Developmental Trauma: The Implications for Treatment in Children With Trauma Histories

Dodi S. Forgione

College of Social and Behavioral Sciences

Northwest University

Author Note

I have no conflicts of interest to disclose.

Leihua Edstrom, PhD, ABSNP, Dissertation Chair. Cherri Seese, PhD, Committee Member. Katerine Skillestad Winans, PhD, Committee Member.

Date of Dissertation Defense: April 18, 2022.

Correspondence concerning this article should be addressed to Dodi Forgione at Northwest University, College of Social and Behavioral Sciences, 5520 108th Avenue NE, Kirkland, WA 98033. Email: dodi.forgione14@northwestu.edu

April 18, 2022

Acknowledgments

I am so thankful and grateful to many people who helped me along the journey of this dissertation process. Special thanks to my family especially my children who sacrificed time with me while I attended graduate school. Erik, Michael, and Anthony (Drew), you are the reason I got up every day and fought hard to get here so you would see how important education truly is. Lucy and Kim, I am so thankful for you both, how you love my sons and have offered love and support over the years to me. I know how difficult it has been to understand the process, but you all kept asking me questions to keep me focused and never give up. To my dad who would make me his famous meatloaf with “double butter double whipped mashed potatoes” when I was having a rough day and feeling discouraged. Dad, your time, effort, and love did not go unnoticed. Mom, with all of our struggles, you are the reason I got into psychology. I wanted to understand why things happened the way they did, and I am so thankful I took this journey.

I would like to thank my dissertation chair, Dr. Leihua Edstrom for walking this journey with me and offering me support with academic and personal issues. For all the edits I counted from draft to draft. Thank you to Dr. Cherri Seese for your probing questions and encouragement. A special thanks to Dr. Katherine Skillestad Winans who joined my committee in the 9th inning and helped me cross home. I could not have done any of this without all of you. Thanks to my peer debriefer for offering me other perspectives and considerations. Her input was highly valuable in providing validation and reasons to continue the work. I also want to share my gratitude to my participants who were willing to share their experiences with me.

In the last few months, I found a wonderful group of dissertation writers via Facebook, The Dissertation Writing Club. To Nicole Smith, Lauren Murfree, Patrick D. Smith, Andrea Craft, Richie Daly, Steve Syoen, Victoria Brinkman, Jene Gray, and Desna Jackson thank you for allowing me to be part of the nighttime crew. The laughter shared over the edits, and the discussions on how we need to be in support of each other truly helped me reach this goal. I am so looking forward to seeing you all finish your dissertations.

I am extremely grateful Northwest University accepted me into the College of Social and Behavioral Science program. I have felt supported by the professors, staff, and my cohort. Cohort 6 accepted me as one of their own, and we became a family I continue to cherish even after our classes are done. I miss you all deeply but am so thankful for each and every one of you.

Finally, but most of all, I want to thank God for the opportunity and the strength to go on this amazing journey. I had doubts throughout this journey, but trusting in Him was the best decision I could have ever made. Without Him, I would not have the relationship I have with my dad. Without Him, I would not have had the strength to stop the cycle of abuse and raise my children with love and support. I know with God all of this has been made possible.

Table of Contents

Acknowledgments ... 2
List of Tables ... 6
Abstract ... 7
Chapter 1: Introduction ... 9
Literature Review ... 10
Typical Brain Development ... 10
The Relationship Between the Environment and a Child's Brain Development ... 12
The Impacts of Child Maltreatment ... 15
Clinical Treatment Issues for Children With Maltreatment ... 31
Study Rationale ... 49
Research Questions ... 51
Chapter 2: Qualitative Methodology ... 53
Philosophical Worldview and Design Strategy ... 53
Research Design and Methodology ... 55
Population and Sample ... 55
Interviews ... 56
Study Reliability, Credibility, and Validity ... 58
Protection of Participants ... 58
Reflection on Researcher's Biases/Assumptions ... 58
Reliability and Validity ... 61
Chapter 3: Results ... 63
Data Collection Procedures ... 63
Data Analysis Process and Procedures ... 64
Reliability and Validity ... 67
Participant Demographics ... 69
Analysis of Data ... 73
Participants' Lived Experiences ... 79
Understanding of Developmental Trauma ... 95
How Developmental Trauma Impacts Treatment ... 105
Summary ... 124
Chapter 4: Discussion ... 127
Interpretation of the Findings ... 128

Participants' Lived Experiences 129
Understanding of Developmental Trauma 141
Developmental Trauma Impacts Treatment 145
Limitations and Future Directions 153
Implications for Graduate Training Programs 154
Implications for Mental Health Professionals, Therapists, and Counselors 155
Conclusion 157
References 160
Appendix A 184
Appendix B 185
Appendix C 187
Appendix D 188
Appendix E 190
Appendix F 191
Appendix G 193
Appendix H 194
Appendix I 198

List of Tables

Table 1. Participant Demographic Data 70
Table 2. Referrals 74
Table 3. Lived Experiences for Clinicians Working With Developmental Trauma 75
Table 4. Themes for Understanding Developmental Trauma 95
Table 5. Themes for Assessing and Treatment Implementation 106

Abstract

Child maltreatment encompasses five subcategories of physical abuse, sexual abuse, emotional abuse and/or neglect, and witnessing family violence. Maltreatment has been proven to impact a child's brain development in a negative way leading to developmental trauma. Areas of the brain that regulate emotional and behavioral responses are impacted as well as the stress response system. The purpose of this study was to learn from clinicians how they understand developmental trauma and its implications on treating children. Nine participants with master's degrees with 5 years of postgraduate professional experience were interviewed. This study was conducted with the phenomenological framework of Heidegger using the hermeneutic circle. Participants' lived experience of working with children with developmental trauma themes were Challenging, Rewarding, and Triggering. When clients do not move forward the theme for the participants were Reflecting. Participants also expressed Normalizing thoughts for graduate students and new clinicians considering working with this vulnerable population. The themes for understanding developmental trauma were Lack of Graduate Training in Trauma, the Pervasive Nature of Trauma, and the Dysregulation Effects of Trauma. Themes for how developmental trauma impacts treatment were Assessing, Observing, Diagnosing, Adapting, Attuning, and Modifying. Coinciding with previous research was the lack of education in graduate school around developmental trauma. Participants expressed how burnout can impact the level of care a clinician can give to their clients not unlike previous research. In addition, participants cautioned against misdiagnosis, as developmental trauma is not a diagnosis in the *Diagnostic and Statistical Manual for Mental Disorders 5th Edition*.

Keywords: clinicians' lived experiences with developmental trauma, developmental trauma, trauma training

Chapter 1: Introduction

When asked how a participant's faith has helped her to separate the stories, she heard from her pediatric clients from her own Participant 5 replied:

> Yeah. Oh, for sure. I mean, I've got a water walking kind of God. One that gets up from the grave, one that says you can beat the tar out of me, hang me on a cross, and I'm still gonna find a way to come back and love you. So that's the way I want to love, you know. I can let a little kid beat the tar out of me. They've bit, scratched, hit, clawed, whatever. That's okay. It's okay. I'm still going to be right here. I'm not going anywhere.

According to the Administration for Children and Families (ACF, 2020) there were more than 678,000 children abused or neglected in the United States in 2018. In 2018, 4,498 children in Washington State were victims of maltreatment: 68.0% from neglect, 13.2% from physical abuse, and 8.2% from sexual abuse; 10.1% were victims of multiple maltreatment types (Administration for Children and Families, 2020). According to the Child Abuse Prevention and Treatment Act (CAPTA) of 1974, child maltreatment is defined as "serious harm (neglect, physical and/or sexual abuse, mental injury, and emotional abuse or neglect) caused by parents or primary caregivers, such as extended family members or babysitters" (p. 4). Wekerle et al. (2014) stated child maltreatment is a tragedy of human error, with child abuse being the result of an adult act. Without the behavioral choice(s) of the adult, the child is much less likely to have developmental problems and/or psychological disorders.

Child abuse or neglect interrupts the development of a child's brain. To understand the myriad of symptoms exhibited by children with trauma histories, it is

important to understand what happens to the developing brain of a child when abuse and/or neglect is introduced. Different areas of the brain and certain responses can be affected by abuse and neglect (Perry, 2004). For example, due to living in an environment of abuse and neglect, children may show symptoms of high levels of aggressive and oppositional behaviors, sleep disturbances, speech and language problems, and relationship difficulties (Chambers et al., 2010; Newman & Mares, 2007). Other symptoms include maladaptive behavior responses, developmental delay (Chambers et al., 2010; Newman & Mares, 2007), and emotional dysregulation (Chambers et al., 2010; Newman & Mares, 2007; York & Jones, 2017). With symptoms of this nature, children who have suffered abuse and neglect must receive proper treatment (McCarthy & Taylor, 1999). Treatment may come in the form of a social worker, counselor, or psychologist working with the child.

The present study aimed to understand the complexity of developmental trauma, and how clinicians view and treat a child who has shown indicators of having exposure to abuse and/or neglect. In the next section, the literature discusses typical brain development, the impact of abuse, and what goes into seeking help for children who have been impacted emotionally, physically, mentally, and relationally by abusive and/or neglectful events. The literature shows the need for the study and the importance of understanding developmental trauma to effectively treat this population.

Literature Review

Typical Brain Development

Healthy brain development in both structure and function is fundamental to positive child, adolescent, and adult outcomes (Cassidy, 2016; Glaser, 2014; Levitt &

Eagleson, 2018; Shonkoff et al., 2011), including cognitive, emotional (Lebel & Beaulieu, 2011; Levitt & Eagleson, 2018; Smith et al., 2017), and behavioral processes (Lebel & Beaulieu, 2011; Shonkoff et al., 2011). Cognitions, emotions, and behaviors are functions of neural circuits (Glaser, 2014; Perry, 2009; Tau & Peterson, 2010; Tottenham, 2018). The human brain goes through many intricate phases throughout its development (Perry, 2009). Each phase is built on the scaffolding of previous phases (Perry, 2009; Sroufe, 2016). When a phase or milestone is missed, due to an unforeseen event such as abuse, neglect, and trauma, there may be a trickledown effect that takes years to observe.

The first areas of brain to develop are lower functioning: the brainstem and midbrain (Perry, 2009). These areas control bodily functions vital for life: arousal, appetite, sleep, blood pressure, heart rate, and body temperature (Perry, 2004). Higher functioning areas such as the limbic system and cerebral cortex are in the developing stages at 3 years of age (Perry, 2004).

If not nurtured and strengthened in the first 3 years, developmental milestones such as language especially before age of 5 (Shonkoff et al., 2011; Vyshedskiy et al., 2017), personal socialization skills, and attachment (Smith et al., 2017; Vela, 2014) can lose stability (e.g., skills learned can be unlearned; Perry, 2009; Shonkoff et al., 2011). For example, if language is not acquired either verbally or nonverbally by a certain age, these skills will be difficult for an individual to achieve later in life (Vyshedskiy et al., 2017). Researchers believe there are critical or sensitive periods where these skills need to be learned (Blair & Raver, 2016; Breedlove & Watson, 2013; Glaser, 2014; Perry, 2009; Vela, 2014; Vyshedskiy et al., 2017; Wilson et al., 2011). Several researchers have

found children learn with a "serve and return" (Levitt & Eagleson, 2018, p. 82) or reciprocal environment (Bruce et al., 2019; Levitt & Eagleson, 2018; Smith et al., 2017). The "serve" and "return" is the interaction between parent and infant or child. An infant serves by vocalizing to the parent with coos and happy sounds and the parent returns by smiling and interacting with the infant. The interaction roles might be reversed, but the key aspects are interaction and connection between parent and infant or child. Serve and return is important for language acquisition development (Vyshedskiy et al., 2017), emotional regulation, and how a child interacts with a potential attachment figure (Bruce et al., 2019).

The Relationship Between the Environment and a Child's Brain Development

The caregiving a child receives has a lasting impact on brain development (Afifi & MacMillan, 2011; Blair & Raver, 2016; Hawkins & Haskett, 2011; McLaughlin et al., 2015; Tottenham, 2018; Vela, 2014), emotional development (Hoemann et al., 2019; Tottenham, 2018), self-regulation, and behavior (Blair & Raver, 2016; Hoeman et al., 2019).

Development depends on environmental stability (Perry, 2009; Shonkoff & Phillips, 2000; Tau & Peterson, 2010; Vyshedskiy et al., 2017; Wilson et al., 2011), including enriched and stimulating interactions with both attentive and nurturing relationships (Afifi & MacMillan, 2011; Hawkins & Haskett, 2011; Perry, 2004, 2009). Shonkoff et al. (2011) identified three domains necessary to provide physical and mental well-being. The first is a stable and responsive environment where a child feels consistent, nurtured, and protected. The second is to provide a safe supportive physical environment, thus allowing physical and emotional safety, free from risk of harm. The

third is to provide appropriate nutrition, teaching healthy eating habits (Shonkoff et al., 2011).

Providing a stable and responsive environment where a child feels consistent nurturance and protective care could be shown in predictable behaviors from the parents. When a child sees their parent consistently respond in a certain way there is an expectation the same response will happen again. This becomes an experience-expectant response. Greenough et al. (1987) termed the phrases experience-expectant and experience-dependent to describe how the environment gives cues to the developing mind, and current researchers (Blair & Raver, 2016; Glaser, 2014; Perry, 2009; Vela, 2014; Wilson et al., 2011) have concurred with the ongoing use of these concepts. Experience-expectant is somewhat related to the idea of sensitive timing of development. Greenough et al. (1987) believed expected experiences can lengthen the time the brain stays sensitive to environmental exposure. Experience-dependent refers to storing information about an experience for future reference. Experience-expectant or experience-dependent patterns of neural activity that occur under stress can lead to reactive and defensive behavioral responses due to the environment, rather than reflective responses (Blair & Raver, 2016; Glaser, 2014; Perry, 2009; Vela, 2014; Wilson et al., 2011). Reactive responses are responses in which the child cannot think through the situation rationally. The child may become over-emotional needing outside help to re-establish physiological regulation, calming the body (Cook et al., 2005). The reflective response is the ability of a child to determine a course of action based on previous experiences (Cook et al., 2005). Experience-dependent responses between parent and child enable the continued development of skills such as language (Vyshedskiy et al.,

2017), which can counterbalance negative events that impact the brain such as trauma and abuse.

By providing a child with a safe, supportive physical environment, the child can feel physically and emotionally safe; this will teach the child how to understand and regulate their emotions and behaviors. Tottenham (2018) stated a parent's brain acts like extensions of the brain of a child. When the parent's amygdala is activated, a child may look to their parent and feel their parent's hidden regulator. The main function of the amygdala is to help with emotion processing (Inman et al., 2020) and to detect threats that can activate the brain's stress response (Glaser, 2014; Vela, 2014). The hidden regulator serves to help the child control their physiological response (Blair & Raver, 2016; Lieberman et al., 2011; van Der Kolk, 2005). The parent is the conduit for the child's emotional experience (Blair & Raver, 2016; Tottenham, 2018; van Der Kolk, 2005), and a moderator or buffer of stress (Blair & Raver, 2016; Lieberman et al., 2011). A parent's care is a link to the development trajectory of the child for dealing with stress, cognition, emotional and behavioral regulation, and attachment (Fujisawa et al., 2018; Perry, 2009; Tau & Peterson, 2010; Tottenham, 2018; van Der Kolk, 2005; Vela, 2014).

Providing proper nutrition, and healthy eating habits for children is important in how they handle stress. Perry (2009) stated a brain which is developing healthily can organize a response to stress based on the environment provided by the parent(s) and culture. The stress response system is designed to sense distress and formulate a way to create homeostasis (Boyce & Ellis, 2005; Perry, 2009; Shonkoff et al., 2011; Vela, 2014). Recovery to homeostasis is created when the primary caregiver provides what is necessary: food when hungry, drink when thirsty, and clothing and shelter for warmth

and safety; thus, the parent provides a positive response in which the child can observe, learn, and practice healthy coping strategies in the face of stress (Blair & Raver, 2016; Kertes et al., 2009; Perry, 2009; Scott et al., 2011; Shonkoff et al., 2011; van Der Kolk, 2005).

In this section, a brief outline of the hallmarks of typical childhood brain development has been provided, as well as the significant role of the parent in providing the child with tools for countering stressors. The next section will discuss the impacts of maltreatment on a child's brain, as well as their emotional, behavioral, and attachment development.

The Impacts of Child Maltreatment

Maltreatment, trauma, and neglect in childhood include five subcategories: physical abuse, emotional abuse, neglect, sexual abuse, and being witness to family violence (Anda et al., 2006; Brown, 2015; Greeson et al., 2011). The impact of these various kinds of child maltreatment and trauma on children varies (Cuffe & Shugart, 2001; Greeson et al., 2011; Lieberman et al., 2011; Shonkoff et al., 2012; van der Kolk, 2005; Wilson et al., 2011) and, in some cases, have a long-lasting impact on the child (Greeson et al., 2011; Gregorowski & Seedat, 2013; Scozzaro & Janikowski, 2015; van Der Kolk, 2005; Wilson et al., 2011). The trauma suffered by maltreatment impacts the daily functioning of a child, including (a) language problems and relational difficulties (Chambers et al., 2010; McLaughlin et al., 2015; Newman & Mares, 2007; Shonkoff et al., 2011); (b) the emotional world of the child (Chambers et al., 2010; Finzi et al., 2001; Newman & Mares, 2007); (c) how the child responds to threats (McLaughlin et al., 2015; Vela, 2014); and (d) the overall course of their development (Chambers et al., 2010; Finzi

et al., 2000; McLaughlin et al., 2015; Newman & Mares, 2007; Shonkoff et al., 2011). Children who are exposed to neglect or abuse fail to learn about their bodies and feelings and are unable to make sense of their world (Farnfield & Onions, 2021).

Farnfield and Onions (2021) performed a study in the United Kingdom with 50 children in residential care. The researchers administered the Child Attachment and Play Assessment (CAPA) to the children when they first arrived at the residential home and again 2 years later. The second CAPA showed the children appeared to be doing worse. The extent of grief and loss the children had experienced was indicated by both physical and emotional breakdowns. Children with more complex trauma and attachment symptoms showed more developmental difficulties (Shonkoff et al., 2011; Tarren-Sweeney, 2013) and a greater need for mental health services due to emotional issues and disorders (Greeson et al., 2011; Tarren-Sweeney, 2013; Zeanah & Humphreys, 2018).

