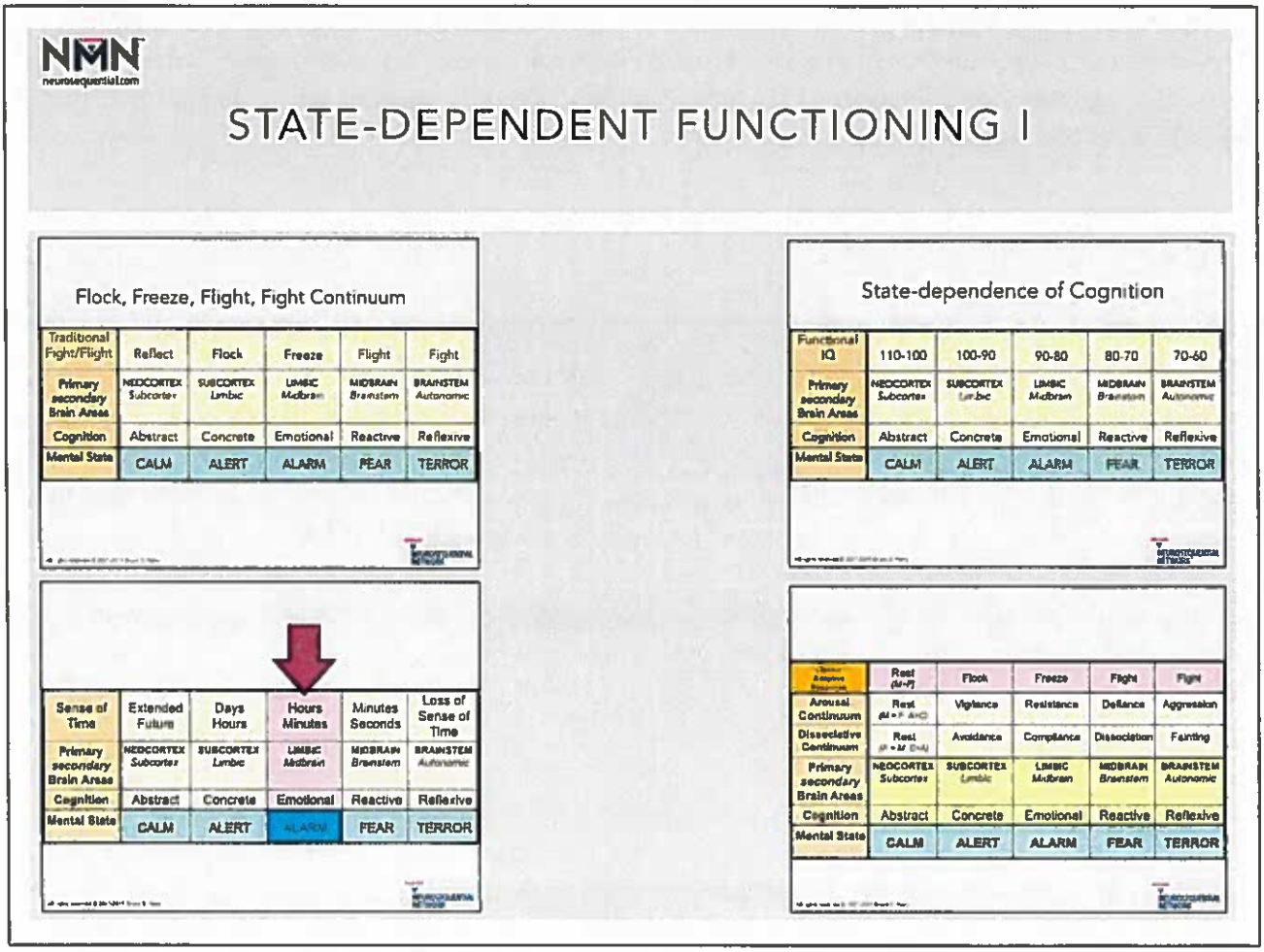


Figure 1: The continuum of adaptive responses to threat. Different children have different styles of adaptation to threat. Some children use a primary hyperarousal response, others a primary dissociative response. Most use some combination of these two adaptive styles. In the fearful child, a defiant stance is often seen. This is typically interpreted as a wilful and controlling child. Rather than understanding the behavior as related to fear, adults often respond to the 'oppositional' behavior by becoming angry and more demanding. The child, over-reading the non-verbal cues of the frustrated and angry adult, feels more threatened and moves from alarm to fear to terror. These children may end up in a primitive "mini-psychotic" regression or in a very combative state. The behavior of the child reflects their attempts to adapt and respond to a perceived (or misperceived) threat.

