EXCESSIVE STRESS DISRUPTS THE ARCHITECTURE OF THE DEVELOPING BRAIN
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THE ISSUE

The ability to cope with novel and/or potentially threatening situations, such as an unfamiliar environment or physical danger, is essential to survival. This capacity is built into specific brain circuits whose development is influenced by multiple experiences beginning early in life. Environmental stimuli that activate these circuits are often referred to as stressors, and stress reactions are the body’s chemical and neural responses that promote adaptation.

Stressful events can be harmful, tolerable, or beneficial, depending on how much of a bodily stress response they provoke and how long the response lasts. These, in turn, depend on whether the stressful experience is controllable, how often and for how long the body’s stress system has been activated in the past, and whether the affected child has safe and dependable relationships to turn to for support. Thus, the extent to which stressful events have lasting adverse effects is determined more by the individual’s response to the stress, based in part on past experiences and the availability of a supportive adult, than by the nature of the stressor itself. This matters because a child’s ability to cope with stress in the early years has consequences for physical and mental health throughout life. Furthermore, categorizing the nature and severity of early stressful experiences helps us make better judgments about the need for interventions that reduce the risk for later negative impacts.

**Toxic Stress** refers to strong, frequent or prolonged activation of the body’s stress management system. Stressful events that are chronic, uncontrollable, and/or experienced without the child having access to support from caring adults tend to provoke these types of toxic stress responses. Studies indicate that such stress responses can have an adverse impact on brain architecture. In the extreme, such as in cases of severe, chronic abuse, toxic stress may result in the development of a smaller brain. Less extreme exposure to toxic stress can change the stress system so that it responds at lower thresholds to events that might not be stressful to others, thereby increasing the risk of stress-related physical and mental illness.

**Tolerable Stress** refers to stress responses that could affect brain architecture but generally occur for briefer periods that allow time for the brain to recover and thereby reverse potentially harmful effects. In addition to their relative brevity, one of the critical ingredients that make stressful events tolerable rather than toxic is the presence of supportive adults who create safe environments that help children learn to cope with and recover from major adverse experiences, such as the death or serious illness of a loved one, a frightening accident, or parental separation or divorce. In some circumstances, tolerable stress can even have positive effects. Nevertheless, it also can become toxic stress in the absence of supportive relationships.

**Positive Stress** refers to moderate, short-lived stress responses, such as brief increases in heart rate or mild changes in the body’s stress hormone levels. This kind of stress is a normal part of life, and learning to adjust to it is an essential feature of healthy development. Adverse events that provoke positive stress responses tend to be those that a child can learn to control and manage well with the support of caring adults, and which occur against the backdrop of generally safe, warm, and positive relationships. The challenge of meeting new people, dealing with frustration, entering a new child care setting, getting an immunization, and overcoming a fear of animals all can be positive stressors if a child has the support needed to develop a sense of mastery. This is an important part of the normal developmental process.
Excessive stress disrupts the architecture of the developing brain

WHAT SCIENCE TELLS US

Scientific knowledge in this area comes from research on animals as well as humans. These extensive bodies of work have generated common principles of developmental biology that support valid generalizations across species and reasonable hypotheses about humans based on consistent findings from animal studies. The ability to control exposure to negative life experiences in animals makes it additionally possible to conduct studies of the impacts of more graded forms of stress on the brain than could be done in human research.

The capacity to deal with stress is controlled by a set of highly inter-related brain circuits and hormonal systems that are specifically designed to deal adaptively with environmental challenges. When an individual feels threatened, stress hormones are produced that convert the physical or emotional stress into chemical signals that are sent throughout the body as well as to the brain.