Potentially traumatic events can result in the likelihood of developing different or comorbid, more than one diagnosis at the same time, psychiatric disorders due to altered brain development (Anda et al., 2006; Carliner et al., 2017; Fujisawa et al., 2018; Shrivastava et al., 2018). Children who have been maltreated show symptoms of depression (Anda et al., 2006; De Bellis et al., 2019; Oshri et al., 2019; Scozzaro & Janikowski, 2015; Shrivastava et al., 2018; Wilson et al., 2011; Zeanah & Humphreys, 2018) and anxiety (Anda et al., 2006; Oshri et al., 2019; Scozzaro & Janikowski, 2015; Shrivastava et al., 2018; Tarren-Sweeney, 2013; van Der Kolk, 2005). Depression in abused youth is highly comorbid with both alcohol and substance use disorders (Carliner et al., 2017; De Bellis et al., 2019; Shrivastava et al., 2018; van Der Kolk, 2005). Children who are victims of sexual abuse have a higher risk of eating disorders, sleep

disorders (Shrivastava et al., 2018), depression (Gokten & Uyulan, 2020), and suicide attempts (Afifi et al., 2018; Miller et al., 2013; Shrivastava et al., 2018; van Der Kolk, 2005; Vinnerljung et al., 2006). Children with a history of abuse and/or neglect have a higher chance of being diagnosed with behavioral disorders.[1] Attention and memory are impacted by trauma due to abuse and/or neglect.[2] Children who have suffered abuse and/or neglect may exhibit symptoms of trauma disorders.[3] Substance use issues (alcohol and other drugs; Oshri et al., 2019, 2020) and self-harming behavior (D'Andrea et al., 2012) are also examples of possible issues children with histories of abuse and/or neglect deal with. If exposed to abuse and/or neglect, a child also might be diagnosed with reactive attachment disorder (Allen, 2016; Barth et al., 2005; Bruce et al., 2019; Chaffin et al., 2006; John et al., 2019; Jonkman et al., 2014; Kliewer-Neumann et al., 2018; Newman & Mares, 2007). Children who have been exposed to abuse and/or neglect also have issues with processing information.

The timing and severity of exposure to abuse and/or neglect are both factors in level of stressors placed on a child and their processing (Cowell et al., 2015; Roos et al., 2016; Wilson et al., 2011). The duration and severity of abuse and/or neglect might not allow time for the child to adjust from one episode to the next. Children who have been abused and/or neglected often do not develop the skills needed to self-regulate; therefore, these children often experience intense feelings without being able to reduce the force of the emotions (Cook et al., 2005; van Der Kolk, 2005). It may appear at times these

[1] Conduct disorder (Carliner et al., 2017; Cook et al., 2005; D'Andrea et al., 2012; Wilson et al., 2011), oppositional defiant disorder (Carliner et al., 2017), aggression (Cook et al., 2005; D'Andrea et al., 2012; Wilson et al., 2011)
[2] Inability to concentrate (D'Andrea et al., 2012), memory disturbance (Anda et al., 2006; D'Andrea et al., 2012; De Bellis et al., 2014)
[3] Posttraumatic stress disorder (PTSD; Scorzzaro & Janikowski, 2015; Shrivastava et al., 2018, van Der Kolk, 2005), and dissociation (Cook et al., 2005; D'Andrea et al., 2012; van Der Kolk, 2005)

children more quickly resort to anger, fear, and anxiety. To understand the dynamics of change in emotional and behavioral regulation and how a child with abusive or neglectful experiences might show attachment, it is imperative to know what changes occur in the brain due to abuse and/or neglect.

Changes in the Brain

The brain is made up of the right and left hemispheres, with each hemisphere regulating and performing different tasks. The left hemisphere of the brain is focused on language, logical, and analytical thought, and positive affect. The right hemisphere focuses on processing and expressing emotions, particularly ones that are negative and unpleasant (Glaser, 2014). Both hemispheres have four lobes, each with differentiating functions: frontal, parietal, temporal, and occipital lobes (Applegate & Shapiro, 2005; Breedlove & Watson, 2013b). The frontal lobe is the decision-making part of the brain; the parietal lobe experiences related to sensory processing and spatial cognition; the temporal lobe is responsible for hearing, associated with the sense of smell, learning, memory; and the occipital lobe is the part of the brain that receives information from the eyes, (Breedlove & Watson, 2013c). When a child experiences trauma in the form of abuse and/or neglect, changes occur in the structure of each of the lobes, changing their functionality (Anda et al., 2006; Belsky & de Haan, 2011; Carrion et al., 2009; McCrory et al., 2010; Tottenham et al., 2010; Whittle et al., 2013).

Frontal Lobe and Temporal Lobe. The frontal lobe is where complex decision-making takes place. The prefrontal cortex is in the frontal lobe and is in both the right and left hemispheres (see Appendix A). The prefrontal cortex is responsible for executive functioning (Boyd & Bee, 2015b; Breedlove & Watson, 2013a; Glaser, 2014). Planning,

logical thinking, processing of information (Boyd & Bee, 2015; Breedlove & Watson, 2013a), self-regulatory skills including inhibitory control, verbal fluency, and working memory (Cassidy, 2016) occurs in this area of the brain. Cowell et al. (2015) found children who were maltreated as infants chronically showed significant impairment with inhibitory control and memory tasks. Roos et al. (2016) studied 694 children who were involved with Child Protective Services (CPS) to determine if maltreated children showed difficulty with inhibitory control and attention. Roos and colleagues (2016) used a flanker task, which measures attention and inhibitory control. The flanker task presented horizontal rows of five blue or red circles on a computer screen. Five blue or red circles were presented as an attention trial and a child was supposed to press a button. If a blue circle was flanked by red circles or vice versa that was an inhibitory control trial and to be ignored. Roos and colleagues (2016) found right away 43.5% of the participants were excluded for poor performance (> 50% correct). Out of the remaining children, average accuracy rate was 66.4% correct compared to nonclinical accuracy rates to be approximately 70%–90% (Roos et al., 2016). Vasilevski and Tucker (2016) looked at executive functioning of children who had histories of abuse and/or neglect.

Vasilevski and Tucker (2016) had 39 children with maltreatment histories do a cognitive assessment, the Stroop Test, the Controlled Animal Fluency Test, and the Controlled Oral Word Association Test. Vasilevski and Tucker (2016) found maltreatment not only affected executive functioning, but also memory, learning, and processing speed. Damage to the prefrontal cortex can bring about impaired decision making, planning, judgment, insight, and diminished self-care. Damage to the prefrontal cortex can also bring about diminished social insight and attention, and an increase in

response time (Breedlove & Watson, 2013a; Cowell et al., 2015; Roos et al., 2016). Right behind the frontal lobe is the parietal lobe, located in both the right and left hemispheres.

Parietal Lobe and Occipital Lobe. The parietal lobe is located between the frontal lobe and occipital lobe (see Appendix A). With assistance from the temporal lobe, the parietal lobe receives information from the occipital lobe of what the eyes see and begins to put a composite together. The parietal and temporal lobes together use the information received from the occipital lobe to recognize faces and identify objects, otherwise known as spatial cognition (Breedlove & Watson, 2013d). Maltreatment affects the visuospatial functioning and processing speed of children (Pears & Fisher, 2005; Vasilevski & Tucker, 2016). Pears and Fisher (2005) compared children with maltreatment histories (n = 60) and nonmaltreated children (n = 31) regarding visual perspective-taking desire reasoning and belief reasoning. The visual perspective-taking was determined by what the child saw versus what the researcher saw (the head versus the feet of a mouse). Desire reasoning was determined by the child being able to recognize emotions of a character in a story. Belief reasoning was determined by whether the child could recognize a multiple of an item could be found in more than one location. Pears and Fisher (2005) found children with maltreatment histories had difficulty recognizing appropriate emotions given the context of a story, difficulty with spatial reasoning, and difficulty with perspective-taking. It appeared there might be some impact on the parietal lobe with the reasoning of visual stimuli.

The occipital lobe processes the visual stimulation of what the eyes see. Based on the age of exposure to traumatic experiences, several studies have shown abused children have a reduction in the left primary visual cortex (Fujisawa et al., 2018; Jedd et al., 2015;

Takiguchi et al., 2015; Teicher et al., 2012), the lingual gyrus (Kelly et al., 2013), and the orbitofrontal cortex (Gold et al., 2016; Kelly et al., 2013). The primary visual cortex sends and receives emotional responses from the amygdala regarding visual stimuli (Adolphs, 2004; Fujisawa et al., 2018). The lingual gyrus is associated with higher cognition and visual information (Kelly et al., 2013). The orbitofrontal cortex is an area of the brain that has a role in emotional processing and emotion regulation (Gold et al., 2016; Kelly et al., 2013). The reduction in these three areas can disrupt how a child processes negative images, such as angry or negative faces (Marusk et al., 2015; McCrory et al., 2013; Tottenham et al., 2010). If there is a disruption in how a child processes information taking place in the occipital and parietal lobes, then the limbic system may not respond properly.

Limbic System. The limbic system uses both hemispheres. The limbic system is comprised of the amygdala, hippocampus, fornix, and the cingulate gyrus (Breedlove & Watson, 2013b; Shonkoff et al., 2012; Vuilleumier, 2005). Two of the main responsibilities of the limbic system are emotion regulation and response to threats (Breedlove & Watson, 2013b; Glaser, 2014; Lucassen et al., 2014; Shonkoff et al., 2013; Vuilleumier, 2005). The corpus callosum intersects both hemispheres allowing communication between the hemispheres and the four lobes.

The corpus callosum, cerebellum, prefrontal cortex (McCrory et al., 2010), hippocampus (Luby et al., 2013; McCrory et al., 2010; Tottenham et al., 2010; Whittle et al., 2013), and the amygdala (McCrory et al., 2010; Tottenham et al., 2010; Whittle et al., 2013) can be affected when a child has been a victim of abuse or neglect. In adults who have experienced abuse and/or neglect as children, the hippocampus which plays a role in

memory was observed to have a reduction in volume (Hart & Rubia, 2012; Luby et al., 2013; McCrory et al., 2010). The hippocampus focuses on episodic memory (Glaser, 2014) and consolidates information into long-term memory (McLaughlin et al., 2015; Vela, 2014). In children and adolescents who were maltreated, the corpus callosum, responsible for arousal and emotion, was shown to have decreased in volume (Belsky & de Haan, 2011; Hart & Rubia, 2012; McCrory et al., 2010).

When exposed to abuse and/or neglect, the amygdala, which helps provide top-down signals both directly and indirectly on sensory pathways, may overstimulate the brain (Shonkoff et al., 2012; Vuilleumier, 2005). The amygdala influences perceptions of emotional events, especially in terms of threat, and facilitates emotional responses (Shonkoff et al., 2012; Vuilleumier, 2005). Eight out of the 13 studies reviewed by Teicher and Khan (2019) showed significantly smaller amygdala volume in adolescents and adults who were exposed to multiple types of abuse as children. An increased volume in the amygdala was observed in children who were exposed to emotional or physical neglect in two studies reviewed by Teicher and Khan (2019). Reduction in the amygdala has been associated with increased anxiety, depression, and alcohol use in adolescents (Oshri et al., 2019). Certain areas of the brain's structure are compromised by abuse or neglect, hormones related to the stress response also show signs of change due to maltreatment.

Stress Response System. Response to threats is also affected by abuse and neglect. Cortisol, a hormone that is part of the hypothalamic-pituitary-adrenocortical (HPA) system helps in stress responses (Boyce & Ellis, 2005; Bruce et al., 2009; McCrory et al., 2010). Maltreatment early in life is associated with blunted HPA axis

responses to both social, nonsocial, physical, and psychological stressors (Hunter et al., 2011; McLaughlin et al., 2015; Whittle et al., 2013). The blunted system may prevent activation or deactivation of the stress response, which is necessary for properly helping a person manage a potentially life-threatening situation (Hunter et al., 2011). Bruce et al. (2009) found of the 117 foster children they studied, children who suffered severe physical neglect had low morning cortisol levels, and those who suffered emotional abuse had higher levels of cortisol in the morning. Abnormal cortisol levels can have negative consequences (Boyce & Ellis, 2005; Hunter et al., 2011). Lower levels of cortisol can impact learning and socializing (Bruce et al., 2009), whereas higher levels can impact cognitive processes, decrease immune responses, and increase the risk of affect disorders (Hunter et al., 2011). Changes in the brain can impact the processing of emotions and visual stimuli.

The number of types of maltreatment was an important predictor of the level of brain alteration (Fujisawa et al., 2018; Jedd et al., 2015; Takiguchi et al., 2015; Teicher et al., 2012). Being exposed to traumatic experiences as a child is associated with negative developmental outcomes, which include mental and physical health and difficulties in social functioning (Blair & Ravar, 2016; DeBrito et al., 2013; Levitt & Eagleson, 2018; Morales-Muñoz et al., 2018; Oshri et al., 2019; Teicher & Khan, 2019; Tottenham et al., 2010; Tottenham, 2018; Whittle et al., 2013; Vela, 2014). Children with histories of maltreatment and trauma manifest these brain changes in the ways they interact with the world around them: behaviorally, emotionally, and how they show attachment to others.

Emotional/Behavioral Dysregulation

Dysregulation refers to emotional, behavioral, cognitive, somatic, and attachment-related difficulties (Spinazzola et al., 2018; Wells et al., 2019; van Der Kolk, 2005). Child abuse and/or neglect causes severe stress on the child's system that may have long-lasting effects on brain development, impacting manifestations of negative emotions and leading to maladaptive behaviors (Burns et al., 2004; McWey, 2004; Morales-Munez et al., 2018), including difficulty with attachment (McLaughlin et al., 2015; Scozzaro & Janikowski, 2015; Shonkoff et al., 2012; Szilagyi et al., 2015; Tarren-Sweeney, 2013; Vela, 2014), attention (Schalinski et al., 2018), and memory (De Brito et al., 2013; Fuge et al., 2014; Schalinski et al., 2018). Children who have suffered abuse and/or neglect have a difficult time regulating their emotional responses.

Children with trauma histories often have difficulty controlling their emotions, especially anger and anxiety (Cook et al., 2005; Hughes, 2004). According to Farnfield and Onions (2021), the 50 children they observed had difficulties with their emotions. They showed anger, violence, helplessness, fear, and self-loathing. Symptoms of emotional dysregulation include difficulty with labeling and expressing feelings, problems in knowing and describing internal states, and difficulty communicating wishes and needs (Cassidy, 2016; Cook et al., 2005). Choi and Graham-Bermann (2018) conducted a meta-analysis, looking at 74 studies published between 1985 and 2017 with the majority (94%) published after 2000. When studies considered child development, trauma symptoms were found to vary between age groups. Young children ages 0–6 displayed fewer trauma and avoidant symptoms, but a greater likelihood to display behavioral and affect regulation issues, and dissociation (Choi & Graham-Bermann,

2018). Abused and/or neglected children may be more reactive to emotional stimuli and more prone to anxiety (Bruce et al., 2009; Shonkoff et al., 2012; Tottenham et al., 2010; Whittle et al., 2013). Anxiety may be observed in a feeling of insecurity rather than trauma-specific anxiety (Tarren-Sweeney, 2013). Emotional dysregulation can influence risky behavior and increase chances of revictimization of child sexual victims (Messman-Moore et al., 2010). Traumatized children may show impaired social judgment and behaviors and they may assign negative attributes to their caregivers (D'Andrea et al., 2012; Hughes, 2004). The stress response to threat (i.e., social judgment) is also impacted by abuse and/or neglect.

Abnormal stress response may result in a child's inability to activate or deactivate the hypothalamic-pituitary-adrenocortical (HPA) axis, meaning they may be unable to differentiate between levels of stressors (Boyce & Ellis, 2005; Bruce et al., 2009; Shonkoff et al., 2012; Whittle et al., 2013). Maltreated children showed more activation in the right amygdala when processing angry faces (Fonzo, 2013; McCrory et al., 2013; Tottenham et al., 2010) and made more errors (Tottenham et al., 2010). When McCrory et al. (2013) had children look at pictures, the children were placed in separate groups based on if they were exposed to abuse or domestic violence or not. The pictures had a neutral face and were partnered with either a happy or angry face. After showing the side-by-side pictures, a scrambled picture was shown for a few milliseconds, then an asterisk was shown on one side of the screen and the child had to answer on which side of the screen they saw the asterisk. McCrory et al. (2013) were surprised to find maltreated children had high right amygdala activation for both angry and happy faces. Tottenham et al. (2010) studied 38 children who were previously institutionalized (e.g., raised in an

orphanage) and had them look at blocks of facial pictures. The child was asked to rapidly detect emotions either negative or positive surrounded by neutral facial blocks. The child was told to press a button when they saw a specific emotional facial block. Tottenham et al. (2010) found the children performed better with happy facial blocks. It took the children longer times with negative faces, and they showed more errors in responding when the distractor was a negative face. Children with histories of abuse and/or neglect often operate in a survival mode in their daily lives, without strategies to cope with their immediate environment (Smith et al., 2014; Vela, 2014). They may show signs of dissociation (Haugaard, 2004; Spinazzola et al., 2018; Szilagyi et al., 2015; van Der Kolk, 2005), social withdrawal, and aggressive behavior out of fear of punishment or rejection (Smith et al., 2014).

Some children with trauma histories display behavioral dysregulation (York & Jones, 2017), which can appear as flat or numbed affect (Carrion et al., 2009), explosive anger, and inappropriate affect (Cook et al., 2005; D'Andrea et al., 2012). For example, some of the children in York and Jones's (2017) study displayed violent outbursts with aggression, damaged property, and exhibited other destructive behaviors such as kicking, biting, and spitting. As a result of this kind of behavioral dysregulation, children in foster care tend to experience multiple residential placements (McLean et al., 2013; Sprang, 2009), further disrupting any feeling of stability, they may have established in their previous placement. Experiences of abuse, such as emotional abuse, neglect, and physical abuse, and witnessing domestic violence can result in a loss of capacity for self-regulation, and social and interpersonal relationship skills (Cook et al., 2005; Tarren-Sweeney, 2013). Emotional and behavioral dysregulation are not the only issues faced by

abused and/or neglected children and their caregivers. The relationship the child has with their primary caregivers may also need to be addressed.

Attachment Issues

How a child is treated by their parents helps them to determine how they see the world and experience it. In general, a father's treatment of his child is a predictor of self-esteem, whereas a mother's treatment is a predictor of humanity-esteem (Luke et al., 2004; Shaver & Mikulincer, 2008; Smith et al., 2017). Humanity-esteem is how the person understands how safe the world is. Responsive parenting can lead to many benefits for a child, such as a child developing the ability to regulate emotions and develop a sense of self (Becker-Weidman, 2006; Bruce et al., 2019; Chaffin et al., 2006; Dozier et al., 2002; Gardenhire et al., 2019; Jonkman et al., 2014), achieve physiological regulation, and emotion concept learning (Dozier et al., 2002; Gardenhire et al., 2019; Hoemann et al., 2019; Hughes, 2003). Emotion concept learning is based on the belief infants and toddlers learn emotions through hearing their caregivers talk about emotions. Having a responsive parenting environment means the infant or toddler will have interactions with their caregivers, thus allowing for predictions to form. The predictions are based on how the caregivers respond to each emotion. The continued same response the stronger the prediction becomes, so the child learns how to regulate and explore his/her own emotions (Hoemann et al., 2019).