When threatened, a child is likely to act in an 'immature' fashion. Regression, a 'retreat' to a less mature style of functioning and behavior, is commonly observed in all of us when we are physically ill, sleep-deprived, hungry, fatigued or threatened. During the regressive response to the real or perceived threat, less-complex brain areas mediate our behaviors. If a child has been raised in an environment of persisting threat, the child will have an altered baseline such that the internal state of calm is rarely obtained (or only artificially obtained via alcohol or drug use). In addition, the traumatized child will have a 'sensitized' alarm response, over-reading verbal and non-verbal cues as threatening. This increased reactivity will result in dramatic changes in behavior in the face of seemingly minor provocative cues. All too often, this over-reading of threat will lead to a 'fight' or 'flight' reaction - and increase the probability of impulsive aggression. This hyper-reactivity to threat can, as the child becomes older, contribute to the transgenerational cycle of violence.

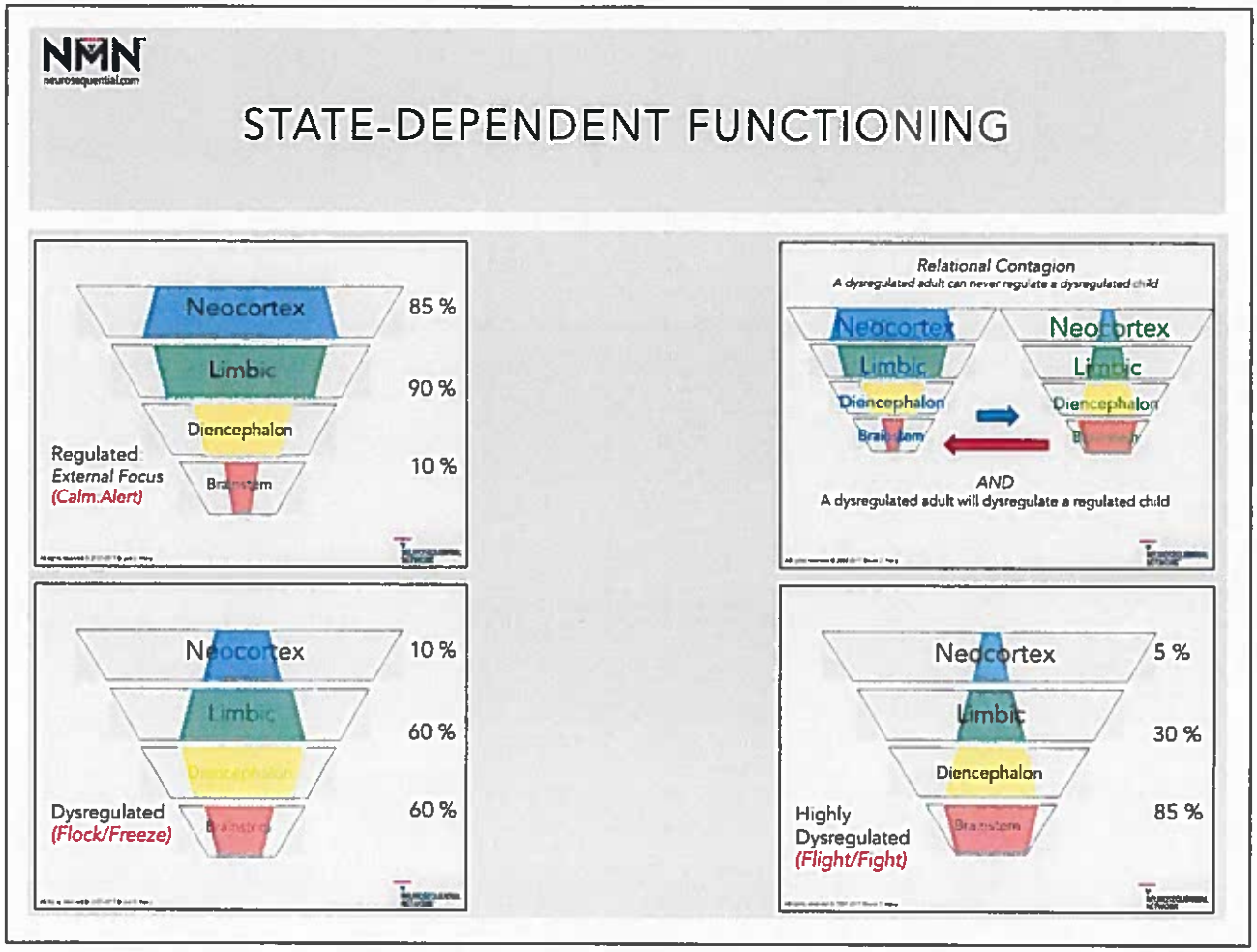


Figure 2: Shifts in brain regions during stress and threat. As we move from a state of calm to alert, then alarm, fear and terror, the regions of the brain that are 'in charge' shifts from the higher, more complex, 'thinking' parts of the brain to lower, more primitive and reactive parts of the brain. This 'state-dependent' shift means that anyone in a state of alarm or fear, will have minimal access to the smarter areas of the brain. The 'solutions' to the present problems will be more reactive and reflexive.