The neural circuits for dealing with stress are particularly malleable (or “plastic”) during the fetal and early childhood periods. Early experiences shape how readily they are activated and how well they can be contained and turned off. Toxic stress during this early period can affect developing brain circuits and hormonal systems in a way that leads to poorly controlled stress-responsive systems that will be overly reactive or slow to shut down when faced with threats throughout the lifespan. ¹,²

Well functioning brain systems that respond to stress are essential to preserve life. However, like the immune system, which defends the body against threatening infections but can cause autoimmune disease when it turns against the body’s own cells, a poorly controlled response to stress can be damaging to health and well-being if activated too often or for too long.³

Frequent or sustained activation of brain systems that respond to stress can lead to heightened vulnerability to a range of behavioral and physiological disorders over a lifetime. These undesirable outcomes can include a number of stress-related disorders affecting both mental (e.g., depression, anxiety disorders, alcoholism, drug abuse) and physical (e.g., cardiovascular disease, diabetes, stroke) health.³

Stress responses include activation of a variety of hormone and neurochemical systems throughout the body. Two hormonal systems have received extensive attention in this regard: (1) the sympathetic-adrenomedullary (SAM) system, which produces adrenaline in the central part of the adrenal gland, and (2) the hypothalamic-pituitary-adrenocortical (HPA) system, which produces cortisol in the outer shell of the adrenal gland.⁴ Both chemicals are produced under normal circumstances and help prepare the body for coping with stressors.

Adrenaline production occurs in response to many forms of acute stress. It mobilizes energy stores and alters blood flow, thereby allowing the body to effectively deal with a range of stresses. Its release is essential to survival.⁴
Cortisol also is produced in response to many forms of stress, and likewise helps the body cope effectively with adverse situations. It also mobilizes energy stores, as well as suppresses immune responses, when it is released acutely. Longer term effects of cortisol include regulation of gene expression in neural circuits involved in modulating stress responsiveness, emotion, and memory.4

Sustained or frequent activation of the hormonal systems that respond to stress can have serious developmental consequences, some of which may last well past the time of stress exposure. For example, when children experience toxic stress, their cortisol levels remain elevated for prolonged periods of time. Both animal and human studies show that long-term elevations in cortisol levels can alter the function of a number of neural systems, and even change the architecture of regions in the brain that are essential for learning and memory.5,6

Much of what we know about the specific effects of stress on the developing architecture of the brain comes from research on rodents, non-human primates, and other animal species. These studies indicate that:

- Increases in the level of cortisol in the brain actually can turn specific genes “on” or “off” at specific times and locations. Examples include regulation of the glucocorticoid receptor gene, which affects the long-term responsiveness of the brain to stress-induced cortisol release, and the myelin basic protein gene, which is involved in regulating the development of the “insulation” that increases the efficiency of nerve signal transmission.8,9

- High, sustained levels of cortisol or corticotropin-releasing hormone (CRH), which is the brain chemical that regulates the HPA system, result in damage to a part of the brain called the hippocampus. This can lead to impairments in learning, memory, and the ability to regulate certain stress responses in both young and adult animals.10

- Significant maternal stress during pregnancy and poor maternal care during infancy both affect the developing stress system in young animals. Pregnant females who experience exceptionally high levels of stress have offspring that are more fearful and more reactive to stress themselves. Young animals that experience inattentive maternal care have similar problems. Both groups of animals also have impaired memory and learning abilities, and they experience more aging-related memory and cognitive deficits in adulthood.3,11

- Positive experiences after infancy in young animals, such as being exposed to an environment rich in opportunities for exploration and social play, have been shown to compensate to some degree for the negative behavioral consequences of prenatal stress and postnatal neglect. This compensation actually involves adaptive changes in both the architecture and the chemistry of the developing brain (such as reversal of the effects of mild adversity on stress hormone output), although deprivation-induced changes in some of the regulatory components of the stress system (e.g. reduced glucocorticoids receptors in the hippocampus) are more resistant to change.12
Individual responses to early stressful experiences can vary dramatically. This variability is thought to be related to differences among animals in the expression of so-called “vulnerability genes,” which make it more likely that early stressors will lead to subsequent problems in stress hormone regulation and behavioral difficulties. In such cases, positive early caregiving can decrease the likelihood of these adverse outcomes, demonstrating that beneficial environmental influences can moderate the impact of genetic vulnerability.¹³

Building on the extensive knowledge gained from animal research, studies of children are beginning to document a compelling story about the relation between early stress experiences and human development. The following findings appear to be particularly salient.