Attachment is one indication a child can maintain healthy relationships with others. A secure attachment is viewed by how comfortable the child is to rely on an adult and form a close relationship (McLean et al., 2013). Those with a more secure attachment are found to be more likely to seek support from others. Those with an insecure

attachment are found to want relationships but have an overwhelming fear of being abandoned (Feeney et al., 2008; Mikulincer et al., 2010; Mikulincer & Shaver, 2005; Monin et al., 2012), and express anger and/or anxiety (Mikulincer et al., 2010; Mikulincer & Shaver, 2005; Monin et al., 2012). A child's attachment schema can reorganize itself to new caregivers, if earlier relationships are disrupted or discontinued (McLean et al., 2013; Raby & Dozier, 2018; Szilagyi et al., 2015), as in the case of foster children who are placed in new homes. In interviews with caseworkers, McLean and colleagues (2013) found many caseworkers believed some foster children are too damaged to form attachments or even express a need for attachment. These caseworkers assumed the foster children would fail yet another relationship (Chaffin et al., 2006; McLean et al., 2013; Newman & Mares, 2007).

There is a link between a child's attachment representation and behavioral adjustment (Scott et al., 2011). Zimmer-Gembeck et al. (2015) reviewed 23 studies on attachment relationships and coping strategies and found attachment does impact how a child copes with stress. Children in foster care with unresolved attachments may show insecure attachment behaviors, resulting in multiple placements (McWey, 2004). Out of a sample of 110 foster children, 54 of them had been in two or more foster homes before the age of 6 (McWey, 2004).

Trauma and disruption of primary attachment impact a child's ability to regulate emotions, learn, and function in relationships vital to psychosocial development (D'Andrea et al., 2012; Spinazzola et al., 2018). Children exposed to complex trauma have attachment difficulties (Cook et al., 2005; van Der Kolk, 2005). Attachment or relational issues may manifest as problems with boundaries, distrust and suspicion, social

isolation, interpersonal difficulties, difficulty attuning to other people's emotional states, and difficulty in taking another person's perspective (Cook et al., 2005; van Der Kolk, 2005). According to Cook et al. (2005), children with histories of abuse and neglect show different attachment styles, including anxious-avoidant, anxious-ambivalent, and unresolved/disorganized, depending on the types of abuse present in the child's life. An anxious-avoidant attachment may develop because the child predicts the unlikelihood their needs will be met, so they learn not to ask for help (McWey, 2004). An anxious-ambivalent attachment may have the same prediction of lack of help but has more anger than avoidance. The unresolved/disorganized attachment style is based on the belief the primary caregiver should be someone to be trusted to take proper care, and yet has been the perpetrator of abuse and neglect (Allen, 2016)

Children who experience inconsistent, violent, intrusive, or neglectful caregiving do not develop an understanding of how to find relief from their environment. This lack of awareness about how to find relief leads children to find it difficult to trust others to provide care, and they often cannot regulate their emotions (Cook et al., 2005; Hughes, 2003; McWey, 2004; van Der Kolk, 2005). Many caseworkers assume an insecure attachment is based on a lack of trust in the adults in their lives (Chaffin et al., 2006; McLean et al., 2013). Children in foster care may show insecure or overly conforming behaviors which can be indicative of an insecure attachment or the child's responses to previous losses, such as multiple placements (Tarren-Sweeney, 2013; van Der Kolk, 2005). McWey (2004) found out of the 110 foster children in his sample, 85.5% showed an avoidant attachment. Attention and memory are also impacted by attachment representations.

Dykas and Cassidy (2011) reviewed over 50 studies on attachment and found there was an agreement on how attachment impacted attention and memory. An insecure attachment was linked to poorer attention and integration of new information. Those with insecure attachments also needed more recall time to provide memories of sad and anxious events. This limited attention span may cause the child to be ineffective in communicating their needs (Cassidy, 2016; Cook et al., 2005; Mikulincer & Shaver, 2005). The lack of attention may support a diagnosis of reactive attachment disorder or disinhibited social engagement disorder.

When attachment issues arise with traumatized children, clinicians seek a diagnosis that fits with the symptoms demonstrated. Two such diagnoses are reactive attachment disorder (RAD) and disinhibited social engagement disorder (DSED; Bruce et al., 2019). Bruce et al. (2019) found the symptoms of RAD are subtle and sometimes overlooked by primary caregivers. The dyad between child and primary caregiver is developed by a serve and return aspect of sensitive responses returned when the child serves, but in the case of children with RAD there is no serve given, and so the needs of connection are often missed by caregivers (Bruce et al., 2019; Dozier et al., 2002). Symptoms of RAD often improve when the child is placed in foster care with improved caregiving (Jonkman et al., 2014). Awareness of the symptoms of RAD and the component of emotional withdrawal is something caregivers should look for when addressing a clinician about a child (Bruce et al., 2019; Jonkman et al., 2014; Shonkoff et al., 2012). The symptoms of DSED include overly engaging with strangers, being indiscriminate between caregivers and unfamiliar adults, and having external behavior problems; and the symptoms are less likely to improve after being placed in foster care

(Jonkman et al., 2014). Given the different emotional and behavioral dysregulation problems and attachment issues, caregivers may attempt to seek help for the child.

Clinical Treatment Issues for Children with Maltreatment

To decide on the intervention to use to treat a child with a trauma history, a clinician should have an idea of a diagnosis (Morrison, 2014). To establish a diagnosis, a clinician can conduct assessments to determine if the patient's symptoms meet one disorder or multiple. Clinicians can use family history and intake interviews to assess a diagnosis (Morrison, 2014). Once a diagnosis is determined, a treatment plan is proposed. A treatment plan is now becoming standard practice (Ivey et al., 2014) and is an outline of recommendations for treatment (Morrison, 2014). In the treatment plan, the most desired change or most traumatic experience might be the first thing to be addressed (Ivey et al., 2014; Morrison, 2014). The clinician will discuss the intervention needed to initiate change with the estimated number of weekly sessions. The client needs to feel safe knowing the clinician knows what is necessary to help the client (Ivey et al., 2014; Morrison, 2014). Even with a diagnosis, treatment plan, and potential interventions, there are other issues when it comes to treating children who have experienced trauma in the form of abuse and/or neglect. Treatment issues can come from past modalities of therapy that were not conducive to the situation, the clinician's expertise and training, diagnosing, and other barriers to treatment, as discussed in the following sections.

Past Treatment Methods and Modalities

One of the most controversial treatments used with children who have experienced trauma is holding therapy. Holding therapy was introduced for use with children with attachment disorders (Barth et al., 2005; Dozier, 2003; Dozier & Rutter,

2016; Hughes, 2003; Newman & Mares, 2007) after the therapy was developed by Robert Zaslow in the 1970s for use with people who had difficulty with emotions (Mercer, 2013). According to Mercer (2013), Zaslow attributed emotional disturbances to a lack of attachment and anger issues. Many clinicians felt holding therapy was more harmful than useful (Barth et al., 2005; Dozier, 2003; O'Connor & Zeanah, 2003). Rage induction, shame induction, and being held forcefully are at the center of the intervention (Chaffin et al., 2006; Dozier, 2003; Hughes, 2003; O'Connor & Zeanah, 2003). According to O'Connor and Zeanah (2003), holding therapy is an intervention where a child is laid across the laps of one or two therapists or a parent and a therapist. The use of touch and eye contact is necessary and encouraged in holding therapy (Chaffin et al., 2006; O'Connor & Zeanah, 2003). The treatment itself is intended to be repeated daily for 2 weeks for 45 minutes or longer per session. The intention of holding therapy as an intervention is to provide an experience of safety and security to the child, which allows them to instill an attachment with the caregiver. O'Connor and Zeanah (2003) found holding therapy to be lacking in empirical support, with no systematic evaluation. The therapy was found to be intrusive, nonsensitive for the child, and counter-therapeutic (O'Connor & Zeanah, 2003). According to Chaffen et al. (2006), the American Psychiatric Association (2002) and the Association for Treatment and Training in the Attachment of Children (ATTACh) both made position statements against the use of coercion or restraint as a treatment. However, according to Mercer (2013), the use of holding therapy still occurred in both the United States and Britain, even though the British Association for Adoption and Fostering (BAAF, 2006) made their position statement known. Clients and, in the case of minors, parents should be made aware of the

intervention by discussing with the clinician, the reasoning and addressing what potential uncomfortable thoughts and feelings might arise during treatment.

One of the tenets in treatment planning is to get permission to do an intervention. If a client states the treatment is not working, feels uncomfortable, or states they do not want to do the intervention, the clinician should introduce another intervention. Holding therapy was listed as a level one potential harmful therapy (PHT), meaning the treatment will probably produce harm in some individuals (Lilienfield, 2007). Holding therapy is not the only therapy proven to be harmful.

Rebirthing therapy is another controversial intervention, a therapy which has brought about the death of at least one child (Barth et al., 2005). Rebirthing has been used to help children with behavioral dysregulation and attachment issues (Mercer et al., 2003). The child is placed in a cocoon of blankets and therapists either use pillows or their body weight to simulate the contraction of the uterus during childbirth. The child is supposed to make their way through the birth canal and be born again (Mercer et al., 2003). Rebirthing therapy was also listed as a level one PHT (Lilienfield, 2007). Between holding therapy and rebirthing therapy, there have been at least six reported deaths of children in the United States (Boris, 2003; Chaffin et al., 2006; O'Connor & Zeanah, 2003). There are other modalities of therapy available which are helpful and not intrusive.

There are many therapies available, but clinicians must have proper training, supervision, and understanding of the issues the child experiences to select the most appropriate therapy (Barth et al., 2005; Boris, 2003; Chaffin et al., 2006; Damra et al., 2014; Dozier, 2003; Pearce & Pezzot-Pearce, 2001). Dozier et al. (2002) stated

interventions should be appropriate to the child's development. trauma adaptive recovery group education and training (TARGET), skills training affect and interpersonal regulation (STAIR), and structured psychotherapy for adolescents responding to chronic stress (SPARCS) are all interventions used in research studies reviewed by Cook and colleagues (2005). There are other interventions used currently to work with children who have trauma histories of abuse and/or neglect.

Current Treatments

Children with histories of abuse and/or neglect require better assessments and evidence-based treatments to help them improve the symptoms they are experiencing (Barth et al., 2005; Gardenhire et al., 2019; Greeson et al., 2011; Gregorowski & Seedat, 2013; John et al., 2019; McLean et al., 2013; Scozzaro & Janikowski, 2015). When clinicians are looking for treatment options for complex attachment and trauma-related symptoms, several researchers point to the need to look for a more symptom-by-symptom approach (Chambers et al., 2010; Dozier, 2003; McWey, 2004; Tarren-Sweeney, 2013). A symptom-by-symptom approach allows for work with individual issues. Dozier (2003) used a gradual introduction to nurturance and care by the caregiver with the understanding the child might show signs of not wanting care but need care and attunement. Dozier (2003) shared once the acceptance of care was given, the child and caregiver could move on to another phase in building trust and relationship. In his study, McWey (2004) showed by healing an attachment injury, secondary benefits might occur, for example, fewer behavioral issues.

Researchers and clinicians try to find interventions which are efficacious. When interventions provide help, relief from trauma and/or emotional pain, and effective

coping strategies, the interventions will continue to be used. Gardenhire and colleagues (2019) reviewed studies done between 1995–2017 and found researchers employed emotion coaching, trust-based relational interventions, family attachment narrative therapy, attachment-based family therapy (ABFT), and cognitive-behavioral and attachment-based family therapy (CB-ABFT) in the reviewed studies. Each intervention will be explored in turn.

Emotion coaching, developed by John Gottman, can facilitate foster parents in nurturing empathy. Trust-based relational interventions work to build trust to help develop emotional regulation. trauma-focused CBT (TF-CBT) uses cognitive restructuring (De Bellis et al., 2019) and behavioral coping skills to process and deal with stressors (Lieberman et al., 2011). Dialectical behavioral therapy (DBT) is used with children who experience depression, suicidality, self-harming behaviors, and PTSD (De Bellis et al., 2019). Play therapy is an evidence-based treatment which focuses on playing with the child. Clinicians using play therapy believe play is both vital and an integral part of a child's development in emotional, mental, and behavioral ways. Dyadic developmental psychotherapy (DDP) brings affective attunement between therapist-child, caregiver-child, and therapist-caregiver (Becker-Weidman, 2006; Gardenhire et al., 2019; Hughes, 2004). An alternative to treating the child may be to treat the parent. A relational intervention with parents allows parents to identify their internal stress levels, as the adult's internal state impacts the risk of child physical abuse (Sprang, 2009). When determining which intervention to use with a child a clinician should have goals in mind.

Allen (2011) believed clinicians providing treatment for children with trauma histories should remember four things:

1. Treatment should focus on improving the dyad between child and caregiver,
2. The child's behaviors are representative of the care received, so improving the quality of care is the target for change,
3. Treatment should meet the goal of improving the child's developmental trajectory, and
4. The child's cognitive abilities should be respected and considered.

The interventions used in the studies reviewed in this section are only a sample of interventions available to clinicians. Clinicians develop areas of expertise, often focusing on trauma, attachment, and/or behavioral concerns. As each intervention requires training and in some cases supervision for a certain amount of time, a cost-benefit analysis needs to be determined. Will this intervention give the clinician what they need to work with their clients?

Clinician Expertise and Training

Clinicians should become developmentally informed to understand how to address the challenges and range of issues related to child maltreatment (Perry, 2009). Given the complexity of working with children with trauma histories, clinicians need to be properly educated regarding the effects of trauma exposure (Burns et al., 2004; Gregorowski & Seedat, 2013; McWey, 2004; Weir et al., 2008). Clinicians should feel they understand the treatments, assessments, and training available, and feel competent in engaging in therapy.

To work with a certain population or niche takes training in each of the different interventions. Eye movement desensitization and reprocessing (EMDR), for example, requires two weekend trainings and 10 hours of consultation to certify a clinician to use

EMDR properly (Shapiro & Forrest, 1997). Lifespan integration (LI) requires at least one-weekend of training, but also offers more in-depth training on a second weekend. To use LI to work with youth and adolescents, there is a 2-day training necessary to be certified. Training for both EMDR and LI requires the clinician to come to the training with something they want to process themselves. For EMDR this may be processing a constant thought which has the clinician feeling stuck (e.g., “I am not good enough,” “I will not finish”). The thought is usually associated with a memory. This memory is processed using bilateral passes (i.e., fingers passing in front of the eyes of the person) in sets of 20 to reprocess the memory and eliminate the recurring thoughts. Lifespan Integration asks for the clinician to bring a timeline to the training. The timeline is made up of three memories (i.e., one good, one bad, and one neutral) per year of the person’s life. A memory is chosen which has impacted the clinician’s life and a basic protocol is used to lessen the impact of the event. Both EMDR and LI employ a scale of 0–10 for the person to determine how much the memory impacts them before, during, and after the intervention. Both interventions recommend multiple sets (EMDR) or multiple passes through the timeline (LI) to process a memory. Bringing in something to process allows the clinician to experience the healing process firsthand and can better explain it to their client. Of the two modalities mentioned, only EMDR is an evidence-based modality, meaning multiple random controlled trial studies have been done to prove the efficacy and efficiency of the interventions used (Berg, 2019). Lifespan integration has been studied by a few researchers and has shown promise, but not enough research has been presented to recognize it as an evidence-based modality.

Evidence-based modalities provide manualized training so clinicians can acquire the skills needed to use the interventions properly. There are many different certifications available to clinicians. Certifications are required with certain modalities to work with trauma such as eye movement desensitization and reprocessing (EMDR) and play therapy. To use EMDR with clients, a clinician must attend two 4-day workshops with 10 hours of supervision in between. The first workshop is for basic training, with the second workshop giving guidance with more complex issues. EMDR has different protocols (i.e., interventions) such as EMD (eye movement desensitization), which can be used with clients. To use EMDR properly, eight phases are scripted and followed from beginning to end to ensure the proper efficiency and effectiveness.

To use play therapy, clinicians go through a rigorous training and certification process. To be a registered play therapist, according to the Academy for Play Therapy Training's website (2022), 150 hours of continuing education credits are used to certify a play therapist, but other requirements are also needed. Coursework in child development, theories of personality, principles of psychotherapy, child and adolescent psychopathology, and ethics must be demonstrated for certification. To be certified as a play therapist, a clinician must have supervision of 350 client contact hours under the guidance of a registered play therapist-supervisor (RPT-S) and 35 hours of supervision documented, of which 5 session observations by the supervisor.

Lifespan integration (LI), which is not evidence-based at the time of this research, provides interventions to use with trauma victims. Lifespan integration does not have scripted forms and uses a timeline to help the client choose what they would like to process or focus on. Lifespan integrations has multiple intentions – standard protocol,

attunement protocol, script clearing, cell being protocol, baseline protocol, and a PTSD (post-traumatic stress disorder) protocol – to use with different clients. The clinician can choose which protocol is needed for specific events on the timeline. A clinician who wants to work with trauma can learn different modalities to provide options for their clients and have access to assessments leading to a diagnosis.

Assessing Developmental Trauma

There are a variety of assessments available when seeking to develop a proper diagnosis. Proper assessment of the child's emotional, social, mental, and behavioral needs is imperative to provide proper care (Scozzaro & Janikowski, 2015). Current behavior patterns, clinical observations, and the client's history of attachment needs should be considered when diagnosing attachment disorders (Kliewer-Neumann et al., 2018; Zeanah et al., 2016). Greeson et al. (2011) stated most children in the welfare system are not assessed for trauma exposure and symptoms of trauma past the initial assessment. Children may initially be referred for treatment for behavioral problems, and information about past traumatic exposure often only emerges after the initial intake assessment (Lieberman et al., 2011).

Awareness of trauma exposure after the initial assessment is a major shortcoming in the foster care system and leads to inadequate diagnoses and treatment plans for traumatized children. Lieberman et al. (2011) shared in a previous 2009 study, the referral information they studied showed 53% of their clinical sample was exposed to one traumatic event, and 6% were referred with exposure to four or more traumatic events. However, after the initial assessment, a more structured questionnaire was given and

found 70.3% of the sample had been exposed to four or more traumatic events and only 3% had a single traumatic experience (Lieberman et al., 2011).

