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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.

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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 (Osofsky, 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 having a similar experience to

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,

2007; Parlakian, 2001; Shahmoon-Shanok, Henderson, Grellong, & Foley, 2006; Shahmoon-Shanok, Gilkerson, Eggbeer, & Fenichel, 1995). 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.

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