The relationships children have with their caregivers play critical roles in regulating stress hormone production during the early years of life. Those who experience the benefits of secure relationships have a more controlled stress hormone reaction when they are upset or frightened. This means that they are able to explore the world, meet challenges, and be frightened at times without sustaining the adverse neurological impacts of chronically elevated levels of hormones such as cortisol that increase reactivity of selected brain systems to stress and threat. In contrast, children whose relationships are insecure or disorganized demonstrate higher stress hormone levels when they are even mildly frightened. This results in an increased incidence of elevated cortisol levels which may alter the development of brain circuits in ways that make some children less capable of coping effectively with stress as they grow up.²

Research has shown that the presence of a sensitive and responsive caregiver can prevent elevations in cortisol among toddlers, even in children who tend to be temperamentally fearful or anxious.¹⁴ Thus, sensitive and responsive caregiving from a parent or a child care provider can serve as a powerful buffer against stress hormone exposure, even in children who might otherwise be highly vulnerable to stress-system activation.

The quality of the early care and education that many young children receive in programs outside their home also plays an important role in whether (and to what extent) their brains are exposed to elevated stress hormones early in life. For example, once a child has adapted to a specific program setting, regular separations from his or her parents do not trigger elevations in cortisol. However, children who spend significant periods of time in poorer quality child care settings show rising levels of cortisol as the day progresses.¹⁵

Children who grow up in families facing economic hardship commonly exhibit elevated cortisol levels. These elevations are often exacerbated when mothers experience symptoms of depression.¹⁶,¹⁷,¹⁸ Recent research also has demonstrated that a mother’s depression during her child’s early years increases the child’s cortisol reactions to adverse family conditions later in childhood.¹⁹,²⁰,²¹

Young children who are neglected or maltreated have abnormal patterns of cortisol production that can last even after the child has been moved to a safe and loving home. This is especially true for children who show symptoms of post-traumatic stress, even if their behavior is not sufficient to warrant a definitive diagnosis of post-traumatic stress disorder.²²,²³,²⁴,²⁵
POPULAR MISREPRESENTATIONS OF SCIENCE

As the public’s appetite for scientific information about the development of young children is stimulated by exciting new findings, the risk of exposure to misleading or frankly irresponsible messages grows. Within this context, it is essential that we distinguish scientific fact from popularly accepted fiction.

Science does not support the claim that infants and young children are too young to be affected by significant stresses that negatively affect their family and caregiving environments. In fact, animal studies have shown that adverse early infant experiences (e.g., neglectful maternal care), as well as serious disruptions of the pre-natal environment (e.g., drug and alcohol exposure), can lead to short-term neurobehavioral and neurohormonal changes in offspring that may have long-term adverse effects on memory, learning, and behavior throughout life. Human studies suggest that similar effects may be seen in infants and children.26

Notwithstanding the preceding statement, there is no credible scientific evidence that supports the conclusion that young children who have been exposed to significant early stresses will always develop stress-related disorders. In both animal and human studies, interventions that provide more appropriate and supportive care help to stimulate positive growth and prevent poor outcomes.12,23,27
EXCESSIVE STRESS DISRUPTS THE ARCHITECTURE OF THE DEVELOPING BRAIN

THE SCIENCE-POLICY GAP

The fact that many young children are exposed to significant stresses is old news. How different aspects of a child’s environment can be a source of continuous stress, and the degree to which children’s past developmental experiences influence their biological responsiveness to later stressful conditions are not appreciated by most adults. The realization that stresses experienced by parents and other caregivers can affect a child’s developing brain architecture and chemistry in a way that makes some children more susceptible to stress-related disorders later in life is startling news to most people.