In 2013, Gregorowski and Seedat reviewed studies to see which assessments were used to help children with trauma histories. The most common assessments were Child Behavior Checklist (CBCL), Trauma Symptom Checklist for Children (TSCC), and the Child Sexual Behavior Inventory (CSBI). In their study, Stolbach et al. (2013) used the TSCC, Children's Depression Inventory, the Diagnostic Interview for Children and Adolescents, and the Children's Dissociative Experiences Scale and Post Traumatic Symptom Inventory (CDES/PTSI). Chambers et al. (2010) used the following assessments in their study: the Assessment Checklist for Children (ACC), Child Behavior Checklist (CBCL), the Kessler Psychological Distress Scale, Ages and Stages Questionnaire Second Edition (ASQ), and the Child Report of Post-Traumatic Symptoms (CROPS). Chambers et al. (2010) used the different assessments to determine the level of care needed for 52 children in out-of-home placement (i.e., foster care) in terms of physical, mental health, and developmental difficulties. As is evident by the large number of assessments mentioned, clinicians are left to learn about and determine the utility of each assessment to decide which ones to use with their clients. Chambers et al. reported the number of assessments was deemed excessive by the caregivers they studied. Chambers and colleagues (2010) further went on to say assessments need to be efficient and readily available.

The Developmental Trauma Disorder Semi-Structured Interview (DTD-SI) was developed by the National Child Traumatic Stress Network (Ford et al., 2018) and is based on criteria established by Stolbach et al. (2013). The interview looks at 15

symptoms divided into six criteria: Criterion A looks at exposure, Criterion B looks at affect/bodily dysregulation, Criterion C looks at attentional/behavioral dysregulation, and Criterion D considers self-relational dysregulation (Ford et al., 2018; Spinazzola et al., 2018; van Der Kolk et al., 2019). For developmental trauma disorder to be a diagnosis, a child must have three out of four symptoms in Criterion B, two of five symptoms in Criterion C, and two of six symptoms in Criterion D (Ford et al., 2018; Spinazzola et al., 2018; Stolbach et al., 2013; van Der Kolk et al., 2019).Criterion E and F pertain to the duration of disturbance in Criterion E and functional impairment in Criterion F. The criteria of post-traumatic symptoms were not used in these studies because the researchers found the symptoms of developmental trauma extended beyond PTSD which was a criterion included in the Stolbach et al. (2013) study.

Diagnosing Developmental Trauma

Developmental trauma as a diagnosis is more parsimonious than giving multiple diagnoses (D’Andrea et al., 2012; DePierro et al., 2019; Foster et al., 2019; Gregorowski & Seedat, 2013; Spinazzola et al., 2018; Stolbach et al., 2013; van Der Kolk et al., 2019). An accurate diagnosis of developmental trauma can help clinicians improve the treatment of emotional, behavioral, and attachment issues for traumatized children (Boris, 2005; Brown, 2015; Cook et al., 2005; DePierro et al., 2019; Gregorowski & Seedat, 2013; John et al., 2019; Lieberman et al., 2011; Scozzaro & Janikowski, 2015; Spinazzola et al., 2018; Stolbach et al., 2013; Szilagyi et al., 2015; Tarren-Sweeney, 2013), as these symptoms extend beyond a PTSD diagnosis (Cook et al., 2005; D’Andrea et al., 2012; DeBellis et al., 2014; DePierro et al., 2019; Foster et al., 2019; Stolbach et al., 2013; van Der Kolk et al., 2019). Children with trauma histories are at risk of showing symptoms of

PTSD, in addition to multiple psychiatric disorders, both internalized and externalized (DePierro et al., 2019; Knefel et al., 2019; Scozzaro & Janikowski, 2015; van Der Kolk et al., 2019). These children face multifaceted difficulties, so clinicians need a more accurate way to assess, diagnose, and formulate treatment plans (DePierro et al., 2019; Greeson et al., 2011; Lehmann et al., 2020; Tarren-Sweeney, 2013).

DePierro et al. (2019) asked clinicians to recall children in their caseload and gave them the Child Complex Trauma Symptom Checklist to determine if their pediatric clients exhibited symptoms of post-traumatic stress disorder (PTSD) or developmental trauma. The researchers also asked about their clients' functional impairment in six domains: school, peer relations, family, health, developmentally appropriate vocation, and legal involvement. Researchers found over half of the clients (52.4%) exhibited comorbid symptoms of both PTSD and developmental trauma. The study also showed those clients who showed the comorbid symptoms of both PTSD and developmental trauma exhibited more functional impairment than someone with PTSD only (DePierro, 2019). Developmental trauma is not in the *Diagnostic Statistical Manual 5th Edition* (DSM-V; APA, 2013), so in place of developmental trauma, clinicians may diagnosis a child with reactive attachment disorder (RAD) if the child is not connecting to their parent, foster parent, or adoptive parent (Barth et al., 2005). The child may receive a diagnosis of oppositional defiant disorder (ODD) if they exhibit rebellious behavior toward authority figures (Harman et al., 2000). In a study conducted by Harman et al. (2000) in southwestern Pennsylvania, an analysis of 39,500 foster children looked at how many had been diagnosed with disorders. ADHD had the highest percentage at 17.7%, oppositional defiance next at 9.8%, depression came in at 5%, conduct disorder was at

3.7%, anxiety disorder at 2.5%, and bipolar disorder was at 0.8%. There was no mention of developmental trauma. Scozzaro and Janikowski (2014) conducted a study looking at 128 foster children and found 76 (59%) had a mental health diagnosis and 9 (7%) had an unknown diagnosis. Again, developmental trauma was not mentioned. If developmental trauma were in the DSM-V perhaps clinicians would be able to provide a different diagnosis.

Stolbach et al. (2013) performed a study to determine how often children exposed to chronic traumatic experiences qualified for a diagnosis other than PTSD. Stolbach and colleagues (2013) developed seven criteria to help determine whether a child could be diagnosed with developmental trauma. The seven criteria were: (a) exposure, (b) affective and physiological dysregulation, (c) attentional and behavioral dysregulation, (d) self-and relational dysregulation, (e) posttraumatic spectrum symptoms, (f) duration of disturbance, and (g) functional impairment.

Exposure was determined if the child had a direct experience or witnessed repeated and severe interpersonal violence. After the level of exposure was obtained, affect and physiological regulation was observed (Stolbach et al., 2013). The second criterion, affective and physiological dysregulation, was determined if the child presented impaired developmental capabilities related to emotional regulation (Stolbach et al., 2013). For this criterion to be met, the clinician must observe the child being unable to do two of the following: modulate, maintain composure, and to recover from extreme emotional stress. The second indicator of affect/physiological dysregulation was if the child had difficulty in regulating bodily functions (e.g., sleep, eating, waste elimination, disorganization during routine transitions, and either hyper- or hypo- sensitivity to touch

and sounds). The final two criteria in the affect/physiological category were dissociation of sensations, emotions, and bodily states, and a reduced capacity to describe both emotions and bodily states.

The third criterion developed was attentional and behavioral regulation (Stolbach et al., 2013), which is when the child exhibits reduced abilities in maintaining attention, learning, or coping with stress (Stolbach et al., 2013). To meet this criterion, three of the following should be observed: (a) a child is unable to recognize a threat, including misreading dangerous situations; (b) a child has a lack of understanding of self-protection, sometimes to the point of risk-taking; (c) the child has inappropriate ways of self-soothing (e.g., rocking, compulsive masturbation); (d) the child has a habit of self-harming behavior; and (e) if the child is unable to maintain or initiate goal-directed behavior.

The fourth criterion for developmental trauma is self- and relational dysregulation. Self- and relational dysregulation are observed if the child shows a reduced ability concerning their sense of self-identity and their involvement in relationships (Stolbach et al., 2013). To meet this criterion, the child needs to exhibit at least three of the following six behaviors: (a) an inappropriate preoccupation with the caregiver's safety or even a difficult reunion after separation; (b) a constant negative sense of self (e.g., self-loathing, helplessness, worthlessness); (c) an extreme and constant lack of trust and defiance; (d) presents with very aggressive behaviors, both physically and/or verbally to peers, caregivers, or other adults; (e) inappropriate attempts for intimate contact, including either sexual or physical intimacy; and (d) presents with an inability to show empathy (Stolbach et al., 2013).

The next two criteria for developmental trauma are posttraumatic spectrum symptoms and duration of disturbance (Stolbach et al., 2013). Posttraumatic spectrum symptoms should include at least one symptom in two of the three posttraumatic stress disorder (PTSD) categories of Criterion B, C, and D. The duration of disturbance was met by symptoms in Criterion B, C, D, and E occurring for at least 6 months. The final criterion to meet was functional impairment, which is met by clinically significant issues in two of the following areas: scholastic, family, peer group, legal, health, and vocational (Stolbach et al., 2013). Scholastic issues for children can present as underperformance, nonattendance, dropping out, disciplinary issues, and conflict with school personnel. Issues with family members include conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, and nonfulfillment of responsibilities in the family. The next criterion observed are issues with the child's peer group, which include isolating behavior, deviant affiliations, constant conflict either physical or emotional, involvement in unsafe acts, and age-inappropriate relationships. The legal criterion indicates whether the child has arrests/recidivism, detention, convictions, increasing levels of offense, crimes against others, and contempt for the law or moral standards. Health issues observed include physical illness or problems which cannot be accounted for, such as physical injury, digestion problems, and neurological issues. The final item in this criterion is vocational, which is observed if the child/adolescent has difficulties in finding or keeping a job if the child/adolescent is interested in finding work (Stolbach et al., 2013).

This section considers some of the main criteria children must meet to be accurately diagnosed with developmental trauma and PTSD. However, even when

clinicians can successfully diagnose a child's problems, there are often barriers which need to be overcome to move to successful treatment.

Barriers to Treatment

Many children with trauma histories do not receive adequate mental health services (Perry, 2009). Some barriers to treatment for foster children include the lack of complete health information, the high cost of treatment, complicated communication between both the court system and the foster care agency, and placement instability (Gardenhire et al., 2019; Hanson et al., 2010; Shea, 2015; Szilagyi et al., 2013). If a child with a trauma history is in foster care, the foster care agency might not be fully aware of the trauma, and it then follows neither the foster parents nor the clinician is aware of the trauma as well. Before being removed from the home originally, the biological parents might not be cooperative with information about the child's previous healthcare providers (Gardenhire et al., 2015; Szilagyi et al., 2015). Once working with the child, it is imperative for the clinician to feel confident in the information they have about the child's history to best design the intervention used.

Clinical social workers who use attachment-based interventions shared experienced feelings of helplessness, hopelessness, and a lack of confidence when working with foster children (Shea, 2015). The social workers interviewed by Shea (2015) shared feelings of helplessness and hopelessness came from a few sources including experiencing the same anger and frustrations as the child at times mirroring feelings of wanting to avoid or disengage. One source of hopelessness and helplessness came from clinicians who struggled to engage the foster child in facilitating repair and developing attachment security. The social workers shared with Shea (2015) at times it

felt exhausting to maintain high levels of attunement between the foster parent and child. Shea's (2015) findings were of the 42 clinicians interviewed 58% cited their lack of confidence in doing attachment-based interventions was due to the inconsistent participation of the foster parent. Another source of helplessness and hopelessness was described by 43.59% of clinicians who reported communication, collaboration, and planning factors impacted their confidence. Clinicians faced difficulties in planning sessions with children in the foster care system, including communication with the court system and the foster care agency, poor documentation or follow-up by referral sources, and instability of placement causing difficulty in planning sessions (Shea, 2015). Family-related issues, such as not knowing where the child would be living, impacted 15.39% of the clinicians in terms of their confidence. Social workers expressed feelings of burnout from inconsistency in treatment planning, and lack of engagement by the parents or foster parents.

Burnout impacted 17.95% of the clinicians in the Shea (2015) study based on the instability of scheduling appointments and cuts in spending for social services by government agencies, which left clinicians under-resourced. Burnout was found to predict psychological distress (Harker et al., 2016). Kim et al. (2018) surveyed 733 clinicians from 65 agencies and found the hours spent at work and the number of evidenced-based modalities the therapists used with clients were associated with burnout, or as the researchers referred to it, emotional exhaustion. Sprang et al. (2011) surveyed a sample of 669 professionals, comprised of child welfare workers, health care, and behavioral health, and found males reported significantly higher rates of burnout than

their female counterparts and African Americans and Asians reported significantly higher rates than their Caucasian counterparts.

Training was another factor in clinicians' lack of confidence, which affected 15.39% of those who participated in the study by Shea (2015). Weir et al. (2008) surveyed 244 accredited clinical programs with a breakdown of 78 Council for Accreditation of Counseling and Related Educational Programs (CACREP), 42 Commission for Accreditation for Marriage and Family Therapy Education (COAMFTE) programs, and 104 Council of Social Work Education (CSWE) programs to determine the level of training concerning foster care, adoption, and child welfare issues. Out of the 42 COAMFTE programs surveyed, only 48% have specific coursework in adoption and foster care, but 19.77% of graduates work in the field. Of the COAMFTE programs, 40.5% reported they offer the topic of adoption as a component in another course and 47.6% mentioned they offer foster care content as part of another course. Out of the 79 CACREP programs, 52% reported they have specific coursework in adoption and 2.6% had foster care specific coursework. 54.5% of the programs mentioned they offer adoption content in another course. The percentage of graduates working in the field of foster care and adoption was 13.38%. However, concerning CSWE programs, 16.3% of the 104 programs surveyed have coursework specific to adoption and 22.1% specific to foster care, with 25.7% of graduates working in the field. Child-development-specific courses went as follows: CACREP 87.0%, COAMFTE 90.5%, and SCWE with 63.1%. Even more trauma-specific coursework might be necessary.

As shown, there are difficulties in working with children with maltreatment histories. Those difficulties can come from a lack of full information from the foster care

agencies, biological parents, the court systems, and the possibility of multiple residential placements. A lack of understanding developmental trauma may pose difficulties in working with children with maltreatment histories. Difficulties can further arise for clinicians in ways of training, feeling confident in using interventions, setting a treatment plan, burnout, and vulnerabilities of the clinician. The difficulties mentioned provide the rationale for performing the current study.

Study Rationale

Trauma can impact a child's brain, causing changes which disrupt normal brain development and skills learned (Fujisawa et al., 2018; Perry, 2009; Takiguchi et al., 2015; Teicher et al., 2012). Children with developmental trauma struggle with emotional and behavioral regulation as well as relational issues (Anda et al., 2006; Belsky & de Haan, 2011; Bruce et al., 2009; Carliner et al., 2017; Carrion et al., 2009; Cook et al., 2005; D'Andrea et al., 2012; Gold et al., 2016; Gregorowski & Seedat, 2013; Hunter et al., 2011; Kelly et al., 2013; McCrory et al., 2013; Oshri et al., 2019; Scozzaro & Janikowski, 2015; Shonkoff et al., 2012; Shrivastava et al., 2018; Tarren-Sweeney, 2013; Tottenham et al., 2010; van der Kolk, 2005; Whittle et al., 2013). The population of children with trauma histories underutilize mental health services because of parental or caregiver concerns with taking time off work, transportation issues, treatment costs, and finding a clinician with expertise in trauma treatment may be difficult (Rugg et al., 2016). Finding a clinician who understands developmental trauma and what is needed to help the child is essential. Training in working with trauma and understanding how developmental trauma can impact the child and the therapeutic relationship are important.

Education and training are essential when working with a vulnerable population such as children with trauma histories. The Weir et al. study of 2008 and reiterated by Gardenhire et al. in 2019 showed graduate programs do not have dedicated coursework for students who want to work with trauma and trauma experienced by children. Shea's (2015) study reiterated over 15% of clinicians surveyed were struggling with working in the foster care system due to the level of training they received. This study may shed light on how additional training is needed to help clinicians feel confident in working with this population.

In addition to finding a skilled and qualified clinician, the next step is to assess the child's level of developmental trauma, which helps in developing a treatment plan. This treatment plan should consider what interventions can be used with children with trauma histories, and when or how the interventions should be modified. Therefore, the researcher asked questions to understand how clinicians work with children with trauma histories where developmental trauma is present.

Understanding how clinicians view the impact developmental trauma has when working with children who have trauma histories is imperative to the clinical community. Regarding how the diagnosis of developmental trauma is not in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)* clinicians need to find an adequate diagnosis and treat children with trauma histories. With that in mind, speaking with clinicians in the field about their experiences when working with children exposed to trauma is invaluable. As for the limitations of their study, DePierro et al. (2019) stated they did not pose any questions to the clinicians regarding the type of training, highest degree earned, services provided, and years of experience. DePierro and colleagues

(2019) felt it would have added more context to their analysis if they had. The researcher for this study sought to help fill this gap by providing details regarding experiences with the population of children with trauma histories, diagnoses, and assessments from the perspective of clinicians.

The literature in understanding developmental trauma and the difficulties in working with children, and foster children who exhibit symptoms has now been broadened by the findings of the current study. After the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* was written in 2013, researchers did not stop studying the phenomenon of developmental trauma or the impact trauma has on the brain (DePierro et al., 2019; Ford et al., 2018; Fujisawa et al., 2018; Knefel et al., 2019; Scozzaro & Janikowski, 2015; Spinazzola et al., 2018; Takiguchi et al., 2015; van Der Kolk et al., 2019). There is an ongoing need for proper assessments, diagnoses, and treatment plans when working with children with trauma histories. This researcher and the findings of this study, provided an understanding how developmental trauma impacts the child, help clinicians gain an awareness of how to work with children who exhibit developmental trauma, and help potential students or new clinicians understand what their role will be if they decide to work with this population.

Research Questions

The researcher wanted to investigate the experiences of clinicians who work with children with trauma histories, and how they understand developmental trauma. The researcher sought to explain the perceptions and experiences of clinicians in how they

work with developmental trauma. In this qualitative study, the research questions included:

1. What are clinicians' lived experiences working with pediatric populations with developmental trauma?
2. What are clinicians' understanding of developmental trauma in children and its impact?
3. How does the presence of developmental trauma in their patients influence treatment planning and implementation?

Chapter 2: Qualitative Methodology

Philosophical Worldview and Design Strategy

Research studies begin with an interest or a concern (Creswell, 2014; Ravitch & Carl, 2016). The goal of the study can stem from personal and professional goals, prior research, or a combination of influences on the researcher's values, thoughts, and interests (Ravitch & Carl, 2016). Qualitative research pursues an understanding of how people make sense of an issue and their experiences, and how they process the world around them (Creswell, 2014; Merriam, 2009). Of the varying methods of qualitative research, phenomenological research has its origins in philosophy and psychology (Creswell, 2014), allowing the researcher the opportunity to engage participants in interviews to ascertain their understanding of a phenomenon based on their own experiences (Merriam, 2009).

Phenomenology is both a philosophy and a methodology of research which aims at understanding the meanings people give to their quotidian lives (van Manen, 2014). There are two different schools of thought regarding phenomenology, originating with Edmund Husserl and Martin Heidegger. Husserl is considered the father of phenomenology (Peoples, 2021). Husserl believed a researcher had to be a stranger in a strange land, knowing nothing about the topic, and putting all biases to the side. On the other hand, Heidegger, a student of Husserl, proposed the researcher does have biases and they should be known. Heidegger posited the researcher was constantly looking through the lenses of new information (Peoples, 2021). Each person is considered *dasein*, being in the world. To understand the essence of a phenomenon one must use the *hermeneutic circle* (Peoples, 2021). The hermeneutic circle is a constantly changing process. A

researcher might have preconceived ideas of the phenomenon (*foresight*), and as new information is gathered the preconceived ideas change. It is through this revisionary lens an understanding of a phenomenon and the lived experiences of people takes place, which is called the hermeneutic circle (Peoples, 2021). This study used the Heidegger phenomenological research method, in which the researcher knew her bias, made them known, and used the information to change the lens of knowledge of the phenomenon of developmental trauma.