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The NM Ten Tip Series

The Intimacy Barrier

If the child you are living or working with has a history of severe early life disruptions such as abuse or neglect in context of his or her primary caregiving relationships (often manifesting as "attachment" problems, *it is highly likely he or she will demonstrate fear-related behaviors in relational interactions.* These children have made an 'association' between intimacy and threat. Common social engagement and especially nurturing behaviors are likely to elicit a range of inappropriate behaviors including 1) avoidance, 2) escalation, and potentially verbally or physically abusive or threatening behavior.

There are three key elements to understanding this abnormal 'intimacy barrier.' First is controllability; if the child controls the timing and nature of the interaction it feels less threatening to him. Second, these children are very sensitive to physical proximity and usually require more 'distance' to feel that someone is NOT in their personal or intimate space. Finally, they are also 'sensitive' and fearful of abandonment. They will over react if you are too close *and* if you seem to be emotionally or physically disengaging.

The end result is a child that makes the adults very confused about how to interact; the very same interaction that seemed so good on one day leads to a meltdown and abusive language the next day. Caregivers begin to feel like they are 'walking on egg shells.' No other problem with maltreated children leads to more misunderstanding and placement disruption than problems with attachment and these 'intimacy barrier' sensitivities.

Here are few practical tips for those living and working with children demonstrating this kind of 'relational sensitivity.'

1. Watch your proximity. It is not unusual for these children to feel you have crossed into their personal space long before you do. Typically give them about 2 more feet of 'space' than you might for a child with no history of maltreatment.

2. Present, parallel and patient. Despite the way they treat you, they do want you to be there. It is much more effective if you avoid face-to-face interactions. Being in parallel is much less threatening and allows you to have some positive and bonding interactions (e.g., coloring, walking

and talking, working with Legos, washing dishes or cooking together, and going for a drive in the car). And then be patient. Quiet presence can be very regulating for these children. Invite them to 'shadow' you – follow you around while you are engaged in some activity (e.g., working in the yard, doing errands).

3. Let them come to you. This is one of the most difficult tips to act on consistently. We want to comfort and sooth these children. Yet so often if we move to do this, they push back. Remember – present, parallel and patient. Rather than running over when they seem upset and asking 'what's wrong?" slowly walk closer. Sit and let them move towards you. If they control it – and they want your comfort – they will come to you. Do this even with conversation; if you ask how school was – make sure you are either parallel or that you both are doing some kind of regulating activity such as walking or sitting in the car. And then don't ask more. One question. If you get, "Fine.", let it go. Don't keep probing. It feels intrusive to these children. Silence is more powerful than you realize.

4. Don't take it personally (easy to say, hard to do). The person that the child loves the most – wants to be connected to the most – will be the one who gets the most abusive language and behavior. As hard as it is, remember their thinking and behavior is 'fear' based. Don't let their behavior 'break' your empathic bond. When you feel yourself pulled into a negative 'co-dysregulation' step back. Disengage verbally and physically. Use other adults to help you with this. No *one* person can ever handle this level of challenge alone.

5. Give them 'elements' of control. Control over physical proximity, touch and discussion of emotionally charged topics is essential for these children. Keep clear and unambiguous boundaries (such as expectations about physical harm to others or destruction of property) but within these 'pick your battles.' If they don't want to eat something, or do their homework, let them live with the consequences of their choices; be hungry and fail the class. Give them options when there are important tasks for them – learn how to use such approaches as reflective listening – or Collaborative Problem Solving (CPS: see ThinkKids.org). Their route through childhood and into adult life will not be typical.

6. Give them adequate time to make choices. Remember that these are often very dysregulated children; their ability to 'think' clearly is fragile. When they get upset, they can't reason well. So, when they are oppositional and resistant to a directive or over-controlling, it is related to their sensitized fear response. When they are more regulated, they will make better choices. Often they need time to 'calm' a bit before they choose.

7. Give them warnings and options when touch or proximity is necessary. The more you narrate and give them adequate 'notice' that you are going to be close and touch them the easier the interaction will be. "Now we are going to wash our hands. When you are ready come over the sink and we can wash our hands together." "Ok, I'm going to rub some soap onto your hands." "

8. Understand that relational interactions ARE their "evocative cues." Most of you are familiar with the 'trauma' cues that are often seen with PTSD: a loud noise may be an evocative cue for a combat veteran – who will have a profound fear response when he hears an unexpected loud noise (such as a car backfire or a firecracker). Evocative cues that cause intense fear reactions can come from many things; for these children and youth, human relational interactions are filled with these evocative cues. Because their traumatic experiences took place in their family and often at the hands of their primary caregiver, relationships become 'mine fields' filled with emotional landmines. And unfortunately, they bring this into your home. You never know when the next 'step' or interaction will blow up the family.