A rich and growing scientific knowledge base illuminates the multiple adverse effects of early life stresses, including their long-term impacts on how individuals cope with stress throughout the life cycle. Yet little attention has been paid to the development and implementation of strategies to reduce stressors that affect everyday life for families with young children. This gap between what we know about the potentially harmful developmental impacts of stresses experienced by both caregivers and children, and what we do to promote healthy coping and adaptation through informal supports, voluntary workplace practices, and formal public policies and programs, is illustrated by the following examples.

- **Limited availability of family leave after the birth or adoption of a baby, and little financial support for parents who wish to stay at home with their newborns but do not have the economic resources to make ends meet in the absence of paid employment.** In some circumstances, this creates situations where the supportive relationships necessary to help very young children manage stress are intermittent or seriously compromised.28,29,30,31

- **Limited supports for working parents at all income levels who are struggling to balance the demands and responsibilities of work and raising children.** These balancing challenges are particularly difficult for low-income, working families whose economic security depends on multiple low-wage jobs, often during non-standard working hours, and for families whose children have chronic health problems or special developmental needs that require multiple medical appointments and skilled child care. In such circumstances, some young children are subjected to excessive stress that can have lasting effects on their health and well-being.31

- **Limited efforts to reduce high job turnover in child care programs, which affects the quality of relationships between adults and the children under their care.** This is a particularly serious problem for those children whose family’s socioeconomic circumstances limit their access to better quality programs that have well trained, adequately compensated, and more stable staff.31,32,33,34

- **Limited availability of expert help for parents and providers of early care and education who are struggling to manage behavioral difficulties in young children.** This is particularly problematic in the face of recent data on expulsion of children from preschool programs, which indicate the extent to which staff members are unable and/or unwilling to deal with challenging behavioral problems.35 The growing “off-label” use of prescription drugs, particu-
larly stimulant and anti-depressant medications, for increasingly younger children with emotional or behavioral difficulties is another sign of the extent to which parents are putting greater pressure on professionals to provide more help in managing behavior problems during the preschool years.36

Limited access to clinical expertise in mental health for very young children and their families. This is particularly problematic in child welfare agencies that are mandated to assess children who are coping with toxic stress that can have lasting adverse effects on their well-being. Most important, young children who experience debilitating anxiety and trauma as a result of personal abuse or neglect, or who witness violence in their family or neighborhood, are amenable to early treatment.37,38
EXCESSIVE STRESS DISRUPTS THE ARCHITECTURE OF THE DEVELOPING BRAIN

IMPLICATIONS FOR POLICY AND PROGRAMS

The science of early childhood development, including knowledge about the impact of stress on the developing brain, is sufficiently mature to support a number of evidence-based implications for those who develop and implement policies that affect the health and well-being of young children. To this end, both public and private actions can prevent the kinds of adverse circumstances that are capable of derailing healthy development, as well as increase the likelihood that effective interventions will reduce potential damage to a young child’s developing brain architecture and thereby promote greater resilience. Five points are particularly worthy of thoughtful consideration.

The rich and growing scientific understanding of how individuals cope with stress should be used to strengthen a range of informal supports and formal services to bolster parents who are struggling to manage the challenges of raising their children. These could be provided through varying combinations of extended family support, community-based volunteer efforts, flexible workplace policies, and publicly funded programs.39

The availability of affordable expert assistance should be expanded for parents and providers of early care and education to provide them with sufficient knowledge and skills to help young children who have symptoms related to abnormal stress responses. This is particularly important for children who exhibit excessive fears, aggressive behavior, or difficulties with attention and “hyperactivity.”31,37

Expertise in the identification, assessment, and clinical treatment of young children with serious, stress-related, mental health problems (as well as access to mental health services for mothers with depression) should be incorporated into existing intervention programs to address these complex and widely unmet needs. Research indicates that young children can experience a range of mental health impairments that used to be viewed solely as adult problems, such as depression, anxiety disorders, and anti-social behaviors.31

Investigations of suspected child abuse or neglect should include a sophisticated assessment of the child’s developmental status, including cognitive, linguistic, emotional, and social competence. This could be accomplished through closer collaboration between child welfare services and early intervention programs for children with developmental delays or disabilities,40 as mandated by the Keeping Children and Families Safe Act of 2003 and the recent reauthorization of the Individuals with Disabilities Education Act (IDEA).