According to Seidman (2019), phenomenology makes meaning out of lived experiences. The phenomenological philosophy uses reflexivity to gain this knowledge. Questions can help a person reflect on the meaning of an event regarding seeing, hearing, and being in touch with the world. Phenomenology is more of a method of questioning than answering (van Manen, 2014), and with deeper questions comes deeper meaning (Seidman, 2019) for both participant and researcher (van Manen, 2014). A deeper understanding for the researcher is shown in the writing of the study (van Manen, 2014). Van Manen (2014) stated writing itself plays a reflective role in the phenomenological method.

This phenomenological research design is meant to be conducted with the use of interviews via a video platform using open-ended questions. Interviews are a way to “see stories and the details of people’s lives as a way of knowing and understanding” (Seidman, 2019, p. 1). Answering a question may lead to the need to ask for more details or another question might stem from the answer given.

This study was based on a phenomenological philosophical worldview, which assumes individuals seek to understand the world in which they live and work by placing

meaning on their history, cultural, and social experiences (Creswell, 2014). According to Merriam and Tisdell (2016), every perception is given equal value, and perceptions are linked thematically to derive a full descriptive meaning. The researcher chose this worldview and methodology based on the desire to understand, diagnose, and treat developmental trauma better. Giving clinicians the space to share their experiences in working with this population was helpful not just for the researcher clinically, but for other clinicians as well. As stated in the study of DePierro and colleagues (2019), in previous studies no questions were asked of the clinicians about their training, years in practice, or even their experiences working with this population. This study added to the literature on developmental trauma and the need to consider it as a possible diagnosis in more cases.

In the next section, the researcher describes the procedures used during the study. The following sections entail the research design, sample characteristics, participant recruitment procedures, data collection, and analysis. The researcher also details the procedures used to enhance credibility, reliability, validity, anonymity, and protection of the participants.

Research Design and Methodology

Population and Sample

The main goal of a Heideggerian phenomenological research study is to acquire information saturation. When no more saturation occurs, the researcher has enough information to draw conclusions (Peoples, 2021). The researcher looked for approximately 6–8 participants with either a master's or doctorate. Degrees can be held by master-level therapists, psychologists, and clinical social workers. The inclusion

criteria include a minimum of 5-years of postgraduate experience and experience working with children who have trauma.

Participants for this study were recruited via Facebook blasts, various Facebook therapists' group pages, and emails to various agencies which provide services to children who are likely to have experienced trauma. A range of clinicians and professional backgrounds was desired, such as master's and doctorate levels of degree, private and community counseling centers, and varying years of experience, thus providing a breadth and depth of information. Once the participants were recruited, they were given a link via Facebook or email to read the consent form (see Appendix B) on an electronic survey platform. After the consent form was signed, the participant was given a screener questionnaire.

The screener questionnaire consisted of 10 questions asking about age, gender, race, years' after graduate school of professional work, preparedness for working with this population, training received to work with children with trauma histories, the setting of practice, and experience working with children who have been abused and/or neglected (see Appendix C). The answers given here were to add knowledge even if the participant is not interviewed regarding training and preparedness.

Interviews

The interviewing process focused on the experiences of the participants and the meaning they associate with a phenomenon or experience (Seidman, 2019). The interviews were semi-structured, which allowed the opportunity to ask questions as they arose based on the responses of other questions to elucidate deeper meaning (Creswell, 2014; Merriam & Tisdell, 2016). Asking a second question helped the participant go

deeper and search for more meaning than what had been shared already (Merriam & Tisdell, 2016; Seidman, 2019). The interview questions and the conversation allowed the researcher and the participant to delve deeper into how the participant understood their own story. The researcher needed to listen intently to the participant to find cues to go for the deeper meaning (Seidman, 2019).

Seidman (2019) stated an interviewer needs to listen on three levels. The first level of listening is listening to what the participant is saying. The second level is listening to what is not the public voice. The public voice is what happens when the participant feels they are talking to an audience. Interviewers look for more of a thoughtfulness or reflective voice. The final level of listening during an interview is being aware of time. The interviewer must be aware of what has been covered and what has yet to be discussed.

The interviews were 90 minutes long in duration, as recommended by Seidman (2019), to ensure enough information is gathered to explicate meaning. During the interview questions about history (e.g., education and why they chose to work with this population), current position (e.g., client base and how long at the position), and understanding of developmental trauma were discussed. Questions about assessments (what if any are given), treatment planning (putting together a treatment plan), diagnosing (what diagnoses are given), and interventions (which modalities and if modifications are made) were asked. Also, questions regarding the length of treatment, difficulties with progress, and when or if the clinician has referred a child to another clinician were discussed (see Appendix D). The next section talks about how the researcher sought to provide reliability, credibility, and validity to the study.

Study Reliability, Credibility, and Validity

Protection of Participants

The researcher sought approval from the Institutional Review Board to ensure proper protocol when implementing the study. No identifying information was asked of the participants, thus protecting the participants' confidentiality. The participant at the time of the consent form and after the interview received resource information for potential distress. To protect their identity, each participant was given a number for reference purposes.

Reflection on Researcher's Biases/Assumptions

According to Merriam (2009) and Peoples (2021), rather than try to eliminate biases a qualitative researcher has, they need to be identified and explained. For the Heideggerian phenomenological researcher, stating bias is an integral part of the process (Peoples, 2021). Statements of identified biases allow the researcher to monitor them during the data collection and interpretation phases. The topic of abuse and/or neglect and the understanding of developmental trauma does hold biases for me, the researcher.

My desire to work with those who have been abused and traumatized stems from my background as a survivor of childhood abuse. I experienced physical, verbal, emotional, and spiritual abuse as a child and teenager. Daily, I dealt with feelings of not being good enough and needing to be in control. The need for control provided safety for me, as I had internalized not being good enough as my voice. When I became a mother, I wanted to treat my children better than I was treated. I wanted them to feel loved, wanted, and cherished. I wanted them to know I loved them, but, at times, their behavior caused problems. I came up with games to deescalate the anger they felt toward each other and

the frustration I was feeling towards them. The games allowed all of us to calm down and be able to talk about our behaviors in a better way. Having the courage and the desire for something better for my children gave me the passion to help others who have been abused, to not perpetuate abuse to the next generation. During my undergraduate studies, I had courses in developmental psychology and Bowlby's seminal work on attachment theory, but I was not prepared for the children and adolescents I would later see in my internship.

Over the past couple of years in my internship, I worked with children who have been adopted, either out of foster care or kinship care. During that time, I came to recognize how pervasive anger, fear, and the need for control are for those children and adolescents. I saw families where the children were adopted out of foster care, kinship care, or currently living with relatives (not adopted). Two young girls were placed in foster care when they were young and adopted by their foster parents. Two young men were adopted at the ages of 9 and 10 from an abusive and neglectful environment in kinship care and were turning 14 and 15 when I started working with them.

Both young girls had issues with anger and the younger sister needed to control others around her. Her anger was quick, volatile, and not easy to manage. The younger sister needed to control everyone, including her sister, mom, grandparents, and friends at school. When someone would not do as she wanted, she became very angry and hostile. I worked with both girls on how to manage their anger and the emotions behind the anger. We did sandtray exercises when looking at the need to control. Sandtray is a therapy where a prompt is asked of a person, and they will use miniatures in a container of sand to put their world together to answer the prompt. The clinician asks questions about the

world to understand the world put together. After a year and a half of weekly back-to-back individual sessions, their mom and grandmother felt a lot of improvement had happened, and they terminated treatment.

That experience was strikingly different than working with the two young men. The young men were adopted when they were 9 and 10. Their biological mother was addicted to drugs and was neglectful. Both boys were left to fend for themselves. The older brother who was 5 or 6 would go to his grandmother's apartment in the same complex for some attention and affection, leaving the younger brother alone with their mother. When the grandmother died a few years later, the boys were taken in by family members. This proved chaotic as the younger of the two boys became violent. He ended up in a hospital for observation when he was 8 years old. By this time, both boys were in the process of being adopted by a couple and were waiting for the adoption to be finalized. I first started working with the younger brother, who had been doing self-harming behaviors. A few months after helping with that issue, the parents asked if I could also work with his older brother.

I had the two boys on my client list for almost 2 years. We had weekly sessions about anger, trauma histories, anxiety, behavioral issues, emotional issues, and violent behavior. There would be weeks where I felt progress, but the very next week the progress was not apparent. Small progress was made in the self-harming behaviors stopped, and some of the anger issues had ceded, but overall, there was not much progress in the other areas.

I recognized these two young men needed more and I might not be able to provide the level of care they needed. As an intern, we learned about what our strengths are and

where we might need more guidance and training. In the case of the two young men, I felt I needed more training to not only assess some of the behavioral and emotional issues but also how to provide interventions that would help them heal from the painful events of the past, especially when they did not want to face what happened to them with their biological family.

Reliability and Validity

The questions for this study were formulated using consultation and review by practicing psychologists with expertise in childhood trauma. The researcher paid careful attention to participants' wording and meaning. With the interviews being recorded via an online platform and transcripts provided via the platform, in vivo coding was available, bringing a source of validity to the study. Other sources of establishing reliability and validity were also pursued.

One method of establishing reliability and validity was to use the services of a peer debriefer. A peer debriefer asked the researcher questions to understand how the personal perspective and value system of the researcher impacted the results of the findings (Spall, 1998). Modifications made due to the interaction of the peer debriefer will be mentioned during the process (Peoples, 2021).

Another form of establishing reliability and validity is to use intra-rater reliability. An intra-rater reads over the transcripts of the interviews and establish their codes. The researcher then looks through both codes and finds the commonalities between the two sets of codes (Moors, 2020). With the use of the intra-rater and the researcher's codes, more balanced and enriched results may be determined.

As mentioned previously, the participants received a copy of the coded interview to garner feedback (Merriam & Tisdell, 2016; Seidman, 2019), which is called respondent validation (Merriam & Tisdell, 2016) or member checking (Peoples, 2021). The participants received a copy of the researcher's transcript and were offered 10 days to provide feedback. Participants determined if the researcher interpreted their words correctly and placed emphasis where the participant wanted (Merriam & Tisdell, 2016). This was done via an email conversation after the participant had a chance to view the transcript and of the interview. There was a second member check performed when the final codes were developed, and each participant received 5 days to review for any last insights or thoughts.

Chapter 3: Results

Chapter 3 presents the research findings and makes connections between the findings of the study and the Heideggerian phenomenological philosophy of using the hermeneutic circle. I discuss the process of data collection and analysis and explain the procedures used to demonstrate validity and reliability in the study.

Data Collection Procedures

Due to recent circumstances with the COVID-19 global pandemic, interviews were conducted on a video conferencing platform after participants completed a screening questionnaire. Once they met inclusion criteria, participants were provided an informed consent form, stating what the study entailed and asking for their agreement to participate in the study. At any time during the questionnaire, participants were able to discontinue without penalty. The interviews were conducted on an online video conferencing platform, which allowed the researcher to both record and have transcriptions made of the interviews. With the recordings, it was then possible to review the interviews to closely observe the body language and tone of voice during the interview. With the transcriptions, the researcher was able to search for themes, commonalities, and even differences of opinion. The researcher made notes and observations were made during the interviews as well for more data points.

All interviews but one took place via an online platform of Microsoft Teams. The lone interview took place on Zoom due to a lack of ability to connect to Microsoft Teams on the participants' end. The interview was still recorded and transcribed. At times, there was a connection issue or interruption; but otherwise, the interviews proceeded smoothly. All interviews were in the designated time allotted. Notes were taken during the interview

for follow-up questions, thoughts, insights, feelings, and observations about the participants (Merriam & Tisdell, 2016; Saldaña, 2016; Seidman, 2019). According to Seidman (2019), working notes are a way to highlight a word or two of importance while not interrupting the participant as they are speaking; the researcher could return to those questions or thoughts later. The researcher is considered an observer during the interview, according to Merriam and Tisdell (2016), and should take notes on symbolic meanings of words, nonverbal communication, and what the researcher is thinking during the interview.

Data Analysis Process and Procedures

The interviews, field notes, and the screening questionnaire were data used to help foster an understanding of how clinicians work with developmental trauma (Merriam, 2009). In vivo coding and note-taking took place due to the availability of recording the interview via the video conferencing platform. The participants' thoughts and feelings about how they view developmental trauma were observed and collected. How the clinicians approached each client, and the trauma history was coded.

Peoples (2021) suggested discussing how each coded theme connected to the researcher's process in the hermeneutic theoretical framework. The researcher developed this framework of dasein, foresight, and the hermeneutic circle to ascertain codes and themes based on the perceptions of the researcher's experience with the transcripts of the interviews. The researcher used dasein to see how the interviews impacted the researcher. Foresight was used to see what preconceived ideas the researcher had about the topic. The hermeneutic circle is an ever-changing concept of ideas with new information, when used shifted the perspective of the researcher. The same framework of dasein, foresight,

and the hermeneutic circle was also adopted to explore the participant's experiences in working with this population.

The researcher developed codes by using the emotions of the participant (emotion), the facts about the participant (descriptive), the values of the participant (value), and numerous others. As codes emerge from the text, themes were developed, checked, and rechecked. Initial coding for the first cycle of coding, and axial coding for the second cycle of coding was used for this study (Saldaña, 2016).

Initial coding can use in vivo coding and process coding as the data is collected (Saldaña, 2016; Seidman, 2019). In vivo coding uses the participants' own words to code the data, and process coding is determined by the action indicated in the data (e.g., surviving pain, avoiding others). The researcher goes line-by-line to determine the code of the line and places the code in the right-hand margin of the transcript with a numeric identifier. The same identifying number is placed by the item coded in the transcript. Initial coding using both in vivo and process codes allows for a plethora of codes to categorize together between the first and second cycle of coding where axial coding took place (Saldaña, 2016).

The second cycle of coding was axial coding. Axial coding links together categories from the initial coding to find dominant and lesser categories (Saldaña, 2016). Grouping of similar codes from the first cycles may form conceptual concepts which can lead to formulating themes in the codes (Saldaña, 2016). Analytic memos aid the process in both the first and second cycles of coding. Analytic memos are thoughts, ideas, and concepts the researcher identifies during the coding process to help move the researcher in more expansive directions (Saldaña, 2016).

There are 12 possible memo opportunities for the researcher to reflect and write on (Saldaña, 2016). The first memo can be about how the researcher connects to the participant and/or the phenomenon. This memo entails examining the researcher's emotions, attitudes, values, and beliefs about the phenomenon. Another memo can be about the participants' routines, roles, rules, rituals, and relationships. This memo details who the participant is in a social environment. The third memo reflects on emerging patterns, categories, and themes. This is made possible by comparing what has already been categorized and marked. A possible memo option would be to bring together overlaps or links to other patterns, categories, and themes. Reflecting on possible or emerging theory is another memo option. Discussing and reflecting on problems with the study could be a memo opportunity. A reflection on any ethical dilemmas with the study would be another memo option. Future directions for the study would be another memo option. A meta-memo reflection of all the memos to date is another memo opportunity. A reflection on possible answers to the research questions is another memo possibility. A reflection on writing the final report of the study is the 12th option for an analytic memo. These memos are meant to help the researcher stay focused on the coding process and continue to seek out the recurring patterns (Saldaña, 2016).

The researcher decided to use three memos. The first memo was the researcher's emotions, attitudes, values, and beliefs about the phenomenon. Another memo was about the participants' routines, roles, rules, rituals, and relationships in a social environment. The third memo reflects on emerging patterns, categories, and themes. This was made possible by comparing what had already been categorized and marked (Saldaña, 2016).

All processes during the coding phase occurred at the same time as still protecting the participants, seeking reliability, and proving validity.

Reliability and Validity

The researcher took steps to ensure reliability and validity during the study. A peer reviewer was brought in during the interview process to discuss potential biases of the researcher. Intra-rater reliability occurred before participants received the second member check. The participants received a copy of the transcript with the initial codes assigned and a second time once all the themes were narrowed down to garner feedback on the interpretation of the interview.

The researcher brought in a peer reviewer to talk about potential biases and interpretation of data. The peer reviewer was found on a freelance site. The reviewer had questions for the researcher about the content and how the researcher processed the information presented by the participants. The researcher provided discussion around the initial reason for the study to give the context of the reasoning and purpose of the peer reviewer. Not unlike the researcher, this person was a survivor of childhood abuse and felt an affinity with the content being presented. The peer reviewer shared how nice it would have been if this had been presented when she was a child to have gained more help growing up. She asked questions about how clinicians went about finding out about developmental trauma as it was not necessarily discussed in graduate schools. The reviewer asked the researcher how the information presented impacted the researcher. She wanted to know if any of the content being provided to the researcher brought up any memories for the researcher.

Once the coding phases were complete, the researcher performed an intra-rater reliability test. After the first set of codes were found with one transcript, the researcher went back and recoded the transcript to find consistencies in the coding. The kappa statistic for the intra-rater test was .896 ($p < .001$).

After the coding phase, each participant was given a copy of the transcript with the initial codes attached to the dialogue in what is called member checking (see Appendix E). Each participant was given 10 days to review the transcript and provide feedback as to interpretation and potential new insights on what they shared (see Appendix F). This was also to ensure the participants recognized any discrepancies they needed or wanted to have changed. It appears some of the transcript copies did not include the codes, as one participant shared. One participant asked for more information to ascertain their feedback. Seven out of the nine returned their feedback. One participant shared a further explanation of one of his statements to help with understanding or clarifying his comments.

As themes were narrowed down further, the researcher sent another presentation of the final codes for a second member check to assess whether their thoughts and feelings were captured correctly (see Appendix G). Each participant had 5 days to view the final codes and provide feedback (see Appendix H). They received a copy of the questions asked, with the themes derived from the interviews. The participants were able to read not only the quotes used by them but also what other participants shared and were allowed to add new thoughts to their quotes in the dialogue. This step was to ensure the credibility and reliability of the data collected. Three out of the nine participants responded to the second request for feedback. Two mentioned everything looked

wonderful from their perspective, and one participant reached out with changes to her quotes for more clarity on what she shared.

Participant Demographics

There were nine participants, including seven females (77.7%) and two males (22.2%). The mean age range of the participants was 35–45 years of age (see Table 1). Eight participants reported working in private practice (88.8%), and one (11.1%) was employed at a community counseling center. All participants had master's degrees in their desired fields. Everyone had over 5 years of postgraduate work. On feeling prepared to work in the field with the population of developmental trauma three (33.3%) reported yes, one (11.1%) reported maybe, and five (55.5%) reported no. Relevant information about the participants and their experiences in working with children who have developmental traumas was discussed during their interviews.