9. Remember they are also 'sensitized' to abandonment. Simple 'notifications' like, "I'm going to my room to get a sweater" will help decrease dysregulation – and melting down. Do this even for older children; the more you narrate and announce transitions, let them know where you are or give them ways to contact you (e.g., if you do leave, give them permission to text or call you anytime). Many of these children have not developed the ability for 'store' you in their mind; they benefit from visual cues and reminders such as photos. In general, the kind of reassurances you give toddlers about where you are – and where you will be – and when you are coming back – are helpful (even for older children and youth).

10. Regulate yourself before you can expect to regulate them. Humans are 'contagious' to the emotions of others. If you feel exhausted, overwhelmed, frustrated, it is likely that rather than helping your child calm so she can connect and reflect, you may (unintentionally) be escalating her. Take care of yourself (a future NMC Ten Tip topic will be on self-care).

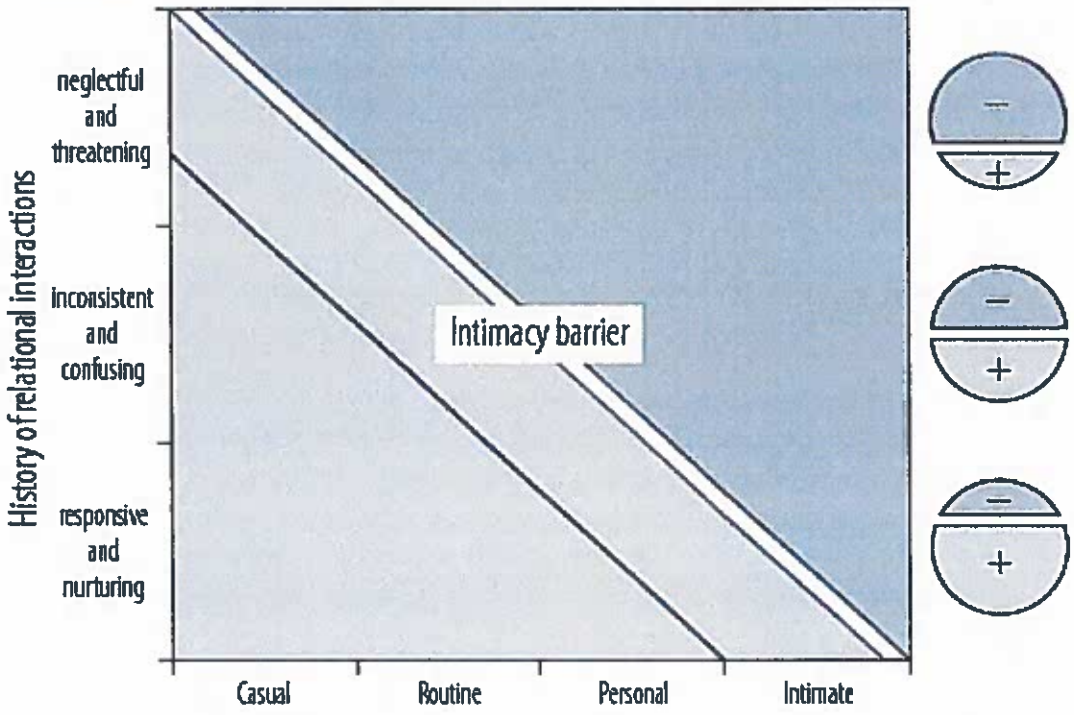

FIGURE 5.2 **The Intimacy Barrier.** As social interactions shift from casual to routinized (e.g., a structured social setting such as a classroom) to more personal and then finally intimate, the individual will interpret the social interaction in context of the 'sensitivity' of their Intimacy Barrier (the tangential white bar separating the dark gray from the light gray portions of the figure). If the individual had generally positive early life relational interactions (bottom "responsive and nurturing" row with larger light-gray "+"), his Intimacy Barrier will be "further out" – making him capable of tolerating casual, routine and personal interactions without feeling threatened and activating a defensive set of responses (see Table 5.1). If, however, either the personal or 'emotional' space boundary is crossed without permission and a sense of control, even neurotypical individuals feel threatened (see Kennedy et al., 2009). Like all brain-mediated functions, the "Intimacy Barrier" is state-dependent. When an individual feels threatened their sense of personal physical and emotional boundaries (i.e., the Intimacy Barrier) shifts (thin black tangential line). For many children and youth from intercountry adoptions, the combination of relational sensitivity following early life attachment disruptions and a sensitized stress response reactivity (see text) lead to very confusing and complex challenges with interpersonal interactions.

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