Children of mothers who are receiving welfare payments or related services under the Temporary Assistance to Needy Families (TANF) program represent another identified group whose experience with stress is likely to exceed that of the general population. In this context, it is difficult to justify the extent to which public discussion about welfare reform focuses primarily on maternal employment and other adult behaviors, while the special needs of the young children in these families are afforded relatively little attention. Our knowledge of the importance of supportive relationships as buffers against the adverse
effects of stress on the architecture of the developing brain indicates the need for serious reconsideration of mandated employment for mothers of very young children, particularly when access to high quality child care is not assured. Research also underscores the importance of timely assessments and intervention services (when indicated) for children living in stressful environments who show early signs of developmental difficulties.\textsuperscript{41,42}
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What happens in early childhood can matter for a lifetime. To successfully manage our society’s future, we must recognize problems and address them before they get worse. In early childhood, research on the biology of stress shows how major adversity, such as extreme poverty, abuse, or neglect can weaken developing brain architecture and permanently set the body’s stress response system on high alert. Science also shows that providing stable, responsive, nurturing relationships in the earliest years of life can prevent or even reverse the damaging effects of early life stress, with lifelong benefits for learning, behavior, and health.

1 Early experiences influence the developing brain. From the prenatal period through the first years of life, the brain undergoes its most rapid development, and early experiences determine whether its architecture is sturdy or fragile. During early sensitive periods of development, the brain’s circuitry is most open to the influence of external experiences, for better or for worse. During these sensitive periods, healthy emotional and cognitive development is shaped by responsive, dependable interaction with adults, while chronic or extreme adversity can interrupt normal brain development. For example, children who were placed shortly after birth into orphanages with conditions of severe neglect show dramatically decreased brain activity compared to children who were never institutionalized.

2 Chronic stress can be toxic to developing brains. Learning how to cope with adversity is an important part of healthy child development. When we are threatened, our bodies activate a variety of physiological responses, including increases in heart rate, blood pressure, and stress hormones such as cortisol. When a young child is protected by supportive relationships with adults, he learns to cope with everyday challenges and his stress response system returns to baseline. Scientists call this positive stress. Tolerable stress occurs when more serious difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury, are buffered by caring adults who help the child adapt, which mitigates the potentially damaging effects of

POLICY IMPLICATIONS

- The basic principles of neuroscience indicate that providing supportive and positive conditions for early childhood development is more effective and less costly than attempting to address the consequences of early adversity later. Policies and programs that identify and support children and families who are most at risk for experiencing toxic stress as early as possible will reduce or avoid the need for more costly and less effective remediation and support programs down the road.
- From pregnancy through early childhood, all of the environments in which children live and learn, and the quality of their relationships with adults and caregivers, have a significant impact on their cognitive, emotional, and social development. A wide range of policies, including those directed toward early care and education, child protective services, adult mental health, family economic supports, and many other areas, can promote the safe, supportive environments and stable, caring relationships that children need.
abnormal levels of stress hormones. When strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse are experienced without adult support, stress becomes toxic, as excessive cortisol disrupts developing brain circuits.

**3 Significant early adversity can lead to lifelong problems.** Toxic stress experienced early in life and common precipitants of toxic stress—such as poverty, abuse or neglect, parental substance abuse or mental illness, and exposure to violence—can have a cumulative toll on an individual’s physical and mental health. The more adverse experiences in childhood, the greater the likelihood of developmental delays and other problems. Adults with more adverse experiences in early childhood are also more likely to have health problems, including alcoholism, depression, heart disease, and diabetes.