Table 1

Participant Demographic Data

Participant	Age	Gender	Race	Prepared to work with population	Degree	Time practicing post grad	Currently practicing
P1	35-45	Female	White	Maybe	Masters in Counseling	10+ years	Private practice
P2	35-45	Female	White	No	Masters in Counseling	10+ years	Private practice
P3	35-45	Female	White	No	Masters in Social Work	10+ years	Private practice
P4	55-65	Female	White	No	Masters in Counseling	10+ years	Private practice
P5	55-65	Female	White	Yes	Masters in Counseling	5-10 years	Private practice
P6	45-55	Male	Other	No	Masters in Counseling	10+ years	Private practice
P7	35-45	Male	White	No	Masters in Counseling	10+ years	Private practice
P8	35-45	Female	White	Yes	Masters in Social Work	10+ years	Community counseling center
P9	45-55	Female	White	Yes	Masters in Counseling	10+ years	Private practice

Participant 1 had not initially wanted to work with children. Her supervisor suggested she work with a child whose parents were going through a divorce around the same age as when the participant had witnessed her own parents' divorce. The sessions with this child brought up memories and feelings for the participant she knew she needed to process and work on for herself, but not during the therapy session for this child. The participant recognized while she had training in working with children, she had not been prepared to feel herself become activated or triggered during sessions. Unsure of what to do with those feelings she eventually developed her modality of intervention to help therapists be present during the session while containing the feelings and thoughts coming up for the therapist.

Before receiving a master's degree in counseling, Participant 2 had a degree in forensic psychology. She mentioned the degree focus did include discussions about the abuse but from the perpetrator's perspective. She had what she considered to be a unique undergrad internship helping with sex offender treatment. She said:

> And that really sparked my interest moving away from what causes it to, oh, these folks can really change. Not only can you commit really heinous acts really horrible aggressions against other people, but you can also learn not to, you can also grow out of that.

Participant 3 had a background in international human rights and children's rights when she went back to grad school for a second master's degree in social work. She had interned working with refugees with the United Nations. She also has experience working with the Red Cross and disaster relief. She became a volunteer with CASA. Her internship for grad school was with the Department of Human Services.

Participant 4, like Participant 1, initially did not set out to work with children. She was interested in using sandtray therapy, studying extensively to become proficient and nationally certified, and found children gravitated to that modality of therapy. According to Participant 4, "So it seems like it just kind of naturally developed." For Participant 4, she recognized she had her own areas of developmental trauma she needed to work through and was still work on.

Participant 5 ran an international kid's camp for abused children for 11 years. She created a curriculum, trained staff, and "introduced good Christian people to the world of the abused child." Some of the children who came to the camp were from Ethiopia, Russia, China, and Haiti. She witnessed how the children who came from orphanages in

both Russia and China were traumatized. After running the camp, she decided to go to grad school and become a therapist. She had seen too many foster care children being bounced around and wanted to help them.

Participant 6 shared before he went to grad school to get his master's degree in counseling, he was a humanitarian aid worker in Asia. He mentioned he was, "being introduced to collective trauma." He shared he has, "been drawn to trauma, partly because of [his]own experiences and because of [his] humanistic drive to make the world a better place." When he started to work in the field, he worked for a rural community nonprofit where he did both group and individual work with kids. The therapies he used with the children were play therapy, art therapy, and family systems. The nonprofit had a ranch with two therapists per group of no more than five children. The therapists would take the kids into nature, riding horses, hiking trails, take the kids to an art center, a sports field, and climbing wall ropes. This had been an after-school program run by the nonprofit. He now has a private practice and trains new therapists on how to work with those with trauma stories.

Participant 7 was initially introduced to developmental trauma due in part to working with a 4 year old who was diagnosed with bipolar. He mentioned he was seeing it firsthand and did not understand what was happening, so he went back to school to find out more. He said, "I saw the developmental trauma before I knew anything to do about it."

Participant 8 mentioned she scored high on the Adverse Childhood Experiences Scale (ACEs), a diagnostic measure developed by Felitti and colleagues in 1998, and these experiences have shaped how she is with her clients. She stated:

> The other piece of it that is really important about that is that having experienced those things allows me to look at children, especially these kiddos who have some really intense behavioral challenges, right. It allows me to be with them in a way that I think is softer and more tender because I don't look at them and go, "oh God, this kid is such a brat." Right. I look at them and go, wow, you are trying so hard to figure out this really intense existential thing that no one should have to figure out at your age and here you are trying to do it.

Participant 9 is originally from another country. She came to the United States for her bachelor's degree and went back to her home country where she began to work in the social welfare system. She mentioned the therapy used in her home country was cognitive behavioral therapy (CBT).

Analysis of Data

There were three overarching research questions for this study:

1. What are the clinician's lived experiences working with the pediatric population with developmental trauma?
2. What are clinicians' understanding of developmental trauma in children and its impact?
3. How does the presence of developmental trauma in their patients influence treatment planning and implementation?

To answer these poignant queries, the researcher posed 17 questions to each participant. Four questions pertained to the first initial research question, four questions regarding the second research question and the remainder seven questions dealt with the final question

and one question was a question regarding referrals. The question was asked to ascertain how the participants received their clients (see Table 2).

Table 2

Referrals

Referral	P1	P2	P3	P4	P5	P6	P7	P8	P9
Past families		X							
Psychology Today		X							
Word of mouth		X					X		
Web							X		
Services in schools		X							X
CPS									X
DSHS	X		X		X				
Court-appointed					X				
Insurance referral				X			X		
Parents	X			X					X
Through agency								X	
No longer working with the population						X			
Previous contract with state					X				
Doctors	X								

Each of the participants shared they receive their pediatric clients in various ways. Parents and DSHS each had three (33.3%) respondents mention this is how they received their pediatric clients. Two (22.2%) respondents reported they receive their clients through word of mouth, services in schools, and insurance referrals. The other answers given each had one (11.1%) participant mention this avenue as a referral source. Participant 6 shared he no longer saw children, but he did share: “so I used to work in a nonprofit community, mental health, where we’d accept state insurance, but I haven’t worked for them for a number of years now.” This participant was now a trainer and consultant for other therapists learning how to work with people who have suffered

trauma in their lives. Themes and quote examples for the lived experiences of the participants are shown in Table 3.

Table 3

Lived Experiences for Clinicians Working With Developmental Trauma

Themes	Subthemes	Example quotes	Frequency, *n* (%)
Challenging	Emotionality/ Success Rate/ Ongoing Abuse/ Expectation of Others	Oh, um, well challenging. (Long pause) I think that long pause was like my brain going off in five different directions. I mean, I think there is, I think it just, I think it stirs up so many different emotions and, wow. Okay. This is interesting. I just, I don't know that I have stopped to think about that question ever. One of the awarenesses I just had is it's stirs up like, frustration and anger that any child would experience, significant traumas. (P2) The success rate when you're working with kids in the populations that I was working with is not that high. Unfortunately. I mean, that's just the reality. Like, it doesn't mean I wouldn't work as hard as I possibly could, but I also knew that there was a good likelihood that this child in 4 or 5 years would be in prison or would be in drug abuse, like their family or whatever that is. And so, again, it doesn't mean that I didn't work as hard and hold out as much hope as I could. (P6)	6 (66.7%)
Rewarding	Privilege/ Small Movements /Beautiful/ Meaningful/ Rich	Holy ground. Yeah. To have the privilege of coming alongside a young one whose life has been shattered and to be able to give any kind of, create any kind of port in the storm for them. Children are so unbelievably resilient and forgiving and wanting connection	5 (55.6%)

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		that to find a way to gently come alongside. And when they let you come alongside is, an incredible privilege. (P5) And the other super rewarding side is like when you're seeing the movement and when you're really, getting into an attuned space with the client, like after the system has settled down to get to repeatedly, come back to, the innate goodness that all of us have and are, is, you know, that that's just the best like the kids that we were talking about. (P7)	
Triggering	Own Abusive History/ Painful Events	Yeah. Yes, I've done my own therapy for the last 16 years and probably will continue that until I draw my last breath. Yeah, I was working with the kiddos at the camp and a child, a six-year-old that I knew had been raped. Um, probably six weeks before coming to camp. And she fell apart at camp emotionally. And as she sobbed, curled up in my arms, I knew that I was, I was done for that season. I had to get, I had to get help. I had to get some things understood between God and I. And I limped through that rest of that week, like I knew something in me was shattered. So often the kiddos, you know, especially when I was a social worker and I only knew maybe a 10th of my story, I would get triggered and I wouldn't understand why. But I would swim, you know, miles after work. I, you know, try and burn off the cortisol somehow, you know, theologically it's really done a lot. I mean, I've really had to work. (P5) That has been, I think on the one hand it's really, healing, if you will, like it has pushed me to look at all that stuff	6 (66.7%)

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		for myself and to, to find my own healing. (P2) It was my life. Yeah. I was abused. Yeah. Severely abused child. And I don't think I realized how much harm, but I was drawn to it like a moth to a flame. And then my, my Christian, um, belief system, especially at that time, you know, lay down your life and serve and what better way than to be a social worker to go into the least of these, you know? And, and they have my heart, they, you know, give me a room full of abused kids and I'm very much at home. (P5)	
Reflecting	Self-reflection/ Right Intervention	Um, well frustrating. Humbling, of course. Then like sad and helpless. And then kind of like I was talking about where my own stuff gets brought up. I mean, I think the other thing of it is it was an opportunity to learn and grow, you know, of like, gosh, I feel so stuck with this kiddo. What's that about? Is that because we are literally stuck and something needs to change of is that because I am just am really in their world and I'm just feeling what they're feeling and not that we're just moving through the therapy that has to happen the same way the therapy would have to happen for anger or for whatever, you know, so, yeah, I think it's so uncomfortable to feel stuck with kids, but I also think there's a lot to learn about that. (P2) That's an important question, you know, where am I, am I afraid to go there? Am I holding it back somehow? Am I not naming something that needs to be named to like, what's my contribution to the stuckness? So those moments, I think, are just beautiful moments to	9 (100%)

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		pause and ask what, what else is needed here? (P1)	
Normalizing	Difficult Work/ Counseling for Self/ Receive Supervision Self-Care/ Burnout	And so for this population, you know what really would want them to know, and this may be biased. I may not be like other clinicians, but I believe that developmental trauma is not an illness. Like we can talk about mental health and we can talk about mental wellness, but this is no disease. There's no disease when you're talking about a child and developmental trauma. And so really the work is around repatterning the systems that got interrupted. And so, however that lands for children, I could imagine that bringing hope, I could imagine that like not fitting with how they see, or what they (new clinicians or students) had anticipated. There's nothing quote, unquote wrong with these kids. They haven't been given the supports they need to grow. And so that's what I would want them to know. (P2)	9 (100%)
		That is going to be really hard and don't do it if you don't want to learn, because this is not something you can read a book and get like a 10-step solution and try to apply it, because then you're going to make the trauma worse. You're actually going to be part of the problem. (P9)	
		What I want them to know, that the feelings, the fear, the activation, all the stuff that inevitably comes up working with this population is normal. That it's normal. And it's not about avoiding it or about, running away from it. It's part of the journey that you are there to help the client, but they're also there to help you. (P1)	

Note. *n* = 9.

Participants' Lived Experiences

To ascertain an understanding of the first research question, Interview Questions 3, 5, 14, 16, and 17 offered insight into the clinicians lived experiences with working with the pediatric population with developmental trauma (see Appendix I). The questions asked were:

- What made you decide to work with this population? For responses see Appendix I2.
- Please describe what your experience working with children who bring a trauma history with them. For responses see Appendix I4.
- Have you ever felt you were not moving forward in therapy with a child? What was that like for you? For responses see Appendix I13.
- As a clinician, is there anything you would want to share with new clinicians or students who are thinking of working with this population? For responses see Appendix I15.
- Has working with this population brought up anything for you? For responses see Appendix I16.

When trying to understand the participants' lived experiences in working with children who have developmental trauma, the researcher asked participants about their decision to work with this vulnerable population (see Appendix I2 for responses). The researcher posed other questions to ascertain an understanding of the participants' lived experienced such as how they experienced it directly, moments when they felt they were not moving forward with the child in therapy, things they would want students or new clinicians to understand about working with this population, and what has been brought

up for them when working with children who have developmental trauma. Major themes about their experiences were Challenging, Rewarding, and Triggering. Subthemes for the theme Challenging were when participants reflected struggling with not making the progress wanted. For participants not making progress with clients in therapy meant they needed to look inside themselves for insights, feelings, and reasons for the lack of mobility forward. For students and new clinicians, the participants tried to share some normalizing advice.

Participants were asked about their experiences in working with this population (see Appendix I4 for responses). Five (55.56%) participants looked off to the side, sighed, smiled, and took a minute or two to gather their thoughts about this question. One participant mentioned she had never thought of that question before and needed to reflect. Participant 2 stated:

> (Long pause) I think that long pause was like my brain going off in five different directions. I mean, I think there is, I think it just, I think it stirs up so many different emotions and, wow. Okay. This is interesting. I just, I don't know that I have stopped to think about that question ever.

Challenging. The main theme participants shared was they found it challenging to work with the population of children with developmental trauma. The subthemes were due to the environments the children found themselves in and stories both heard and shared with the therapists, due to the continued abusive environment the children found themselves in, or sometimes a push for progress from the system (e.g., parents, teachers, clinic).

Three participants (33.3%) mentioned the environment in which the children lived might still be abusive, making it challenging. Participant 5 stated:

> I ran a camp for abused children for 11 years. I had a staff of 44 and we took 350 kids that were foster, adopted, mostly foster high-risk kids through that program, ages 7 to 11, actually really 5 to 11. And, they were kids, some of them out of the state mental hospital, some of them out of foster care and some would have been, high-risk kids that had been temporarily placed back into their biological parents' home, but the state was still keeping an eye on them.

Participant 6 said:

> Wow, that's a big question, many places I could go with that question, but I guess, I mean, the first is it's heartbreaking. Um, I work, I live in a rural community, lots of poverty, lots of drug abuse, um, lots of domestic violence and child abuse, a lot of intergenerational trauma. There's quite a few native American reservations in the area, a large Hispanic population. Um, so just a lot of trauma, um, just a lot, a lot of trauma. So it was heartbreaking.

Participant 4 stated:

> Some of the biggest challenges have been kids that, are in the court system, maybe with parenting plans. Some kids with pretty abusive dads, but the courts were requiring that he had visitation with the kids, and the kids were coming back, just messed up in some cases. I think in one situation the child well, his dad had been choking him and also hitting him in the head. So finally, when he got the attention of someone who stopped the visitations, and they were now going to be supervised. That little guy has really made some strides since then. Yeah, that,

> and the other challenges being that sometimes the parents are still kind of struggling, whether it's in a system of conflict between parents or custody or court issues, things that are really outside of our control that affect the child, that can be really difficult.

A couple of participants discussed the challenge to meet the expectations of others (e.g., parents, teachers, clinic) who were looking for symptom reduction and behavior modification. Participant 6 said:

> So, there was a pressure, not just within the families, but in the teachers, but also within, you know, when you're working in a system that relies on federal funding or state funding, then there's also pressure coming about progress and about symptom reduction and all that stuff. And so, there was always this tension within the organization even from supervisors and from staff, like, you know, are you doing enough to fix that? All this kind of stuff. So, a lot of our funding would go towards treatments that I personally felt were quite objectifying actually for kids. Cause it was always focusing on symptom reduction and behavior modification and not about the child's inner world.

Participant 9 stated:

> So, I did my BA first here in America, and then I went back home and I worked within the social welfare system at home. And all we do there is cognitive. It's all CBT. There is very little attachment theory or ideas of any kind of emotional focus therapy, especially back then. So, everything was like, we can recognize that you probably have some traumatic experiences, but still here's the list one through ten for you to do, and then you're going to be fine and done. Right?

> Yeah. So, when I was doing that and I was working in different programs with kids that had been in severe traumatic, like places or situations and experiences, we did nothing predominant, everything was solution-based. Right? Solution-focused therapy. And I just realized like, this is not helping, it's actually making it worse, cause we not looking at the hurt, we just, you know, do this and be done.

The participants each discussed ways in which working with children exhibiting developmental trauma has been challenging. The experience has been challenging not only because the child might still be exposed to the abuse, but also from the system itself and its persistence in progress.

Rewarding

The theme of Rewarding came from five participants (55.6%) who communicated working with children with trauma histories can be rewarding for various reasons. The subthemes for Rewarding were in seeing the small steps in healing and growth, watching how a child reconnects with themselves, meaningful, and "some of the richest work we can do as therapists," according to Participant 8. For example, Participant 3 said:

> Um, it's just a very complex kind of a system that's challenging, but I will say, and sometimes children, they go at their own pace in terms of healing. So, depending on, they have a lot of ups and downs, which can be very exhausting as a therapist. So sometimes our reward is that we're helping a client work through the therapeutic process, but when your client is actually not reaching full empowerment because of this challenge they have going on there, you have to, you have to be able to take care of yourself. You have to be able to like, um, look

> for the small moments of overcoming that they're doing overcoming their challenges, small moments of empowerment which are hard to see.

Participant 3 said:

> The beautiful process I have seen with these children is that they have been able to attach to themselves despite what they've experienced, despite being in the boxing ring, despite experiencing developmental trauma, they can go through a process of connecting with themselves. That's the beautiful process.

Participant 6 shared a story of how meaningful and rewarding this work can be. He stated:

> You know, I had this really great experience a few years ago. I was getting money at the ATM and someone tapped me on the shoulder and it was kid who, uh, this is probably 3 or 4 years ago now. He was probably 20. So, I knew him when he was 10 to 12 or 13. And he was a nightmare for the program. I think he ended up in juvenile hall several times, and I think he was homeless for a while and stuff. And he was so he was beaming to see me because he, he had a house, he had an apartment with a girlfriend that he had been with for a while. He had three jobs, he was working and he basically said to me, I'm sorry, I was such a pain in your butts. Although he really wasn't for me, but he said, I've pulled my life together. And I thank all of you for being patient with me back then and stuff, and it was just like one of these moments that doesn't always happen that, you know, was really meaningful because, you know, you never know what's going to happen to these kids.

Participants shared how this can be the richest work a therapist can do when helping a child who has developmental trauma. Participant 8 stated:

> Well, I always learn just as much from them as they do from me, always, every single time. Um, and I think that it is, I think it's some of the richest work we can do as therapists, because when you were in the room with a young child, providing them with a regulated nervous system to learn how to regulate themselves and feel what it feels like to have a sense of felt safety. I think that the changes that we see as a result of that are really just incredibly remarkable. And that to me is why the work is so fulfilling is that there's, there's constant change towards, towards healing all the time.