**4 Early intervention can prevent the consequences of early adversity.** Research shows that later interventions are likely to be less successful—and in some cases are ineffective. For example, when the same children who experienced extreme neglect were placed in responsive foster care families before age two, their IQs increased more substantially and their brain activity and attachment relationships were more likely to become normal than if they were placed after the age of two. While there is no “magic age” for intervention, it is clear that, in most cases, intervening as early as possible is significantly more effective than waiting.

**5 Stable, caring relationships are essential for healthy development.** Children develop in an environment of relationships that begin in the home and include extended family members, early care and education providers, and members of the community. Studies show that toddlers who have secure, trusting relationships with parents or non-parent caregivers experience minimal stress hormone activation when frightened by a strange event, and those who have insecure relationships experience a significant activation of the stress response system. Numerous scientific studies support these conclusions: providing supportive, responsive relationships as early in life as possible can prevent or reverse the damaging effects of toxic stress.

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PERSPECTIVES ON HELPING TRAUMATIZED INFANTS, YOUNG CHILDREN, AND THEIR FAMILIES

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ABSTRACT: Traumatized infants, toddlers, and young children can affect adults in different ways but most often pull extreme reactions ranging from empathy to anger. It is important for those who support, intervene, and provide therapeutic services for traumatized young children and their families to understand that various traumatization, compassion, fatigue, and burnout can be an integral part of the work. All interveners, including child welfare workers, clinicians, home visitors, teachers, and even nontraditional responders, such as those who supervise therapeutic visitation, must find their own ways to cope with the overwhelming feelings that may be aroused. Support or regularly scheduled reflective supervision as well as self-care is crucial for those who work with trauma. This paper describes helpful ways to intervene and provide support for infant mental health therapists and others working with traumatized young children who may experience vicarious traumatization.

* * *

Think of how you might feel—as a parent, teacher, or therapist—when a 3-year-old will not let go of his teddy bear 2 years after Hurricane Katrina, saying “If I let go, he will drown” or a 5-year-old who lost her home in Hurricane Katrina and subsequent flooding and says to you “If I only had my old room back, I’d be good.” A usual response is that your “heart will melt,” you feel sad, and at some level, want to try to make it all better for infants and young children who have experienced a trauma. These feelings relate to caring, empathy, and emotional investment as well as the development of compassion fatigue in helping those who suffer (Bride, 2007; Figley, 1996, 2002; Pearlman & Saakvitne, 2002).

Wilson and Lindy (1994) sensitively described the empathic strains, including tendencies for overidentification and avoidance, for therapists working with torture victims and other patients with severe posttraumatic stress disorder. At times, the nonverbal behavior and play of infants and toddlers as well as stories told by young children exposed to disasters, war, or domestic and community violence are so painful that therapists may wish to prematurely try to solve problems and cut off the important work of “observing” and “listening.” The desire to interrupt the traumatic play and “rescue” the child and the family, while unrealistic, also interferes with the ability to carry out effective therapeutic interventions. Of equal importance, therapists might

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shut down emotionally, terminate the case prematurely, or leave the field when faced with overwhelming trauma and loss. A therapist who feels overwhelmed or helpless may find it difficult to observe infants and toddlers at play and listen to the painful stories that children tell. They may not be able to psychologically “hold” the trauma, and it may be more challenging for the therapist to help the infant, young child, and family deal with the trauma they have experienced. For these reasons, it is crucial that therapists receive supervisory support that is sensitive and reflective. They do not need to be told “what to do.” Rather, they need to understand the overwhelming nature of the feelings that emerge when working with trauma, especially with vulnerable infants and toddlers, and find ways through supportive supervision and, when needed, self-care to continue to be effective (Ososky, Putnam, & Lederman, 2008).