Hermeneutic phenomenology interviewing allowed for follow-up questions. When discussing the experience of working with children who have developmental trauma, Participant 8 shared the term "felt safety" describing a way in which the child experiences their regulation. When asked what this term meant to her, Participant 8 mentioned:

> In our brains and our nervous system, we have this beautiful system of circuitry that takes in information, from the environment. So sensory information what's going on around us, different kinds of cues in the environment. And it takes all of that in instantaneously, makes a decision. "Am I safe or am I not safe?" Right. And this comes from our evolutionary history of having to, figure out real fast. "Am I going to get eaten by that tiger? Did it see me? Oh. Nope, it didn't see me. Cool. I'm safe." Right. So we are instantaneously all the time, making some conscious decisions about whether we're safe or not. And that subtype conscious

> decision is called a neuroception. Right. So if my neuroception, if I'm in a situation and my neuroception goes, "Whoop, I'm not safe," then that is really what is happening inside children, right? So the felt safety of it is how are we helping kids who had different experiences in their environments that led their neuroceptic experience, to go, "uh-oh." This is actually safe instead of pulling on previous traumatic experiences and finding some cue in the environment that may be, felt like something from back there and going, "Oh no, I'm not actually safe." Even when they're in an environment where are actually are. Helping them match their perceptions of the environment with what's actually going on. "Oh, I'm actually okay. I'm in Participant 8's playroom with her. I'm not actually back there where that person was screaming." Right. So, we're helping them shift perception to the current moment.

This concept of "felt-safety" was not in the researcher's understanding and the hermeneutic circle gave information to add to the experience of working with children who have developmental trauma.

For many of the participants, the sense of reward was coming from seeing the small changes take place in pediatric clients they were seeing. These changes came in small steps, small growths, learning and recognizing self-regulation, and even when all-grown-up the impact of help on those children were helped.

Triggering

The theme of Triggering was extracted due to six (66.7%) participants reporting working with children who exhibit developmental trauma has been triggering for them (see Appendix I4 and Appendix I16 for more responses). The subthemes were the

participants either had their own abusive histories or had memories of painful events triggered by working with children exhibiting developmental trauma. Three (33.3%) reported they had been abused themselves as children and working with this population brought up some of their abuse histories. Another three (33.3%) reported working with this population brought up events or memories of their childhood were difficult to face. Participant 1 stated:

> And I knew right after my first session, why I had been scared. And it was because intuitively and instinctively knew that if I was going to work with children, I was going to be facing myself and that children were going to throw something and maybe about the vulnerability of children or the part of me that was willing to be vulnerable with the child. But I instinctively knew that I was going to be looking in little mirrors. And I think that's true across the board with all client.

Participant 8 stated:

> So, I have an ACEs score of seven, um, the Adverse Childhood Experiences scale. Um, and so working with this population has often brought up my own stuff, you know, uh, you know, I had a very traumatic childhood with two mentally ill parents, um, which I'm sure it's like what directly led me to the place that I'm in today.

Many of the participants discussed working with children who present with developmental trauma has been triggering. Triggers came as either memories of their abusive past or memories were traumatic (e.g., parents' divorce).

Reflecting

The theme of Reflecting was determined due to all nine participants (100%) sharing they have experienced not making progress with their clients and had to ask themselves questions about what to do next to help the child move forward (see Appendix I13 for more responses). The subthemes were participants recognized the need to self-reflect when they felt they were not moving forward with the child and the potential reason for lack of mobility. Questions such as if they were the reason for the immobility, if they were doing the right intervention, and the right timing of interventions were a few of the questions they asked themselves. Participant 4 stated:

> Oh yeah. Kind of frustrating. And sometimes you kind of feel like, 'Oh, am I doing any good?' This is helping, but that's not very often, but sometimes depending on the situation, there can be factors that are just roadblocks and setbacks and how to cope.

Participant 9 stated:

> Usually when that happens is because the parents have their own trauma and they are so triggered by it, that they can't help their kid. That's usually when I hit a hard wall that they cannot come out of their own hurts and it's so hard to be vulnerable and work through it that they can't reach their own kid. That's usually when we get into trouble, that's usually when I have to step back and work more with the parents to show them that it's still safe to work through their own problems and maybe rely more on their partners so it becomes more of a couple's session. So they feel safe to be vulnerable with each other and to help each other,

> and then to be able to help their kid that can be a step back that might take like five session to do to get to that point that we can start over with the kids again.

Participant 3 stated:

> Absolutely. So that does happen. It's just part of the process. Sometimes we have to reassess, and look at what we're doing, and what modality we're using. We might have to bring in other things into the child's work such as kickboxing or equine therapy or occupational therapy. Kickboxing offers a body visceral experience that can be quite empowering and really aid the therapeutic process. Sometimes children with developmental trauma hit a ceiling with their work and can't go any further. We need to honor the amazing work they've done up until that point and take a break. Integration requires a rest and digest period, as well as recognizing that healing takes all of childhood, adolescents and sometimes into adulthood for those that have experienced developmental trauma.

Reflecting on what is happening in the therapy session to understand when the child is not moving forward was something all of the participants experienced working with children with developmental trauma. Participants might ask if they are the reason for the block or if a new intervention is needed, but the participants shared this happens all the time during therapy.

Normalizing

The theme of Normalizing was parceled out due to the question asked of the participants was what they would want students or new clinicians to understand about working with children who exhibit developmental trauma (see Appendix I15 for all responses). All nine (100%) advised normalizing the experience of up-and-coming

therapists. Subthemes came from participants recognizing how difficult the work might be at times, how it might bring up things from the past, the need to have counseling to work through their past, how dysregulated the therapist or student might feel when they are working with this population, the concept of self-care was something some participants made sure to mention, and the possibility of burnout.

Working with children who have developmental trauma can be hard work as expressed by three (33.3%) of the nine participants. It can be from the lack of regulated parents, push from agencies to use certain interventions, or perhaps not feeling prepared enough. When discussing a time when therapy has hit a wall, Participant 9 shared this perspective:

> Usually when that happens is because the parents have their own trauma and they are so triggered by it, that they can't help their kid. That's usually when I hit a hard wall that they cannot come out of their own hurts and it's so hard to be vulnerable and work through it that they can't reach their own kid. That's usually when we get into trouble, that's usually when I have to step back and work more with the parent to show them that's it's still safe to work through their own problems and maybe rely more on their partners so that it becomes more of a couple's session. So, they feel safe to be vulnerable with each other and to help each other, and then to be able to help the kid that can be a step back that might take like five sessions to do that to get to that point that we can start over with the kid again.

Participant 6 stated:

> When I first came to the organization was much more family systems therapy. I was trained both in structural family and strategic family systems. And over the years, the new clinical director brought in more CBT-oriented treatment, we all got trained in trauma-focused CBT. I didn't use it, well very barely at all, because it doesn't align with how I believe healing happens. That was what most of my staff was using though.

The importance of doing one's work was expressed by seven (77.8%) of the nine participants. Many of the participants shared they had been abused as children and working with this population brought up memories or feelings of their own abusive histories and they were continuing to work on their own past for healing. Participant 2 stated:

> I wasn't sure if this would directly relate to kids with developmental trauma, but I was just thinking for sure, anybody going into this field, I would say, "Please be willing to do your own work, because the more we understand our own process, our own emotions, our own stress response, all of that, the much better equipped we are to help other people.

Participant 9 stated:

> So, if grad students want to work with this population, be prepared to do your own work. Take a look in that invisible bag you are dragging with you where you stuffed all your shit. I'd start looking at it because otherwise you are going to be part of your problem.

Participant 5 stated: "I've done my own therapy for the last 16 years and probably will continue that until I draw my last breath."

Supervision and/or consultation was something recommended by five (55.6%) of the participants. The five participants are supervisors or consultants with interns, or newly licensed clinicians needing hours or experience. Participant 1 said, "Get lots and lots of supervision, get lots of support and supervision because looking in the mirror is not the easiest task." Participant 2 said:

> I'm a registered play therapist, a registered play therapist supervisor. I'm a certified synergetic play therapist. I'm a certified synergetic play therapist supervisor. I'm a certified synergetic play therapist consultant. So I train, help support the training of other therapists, both in the play therapy world in general and in synergetic play therapy.

Participant 8 said, "I supervise six therapists, as I'm also a clinical supervisor."

Another example of normalizing the experience for new clinicians or students wanting to work with children who have developmental trauma is the need for self-care. Three (33.3%) of the participants pointed out the need for self-care. Participant 9said:

> I think it's like, a scheduling thing. So, I only work Monday through Thursday. Those are my 20 hours and I do it. I'm in the afternoons. I don't have to get up in the morning because I need a time in the morning to reboot and do things like this (the interview), drink coffee, hang out with animals, do my own thing. And then by 2 o'clock, I am ready to work again. So, every day I make sure that in the morning I have enough time to say yes, be quiet and do my own thing, and slow down.

Participant 8 mentioned:

> If you are dedicated to discovering your own boundaries and the things you need to be able to keep yourself emotionally safe while doing this work, figuring out the ways that you keep your work life and your personal life separate. I always tell my supervisees “Don’t come early, don’t stay late. Take all of your lunches, do not work though lunch, do not take work home with you.” And, they say, “Oh really? Is that like the secret to working in community mental health with developmental trauma?” And I’m like, “Yeah, basically just keep, find your boundaries and find the things that you need that fill you back up and find some kind of regular practice for caring for your nervous system.”

Burnout is a possibility for clinicians and especially when working with a vulnerable population of children with developmental trauma and three (33.3%) of the participants wanted to normalize the experience. Participant 6 shared his impression of working in the field and how important it is to continue to process one’s trauma history because of the potential to burn out. Participant 8 gave tips for new clinicians to help prevent burnout. Participant 6 mentioned:

> There’s a lot of incredible empathy that we bring a lot of big-hearted compassion. And we also have our own kind of countertransference that sometimes we’re not so aware of and in my, some of the most admirable people in the world that work that they do. And yet they are some of the most unhealthy people because all of them came into this profession for a reason because of their own childhood experiences. And they’re not always so aware of how much it’s triggering inside of them to not only just be dealing with these horrible situations, but what it triggers up for them, their own experiences that they haven’t fully processed. A

> lot of them end up going out on medical leave and things like this, which then brings them to see me. So I guess it's hard because of that, because of how sacred it is, it's so important to continue to do our own internal work and be ready emotionally for the challenges.

Participant 3 mentioned:

> I think like learning and adapting and continuing to grow in yourself as a therapist, this work is so hard. It will activate the therapist. I will trigger the therapist. It will burn out the therapist. And if we don't have things like I have found synergetic play therapy, that helps me to be able to connect to myself, to help me in taking care of myself in this work. If you don't have something like that, then we lose the therapist that is really awesome and starts out awesome and so motivated and excited. Then we lose them and that's unfortunate. So I think it's just really important to look at that.

See Table 3 for more quote examples.

Participants gave information about their experiences in working with children who demonstrate developmental trauma. Experiences were challenging, rewarding, yet triggering were felt by many of the participants. They further shared how reflective they become when the child is not making progress. When sharing with students or new clinicians, the participants wanted to impart normalizing statements regarding the need for doing one's own work if needed, having self-care built into their work. Two participants talked about the harmful effects of burnout and one participant shared how to possibly prevent it.

Understanding of Developmental Trauma

The researcher asked Interview Questions 2, 4, 6, and 7 to gain an understanding of the second research question of how the participants understand developmental trauma in children and its impact. The themes for understanding developmental trauma are shown in Table 4. Those questions were:

- What courses do you remember in grad school that dealt with children and trauma? For responses see Appendix I1.
- What training or certifications do you have to work with children and/or adolescents with trauma histories? For responses see Appendix I3.
- How do you view developmental trauma? And how would you define it? For responses see Appendix I5.
- How do you see developmental trauma manifest? For responses see Appendix I6.

Table 4

Themes for Understanding Developmental Trauma

Themes	Subthemes	Example quotes	Frequency, *n* (%)
Lack of Graduate Training in Trauma	No Specific/ Some Specific Course Work	I didn't receive a course specifically that told me what, what am I looking for with the different, and what do I do with the different, does that make sense as I described that? Yeah. So, it gave me something to compare to, but not necessarily what do I do when I discover, oh, we have something here. (P1) I'm a licensed clinical social worker and have a master's of social work.	(88.9%)

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		My program was a generalist program and there was not a focus on specialties or within mental health treatment. (P3)	
Pervasive Nature of Trauma	Early Stressors/ Needs Not Met/Impact on Sense of Self	So, the way I talk about it is, well kind of depends on what the child is going through. I would say experiences that occurred, in utero, or post-birth that the child registered as too much, too fast, too overwhelming, and therefore they weren't able to integrate whatever the experience was. And the result of that is it either caused a delay in development itself, a delay like physical development or emotional development, it impacted their sense of self, their sense of belonging in the world that they take with them, you know, as they grow older. (P1) It's when a child doesn't have a port in the storm, there is not a caregiver, safe enough to lean into. There is no one emotionally regulating. There is no one, there's no adult to be found and whatever adults are around are harmful when their ability, their ability to pay attention to what's going on inside them is by their need to pay attention to what's going on the outside. (P5)	9 (100%)
Dysregulation Effects of Trauma	Angry Outbursts/ Emotional Dysregulation/ Behavioral Dysregulation	So aside from the things we've already talked about, like the literal physical or emotional development, like actual signs of regression, a lot of it also, I see manifest in the way that they are or are not able to regulate. So, we know that with developmental trauma that one of the things that can get interrupted in development	8 (88.9%)

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		with developmental trauma is the development of the regulatory capacity in the child. And so, I see, children that really struggle with, how to manage impulses, how to work with the intensity, how to work with their anger, how to work with their sadness, how to work with their ability to stay connected to themselves is, ruptured. I also see it in their recovery time. So, there can be like an excessive response of dysregulation, and even their recovery time after can feel a lot larger than your child that doesn't have that type of developmental trauma. (P1)	
		I use Bessel Van derKolk's diagnosis, like diagnostic criteria that he came up with. So I think it's very beautiful, I share it sometimes with parents and foster parents, because to me, that's what they see. They don't see the diagnosis PTSD, they see a child who's extremely dysregulated, a child who is emotionally flooded and who either shuts down or just dissociates or has these kind of overwhelming kind of outbursts. They see children with sensory issues. They see children with attachment, or push/pull behavior. (P3)	

In wanting to know how the participants view and understand developmental trauma several questions were asked. The main themes for how the participants understood developmental trauma were Lack of Graduate Training in Trauma, the Pervasive Nature of Trauma, and the Dysregulation Effects of Trauma. Subthemes for the

Lack of Graduate Training in Trauma were, participants described as a result of a lack of training in their graduate programs they learned about developmental trauma through trainings outside of the program or through internships, and only one participant had specific course work in trauma during grad school. Under subthemes for the Pervasive Nature of Trauma, participants shared when they saw the children with developmental trauma, they recognized the children were overwhelmed due to early stressors in their lives, and the child's overwhelmed nervous system then proceeded to show dysregulation through emotion, and behavior.

Lack of Graduate Training in Trauma

One of the themes to come from asking about the understanding of developmental trauma was the Lack of Training or Education during graduate school. Eight (88.9%) out of the nine participants mentioned they had received no specific coursework dedicated to children who might exhibit developmental trauma.

Participant 4 mentioned:

> No, although I did do some practicum as part of my program and they worked quite a bit with developmental trauma. So, through there, I did get some experience, but not in the general coursework.

Participant 3 shared:

> So, that void of not having specific training and coming from a generalist background, along with realizing I needed more skills, drove me to find more training, more understanding, and additional ways of supporting children through a therapeutic process.

Participant 6 stated:

> Yeah, mine's a little bit of a unique situation because I was doing trauma trainings on the side. Um, because there wasn't trauma education, uh, you know, as part of the program back then, I think it's gotten better over the years, but that was 20 years ago.

Participant 1 said:

> So, I recognized early on that when the activation, so for example, this child was going through, the parents were going through a divorce at a similar age that my parents had gone through a divorce and I recognized early on then that wasn't just me in the room. It was me and my nine-year-old and the client. Yeah. And so I just think that brings a whole other level of conversation and training to, well, what do I do with my 9-year-old? Because I don't tell my 9-year-old, "Hey, you can't be in here. I'll get to you later." My 9-year-old is in there. I can't go check my nine-year-old at the door or tell my 9-year-old go sit on the couch over there. So there's this beautiful place in us where I think we have to learn how to attend to both the young parts of ourselves while we are attending to this young person that's in front of us. And that was something I did not hear talked about in graduate school. At least not at the level I have experienced it. And again, part of what I felt like was missing in the training.

One participant shared her experience in graduate school where she did have very specific courses and professors who discussed developmental trauma. Participant 8 mentioned:

> Um, so I had a couple really excellent courses at my graduate school. Um, I had one that I believe was just called something like 'Trauma and children' or

> something like that. Um, with an amazing adjunct professor who had a private practice treating children, who'd experienced pretty extreme traumas. Um, and I did, I also did an independent study with her, where we helped her with a video project for one of her long-term clients who wanted to make a trauma narrative project. Um, and then I also had an infant and child mental health class, um, with another adjunct professor who had a practice seeing children, uh, mostly who had come out of institutions. Um, so that was first specialty. Um, and then with her, I also had another class that I don't remember the name of, but I think it was mostly around attachment. So of course, a lot of trauma stuff came up in that class.

The lack of training was most consistent with the participants. Most of them had to look outside for understanding of what they were seeing, and how to develop treatment.

Pervasive Nature of Trauma

The theme Pervasive Nature of Trauma had three subthemes; Early Stressors, the Child's Needs Were Not Being Met, and the Impact on the Sense of Self. All nine (100%) of the participants recognized developmental trauma is due to stressors occurring early in life overwhelm the system of the child. Four (44.4%) participants discussed how developmental trauma occurs when developmental needs are not met. Participant 5 shared:

> Um, developmental trauma abandonment, right? It's when a child doesn't have a port in the storm, there is not a caregiver, safe enough to lean into. There is no one emotionally regulating. There is no one, um, there's no adult to be found and whatever adults are around are harmful when their ability, ability to pay attention

> to what's going on inside them is by their need to pay attention to what's going on, on the outside. They lose connection with themselves at that point, which affects their development.

Five (55.6%) participants shared then how the lack of needs being met led to an impact on the sense of self of the child. Participant 6 stated:

> So, I would say kids would fall in different areas of the spectrum in terms of their ability to be trusting and to be honest, and you know, so many of them had to learn strategies to manipulate their environment. And so, they would bring that into all elements of their life. Then the third category probably the most important category is what they call CPTSD [Complex Post-Traumatic Stress Disorder] diagnosis, negative self-concept, which just basically has to do with the child's shame-based identity that a child, we talk about how a child internalizes their environment failure. So, children can't as young children, can't say, "Oh, I'm a good person. It's just my environment that's messed up." For a child, their environment has to be okay for them to survive. And so, they make themselves bad.