Traumatized infants, toddlers, and young children “pull” many different reactions and responses from clinicians, interveners, teachers, home visitors, child welfare workers, and even nontraditional responders such as those who supervise therapeutic visitation. Intense feelings can emerge that must be understood. Well-trained mental health professionals working in a supervisory capacity for community mental health agencies have commented frequently about how difficult it is to maintain consistency of staff when working in settings serving traumatized infants and toddlers, especially those working with child protection and the foster care system. Not only is reflective supervision important, especially when working with traumatized infants and young children, but also preparation is crucial so that therapists and other interveners are able to anticipate and be prepared for the fact that the stories they hear and situations they deal with may lead to strong emotional reactions. They need to be prepared to ask for help, including additional supervision, when they need it and recognize that they may feel confused and even helpless at times; they need to be able and willing to talk about their feelings. At the same time, supervisors also must be aware of the emotions evoked when they listen to the traumatic material presented by the supervisee, and while encouraging reflection and awareness of feelings, they also must clearly observe boundaries so that support, clarity, and understanding are provided appropriately.

To make this scenario come to life, I will describe several cases and situations that have emerged for our team in the past few years. We were referred twin boys almost 3 years of age who had witnessed the shooting death of their mother at the hands of their father and, as a result, were extremely dysregulated, showing disorganized, aggressive behaviors. They were impulsive, showing little ability to control their behaviors and their affect. Their facial expressions were bland, and they showed little joy in their play. Typically, our team videotapes assessments and play with parental/caregiver permission for purposes of supervision and to review the progress of the case. I was one of the supervisors for the case, both to help guide the therapeutic work and to gain more knowledge related to the treatment of traumatized twins, as we had not been referred young traumatized twins. As I observed the therapist’s play sessions with the young boys through a one-way mirror, I noted that their play was often disorganized. As I observed the boys and reviewed the tapes, I found my emotions intensifying with feelings of both frustration and anger. As I reflected on these emotions, I realized that I was distressed about the idea that these young children had to experience the trauma not only of losing their mother but, even more, the horror of witnessing her violent death. I thought to myself as I studied their dysregulated and anxious behaviors and traumatic symptoms that no child, young or older, should have to experience such tragedy. I realized, at the same time, that such my strong, negative feelings needed to be recognized, understood, and used in a positive way to help inform the work with these little boys; however, I also wondered if the therapist might have a similar experience to

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mine with a range of emotions as she provided treatment for the little boys as well as support to the grandparents in their nurture and care of their grandsons while they were experiencing grief over losing their daughter. As I became aware of these feelings and processed them, I was able to use my experience in supervision to not only empathize and be open to the therapist’s feelings, responses, and questions about the case but also to help me understand the inner confusion and distress of the young boys. Being aware of these feelings and being able to put them in context was very helpful in my conceptualization of the case and my openness to provide reflective supervision for the therapist.

Another slightly different example may help to broaden the reader’s perspective related to the importance of reflective supervision in working with traumatized young children and sensitivity to different ways that trauma can impact on therapists. The Louisiana State University Health Sciences Center Department of Psychiatry Trauma Team typically responds to traumatic events that occur in school settings, providing crisis intervention and support. One morning, we were called by a school principal because a 6-year-old child had been hit by a car that was speeding and was killed in front of the school. One of the social workers on our team went to the school and provided intervention and support to the teachers, parents, and students in the school and also the parents of the child who had been killed. When the social worker returned to the office to debrief, as we always do, he appeared visibly shaken. Since I had supervised him for some time, I immediately recognized that this response was unusual for him and asked him what happened. He reviewed what he did at the school, not mentioning anything unusual. Then he said, “I have to tell you something.” He continued with tears in his eyes, “All I could think of at the school was my 6-year-old son at home.” I immediately empathized with him and said, “Why don’t you go home and be with your son, and we will take care of any additional needs at the school.” He looked at me with relief and went home. Without reflective supervision, the traumatization that can occur and be triggered by events in a person’s life that are unexpected for them will not be recognized.

Finally, I will share a situation that comes up frequently in work with abused and neglected infants and young children in juvenile court. A well-trained and experienced clinician with whom I was working was providing therapeutic intervention and services for an abused and neglect infant and her caregivers through a program in juvenile court. She had recently had her own child, who was about the same age as the abused and neglected infant who had been exposed to drugs during pregnancy, remained in the hospital for several months due to withdrawal, and was immediately taken from her mother. By the time the infant was 1 year old, she already had experienced multiple placements: first with relatives for a month who could not care for her, then with foster parents who immediately “fell in love” with her, and then, after 8 months, with other relatives who were found only when the child was almost 1 year old. The sensitive clinician found herself empathizing with the foster family having to give up an infant that they had come to love once relatives became available to take care of her. Being strongly attached to her own child, she found it difficult psychologically to observe and experience the early bonds and attachment for this infant being broken by the multiple moves. Reflective supervision, which allowed the clinician to talk about her feelings in a safe environment, including her distress about seeing the child moved several times in the first year of life, was crucial for her work with this family. She then was able to respond sensitively with the child protection agency and provide support to the relatives who would be caring for the child as well as to the foster parents who had built a bond with the child and now had to give her up.

Principles of reflective supervision that are important for work with traumatized young children and families include reflection, collaboration, and regularity (Eggbeer, Mann, & Siebel, 2002).
Reflective supervision is carried out regularly in a safe and trusting environment, allowing the therapist to learn how to understand and provide relationship-based treatment for infants and toddlers in the context of their families. The therapist learns ways to build on the capacities, resilience, and resourcefulness of children and families, being aware not only of principles of intervention and treatment but also the idea that emotions and feelings are crucial to understanding work with infants and families. Reflective supervision also allows therapists to learn that by recognizing our own emotional responses (with appropriate boundaries), it is possible to recognize, understand, and respect the emotional responses of infants, toddlers, and their families/caregivers. In a trusting environment, as was illustrated in the earlier examples, the supervisee feels free to express anxieties, concerns, and feelings that may arise in the course of the work, which may be very intense when working with traumatized infants, young children, and families. If the supervisee has the opportunity to share and discuss these feelings in a safe environment, the therapist will be able to better understand and to “hold,” if needed, the intense feelings that arise in the course of treatment of very young children and their families. Because issues of vicarious traumatization and compassion fatigue come up often in work with trauma, this type of supervision allows the supervisor and supervisee to step back from the immediate intense experience of the work to better conceptualize what is being observed and what may be happening. The supervisee is encouraged to talk about what he or she “thought” and “felt” in addition to what occurred in the session and what was said. Thus, issues of ambiguity that may arise in the course of the work are discussed as well as areas of confusion for both the supervisee and the supervisor. With very young children and their families, it is important to just “be there.” It is this type of supervision that helps support the therapist to be emotionally available and responsive while providing effective intervention and care. Jeree Pawl has emphasized in her sensitive approach to reflective training that how you are with the parent or child is often as important as what you do (Pawl & St. John, 1998). Further, the open communication that occurs between supervisor and supervisee can serve as a model for needed communication between professionals and parents as well as between parents and young children.

CONCLUSION

For those who choose to support, intervene, and provide therapeutic services for infants, young children, who have been traumatized and their families, dealing with issues of vicarious traumatization, compassion fatigue, and burnout are an integral part of the work. Each intervener or therapist must find his or her own way to cope with the overwhelming feelings that often may be aroused. Support or regularly scheduled reflective supervision is crucial for those who work with trauma. Programs need to build supervision as a best practice; individual therapists who work alone need to determine how to gain the support that they need. A supportive team, if at all possible, is crucial for the work. Relationship with a supportive supervisor is equally important. Self-care is crucial to reduce the risks of inappropriate responses or burnout. I have always found the guidelines provided by Nader (1994) very helpful in working with infants or young children who have been traumatized and their families. First, the therapist needs to develop a willingness to hear anything. Second, it is important for the therapist to recognize the phasic nature of trauma recovery. There may be a need for occasional timeouts from direct focus on trauma in that healing occurs over time. Finally, issues of burnout, vicarious
traumatization, and compassion fatigue need to be considered as an integral part of training and supervision.

REFERENCES