Participant 8 shared, "And now they have a defensive mechanism and kind of holes in their neurobiology, um, that they, that they didn't get what they needed developmentally."

Participant 2 mentioned:

> With that term developmental trauma, we're talking about young kiddos and we're talking about recurring or multiple stressors, that are so significant that it then impacts the growth and development of the person.

Participant 1 shared:

> And the result of that is that it either caused a delay in development itself, a delay like physical development or a delay in emotional development, or, um, yeah, impacted their sense of self impacted their sense of belonging in the world that than they take with them, you know, as they, as they grow older, but early experiences that, that, that the impact, the natural rhythm or the natural process of, um, of, of development, physical, emotional, social, all that.

Participant 8 mentioned:

> And then we don't know how to come back to ourselves and feel safe again, because this is where it felt safety resides inside of us. And so when we dysregulate outside of ourselves, and sometimes we, especially with developmental trauma, when that scary dysregulation may happen over and over and over, for example, if we're in an environment like, um domestic violence is happening around us, so we are over and over, over dysregulated, and then we can't figure out how do I get back inside? And how do I feel safe again? Pervasively when children experience those things, you have this pervasive sense of just nothing ever feeling safe.

All participants recognized how pervasive the trauma must be to the child to overwhelm their body. The lack of knowing who is safe to go in times of hurt and pain is difficult and part of the upheaval of trauma in the home.

Dysregulation Effects of Trauma

The theme of Dysregulation Effects of Trauma had three subthemes: Angry Outbursts/ or Irritability, and Emotional and Behavioral Dysregulation. Participants

approached this question in varying directions all resulting in how developmental trauma in a child dysregulates his system. Six (66.7%) of the participants shared how developmental trauma manifests in children with angry outbursts/or irritability. Participant 3 stated:

> Dysregulation shows up in a combination of hyper- and hypo-aroused symptoms happening simultaneously. The child is showing up angry, anxious, or hypervigilant, is also struggling with avoidance, dissociation, and numbing. It's important to not just look at the arousal behavior/pattern that the child is presenting with (e.g., anger outbursts), but what's underneath (e.g., feeling powerless, helpless, sadness, lacking a sense of agency).

Participant 1 mentioned:

> And so, I see, um, children that really struggle with, um, yeah, with how to manage impulses, how to work with the intensity, uh, how to work with their anger, how to work with their sadness, how to work with their, they, their ability to stay connected to themselves.

Six (66.7%) of the participants discussed how developmental trauma can be exhibited in a child by emotional dysregulation. Participant 6 shared:

> The first is what they referred to as affect dysregulation. The key aspect is, you know, I would expand that word affect, but that they lost the ability to regulate their internal states. So a lot of these kids were bedwetting and, you know, like there was a lot of physiological as well as aspect emotional, uh, dysregulation that would turn into symptoms.

Participant 1 said:

> Um, I also see it in their recovery time, even from, so there can be like an excessive response of dysregulation and even their recovery time after can feel a lot larger than your, your, your child that doesn't have that type of developmental trauma. Um, almost like a compounded effect inside of the nervous system.

Five (55.6%) of the participants also shared they noticed children with developmental trauma have problems with behavioral dysregulation. Participant 6 mentioned:

> Yeah, well, you know, the complex PTSD diagnosis really captures it really well. So, there's three additional kind of categories that they talk about. And, I would say this is the way I would use the language too. The first is what they referred to as affect dysregulation. The key aspect is, you know, I would expand that word affect, that they lost ability to regulate their internal states. So, a lot of these kids were bedwetting and, you know, like there was a lot of physiological as well as aspect emotional, dysregulation that would turn into symptoms. It would turn into all sorts of different ADHD of course and all kinds of stuff. So, that was one category. The other category was interpersonal difficulties. So, kids who either don't trust at all or trust too much, that's kind of a classic reactive attachment disorder.

Participants shared they received most of their training to work with children who demonstrated developmental trauma outside of graduate school. One participant did share she had course-specific classes around developmental trauma. The participants shared about the pervasive nature of trauma by sharing what they knew through experience with

the children who exhibit developmental trauma. The participants also expressed their understanding of the dysregulating effects of trauma by how the child appears and behaves.

How Developmental Trauma Impacts Treatment

The presence of developmental trauma impacts treatment planning and implementation. Questions about assessment, diagnosing, treatment modification, length of treatment, and referrals for children were asked to gain an understanding of how the participants understood the impact of developmental trauma on children. The themes and participant quotes are shown in Table 5. The questions were:

- How do you assess for developmental trauma? For responses see Appendix I7.
- How do these assessments help you develop a treatment plan for a child who had a trauma history? For responses see Appendix I8.
- When diagnosing a child with a trauma history how often are there comorbid diagnoses? For responses see Appendix I9.
- What therapies have you used in working with a child in healing from traumatic experiences? For responses see Appendix I10.
- Have you had to modify interventions when working with a child who has had traumatic experiences? And so how? For responses see Appendix I11.
- On average, how many sessions have you had with a child who has had traumatic experiences? For responses see Appendix I12.
- Have you ever referred a child to someone else? If so, why. For responses see Appendix I14.

Table 5

Themes for Assessing and Treatment Implementation

Themes	Subthemes	Example quotes	Frequency, *n* (%)
Assessing	No Standard/ Emotional Age/ Always Assessing	So, you know I'm looking for things like actual signs in the physical development, speech patterns, that type of thing. Then I'm also looking for the level of activation and dysregulation that's emerging in their play, in the conversation, the types, things they are talking about that they're playing with. So, my assessment is more of, looking at the child, what I know about the child and, then my own understanding about child development and the milestones, and really looking and saying, okay, we have areas that there has been a rupture of some kind. (P1) I don't have a standardized assessment. I have recently started giving the ACEs checklist. I use my intake interview, and the other thing that I really use to look at it is the current functioning, both what parents are describing or caregivers are describing, but also what do I see in the playroom? You know, what's the level of response if a toy doesn't work or if, there's a loud noise outside, like a loud unexpected noise, so I use my clinical observation. (P2) So, I get some information before I meet with the child, and then usually I'm contacting the foster parents unless this is a child who's been adopted. If I'm not working with foster children, I don't get that collateral information, but if we're just looking at children in foster care, I will meet with the child. I	9 (100%)

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		will typically meet with the foster parent without the child at some point together, like to see what they're seeing and to understand what the child's behavior looks like in the home. I'm typically looking at lots of different pieces, but I find that the foster parents are, you know, they see the child day in and day out, so they know how the child is sleeping. They know how the child is doing. They know lots of different pieces. That's where I begin, but to me, assessment is ongoing. So, the assessment really continues as we treat. (P3)	
Observing	Physical Changes/ Emotional Changes/ Behavioral Changes	It is, watching and observing the different parts that are emerging in the child. So, I'm listening for the way that their behaviors are described outside of the therapy process. So, I'm looking for clues there. I'm also looking for physical clues within the, you know, within the child, whether that's you know, speech. (P1)	9 (100%)
		Uh, their eyes, their body language. It tells me more than anything. The parents come in reporting or the child usually doesn't say. Um, how they're able to hold themselves or express themselves, or connect with their world. Gives me lots of information. Okay. How embodied or disembodied, how disassociated, how erratic that we're disorganized as huge, you know, a disorganized child, kids are great because they don't, they may not say much, but they say tons, right. They find their way, their filters aren't nearly as, socially appropriate as adults. (P5)	
		So, then it's an ongoing assessment process. It's like starting with the	

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		child and seeing what's showing up and continuing with, you know, what symptoms are emerging or do we have some hypervigilance in the sessions? Do we have exaggerated startle? Do we have post-traumatic play happening right now? (P3)	
Diagnosing	What's Presented/ Misdiagnosing	If I absolutely have to diagnose, then I'm just going to look for what is, what's the presentation? What is the majority of symptoms of dysregulation showing up in the cluster of anxiety? Are they showing up in the cluster of attention issues? Are they showing up in the cluster of depression? And so that's if I have to, then I'll just pick that. But, what I know I'm doing is, I'm really saying is this child has perceived a challenge and their nervous system is either revving up to deal with it. And they're going into an anxious, hyper aroused, aggressive response, or the way they're choosing to it, to deal with it is to shut down and internalize it. In which case they're going to into a more of an isolated, depressive response. (P1)	9 (100%)
		When I'm thinking about a kiddo and their development at like, I think a lot about the stress response and so the physiological stress response. And so if a kiddo has a tendency towards sympathetic, like fight or flight, often they have enough behaviors that look like anxiety. And so, it's easy to say, this is generalized anxiety. This is social anxiety. This is whatever kind of anxiety. And another pathway would be, does this kid have enough collapsed enough of the dorsal vagal stress response that it starts to look	

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		like depression, that there's low motivation. There's like wanting to sleep a lot more, there's irritability, you know, those sorts of things. (P2)	
Adapting	EMDR/LI/ Play Therapy/ Synergetic Play Therapy/ DDP/ Assisted Animal Therapy/ Internal Family Systems	So, my initial training was in child-centered play therapy, and then I went on to study experiential play therapy, which for me was a deeper understanding of how to work with trauma. I got a deeper understanding there than I do in child-centered. I'm also a certified gestalt therapist, so there's a lot of training there, although not in graduate school, that was a secondary training that I went on and did, I would say that training really helped bring into how to work somatically and experientially with trauma. (P1)	9 (100%)
		Yeah, I mean the big one that's easy to point to is, like all my, play therapy training. So, becoming a registered play therapist and having to do, you know, a lot of different stuff with that, including some child development. I have studied synergetic play therapy, so that's the big one for me. I'm also trained in EMDR. (P2)	
Attuning	Meet the Child Where He's At	Yes. Cool. And, in fact, it's necessary. I feel like if we're not attuning, and even if there's a protocol, if we're not, making sure that that protocol is done in a way that, meets where the child is at. I feel like, we've gotta meet the client where they're at. (P1)	9 (100%)
		Um, it's really tough. You know, it's as hurt and as disorganized as a human being can get, to have that happen. So, there's a lot of pressure in learning how to do it in that. It's really important to kind of be just	

Themes	Subthemes	Example quotes	Frequency, *n* (%)
		right. Kind of like Goldilocks and the porridge, like, you know, a little too far this way, and you're going to freeze and a little to far that way, and you got kind of hyper psychosis. So yeah, it's difficult. (P7)	
Modifying	Bring Other Specialists/ Change Level of Stimuli/ Development-ally Appropriate	The question for me is often, the level of dysregulation., like the capacity to regulate. So, one of the modifications I have definitely made multiple times is to take toys out of the room so that the offering is just smaller. So, it's less overwhelming. There's just fewer choices, or I've done shorter sessions. Like typically my sessions with kids are 40 to 45 minutes. I remember with one kid; we just did 30 minutes. That was about the tolerance that kid started with. (P2)	9 (100%)
		I've talked with Peggy Pace, and I definitely have my own form of all of the protocols for children. And the words I use, even some of the latest ones, there's an agreeable/disagreeable one. I use nice/not nice with children, but I'm adapting. Like some of the kiddos I have, I've got a kiddo who does bounce and literally all over the furniture could not hold still. So I just let them bounce, I let them move. I was working with one kiddo just literally bouncing off the walls and I really try to be creative with what's going to help him. (P5)	

Note. *n* = 9.

To discern how developmental trauma impact how clinicians assess, plan their treatment, recognize need for modification, and the types of intervention to use with children who exhibited developmental trauma questions were asked. The main themes for the third research question were Assessing, Observing, Diagnosing, Adapting, Attuning, and Modifying. The subthemes for assessing were No Standard Assessment, the Agency Has an Intake Given, “Emotional Age”, and Assessing the Child During Therapy. The subthemes for Observing were Physical, Emotional, and Behavioral Changes they witnessed in the child during therapy. For diagnosing, the participants shared they diagnose based on what they are being presented with by the child but cautioned about the possibility of misdiagnosis. The theme of Attuning had one subtheme which was the participants recognized to help the child the participant had to meet the child where they are. The theme of adapting had many subthemes, as the participants recognized there is not one intervention works universally for their clients, so they have various methods to use to help children. For the theme modification, the subthemes were the participants explained how they are trying to attune to the child developmentally, meet the child where he is, and change the level of stimuli.

Assessing

The theme of Assessing had four subthemes: No Standard Assessment Is Given to the Child, Looking at Emotional Age, the Agency Gives the Family Their Assessment, and the Participant is Constantly Assessing the Child Throughout Therapy. Three (33.3%) of the participants mentioned they do not have a formal assessment. They shared they are always assessing the client. Participant 3 stated:

> I'm assessing throughout the process and as I work with the child and their caregivers/parents. I begin with what the parents/caregivers/foster parents are seeing. They know the child from a perspective that I don't. And continuing to check in with them as it relates to the child's therapeutic process and what I'm seeing in the therapy room.

Participant 8 shared although she works at an agency, and the agency requires an assessment to be done, she does do her own continual assessment for each of her pediatric clients. They said:

> I do agency work, we have to do an assessment. We do a pretty, standard mental health and medical necessity type of assessment. So that's kind of part of it. For me as a synergetic play therapist, my assessment comes in because I'm using my own nervous system to pick up the cues from the child's nervous system so that I know what's going on. Because our nervous systems are incredibly social. So we're always sort of bumping up against each other, going, "well, what's happening with you, but what's going on over there with you?" It's all the time I'm in synergetic play therapy, we call the concept of that information exchange nervous systems. We call it the setup or the offering because where the child is setting up the toys or whatever they're using to give the therapist an understanding of what the child's experiences is.

While discussing how she assesses the children she works with, Participant 1 mentioned "emotional age." When asked what "emotional age" meant to her and how she would explain it to others, she had this to say:

> Well, I think the first thing that I help people understand is that, we aren't just one age at any given time. We're all ages because we have different parts, we're a multiplicity of parts. And so, you know, inside of still lives the 2-year-old, the 8-year-old, the 15-year-old, the 20-year-old. Great. And, depending on the different, ruptures that occurred at certain ages, when we are under stress, we naturally go back to those places. And, the more stressed we are, we naturally regress back to where our early developmental ruptures took place naturally. And the wisdom for me in that is that there's something innately brilliant in us. That is, trying to go back and have another look, it's trying to fill the developmental hole is trying to go back and do that early developmental repair.

A few of the participants shared they do not do a formal assessment and it is ongoing throughout the course of therapy. One participant recognized the need to assess for the child's emotional age to help determine what the child lacked compared to a developmentally normal child.

Observing

Participants shared what they see in children who have developmental trauma. Participants shared whether physical changes, emotional changes or behavioral changes were how developmental trauma manifests. Physical changes were observed by one (11.1%) of the participants, emotional changes were reported by six (66.7%), and behavioral changes were reported by five (55.6%) of the participants when observing how developmental trauma manifests. Participant 1 shared:

> I worked with a 17-year-old who grew up in a Russian orphanage that was incredibly, incredibly neglected as a small child. And even though he was 17, his

> face, he still looked like he was about 10. So literally his development was stunted. You know, I'm looking for things like that, like actual signs in the physical development, speech patterns, that type of thing. I'm also looking for the level of activation and dysregulation that's emerging in their play, in the conversations, and then with my understanding of child development and milestones, and really looking and saying, "Okay, we have areas where there has been a rupture of some kind."

Participant 3 mentioned:

> And instead of like, just looking at the child's behavior, it's like, what's the behavior saying? What's the child trying to communicate through the behavior? What's the perception of the child about their world and about themselves?

Participants shared although some of them do not do assessments there are certain things they look for when deciding a child has developmental trauma. For some, it might be behavioral issues, others behavioral and emotional changes are observed to determine if a child has developmental trauma. For one participant, she shared she saw physical growth delay in a child which determined for her the child had developmental trauma.

Diagnosing

Developmental trauma is not a diagnosis in the *Diagnostic Statistical Manual 5th Edition (DSM-5)*. When considering a diagnosis for a child who exhibits developmental trauma, all nine (100%) participants based their diagnosis on what was being presented in behavior and emotion. See Table 5 for more quote examples.

Participant 4 mentioned she looks at what mood is being presented, “Yeah, if they have some anxiety as a result or depression as a result of then those, definitely. I see a lot of that and sometimes physical or somatic conditions.” Participant # 3 said:

> Often children do not meet criteria for a PTSD diagnosis. It often starts with a diagnosis of Other Specified Trauma and Stressor Related Disorder because what they are presenting with are pieces of other diagnoses – depression, anxiety, mood dysregulation, attention issues, attachment, oppositional defiant, impulsivity, etc. Even autism spectrum (for this one, the Coventry Grid out of the UK does a beautiful job distinguishing the symptoms of ASD from developmental trauma). As therapy starts, symptoms emerge with more clarity. There is a need to rule out before just offering a diagnosis.

Another aspect of diagnosing someone is the possibility of misdiagnosing. Three (33.3%) participants recognized the implications of a child receiving the wrong diagnosis. Participant 3 shared:

> So oftentimes that’s what goes into my helping people understand developmental trauma. Now that’s a little tricky in the insurance world. So, I do take, because obviously these children are in foster care, so they have state insurance. I do take state insurance, and this is the tricky part because we only have to speak to the *DSM* diagnosis of PTSD and other specified trauma and stressor-related disorder and, you know, blah, blah, blah. I will say a lot of children, there was a running joke when I was in community mental health, that if you ever met a child who had a diagnosis of ADHD and odd, where’s the trauma, show me the trauma because I

> mean, really the most children with developmental trauma get misdiagnosed frequently with ADHD, or ODD like disorders with, I assume, even with autism.

Participant 6 recognized some of the diagnoses possible for children with developmental trauma, but also stipulated:

> Well, depression, anxiety, and of course, oppositional defiant disorder, the one's that's the most controversial is autistic spectrum disorder because this, this gets us into some very complicated territory and I'm not an expert at all. I can't debate people that know more than I do. All I know is that it mimics the shutting down behavior that you see in children that have had experienced profound, early trauma. So now whether it's genetic or I don't know, I don't know enough about autism to know about it, but the kids that would get autistic spectrum disorders. And as I, in my career, I noticed that every year there was more and more kids getting that diagnosis, I couldn't just help, but see the overlap between these kids who are coming from often profound, dramatic environments.

Participant 7 had mentioned he wished oppositional defiant disorder would be taken off as an option for children with trauma. When asked for more of an explanation he stated:

> Yeah, to me, it's like a knee jerk. The kid doesn't behave in class, you know, is violent towards other kids. Like I told you, the 4-year-old that I worked with, they got diagnosed with bipolar. You know, most people would be like, "Uh, I don't think he could diagnose their kid with bipolar. They had him on real mind-numbing medication cause he had broken the rib of a teacher, by bashing his head into her ribs, and that was my first job out of undergrad." But, it's always

> something deeper and like oppositional defiant says like they're making a choice to be bad or behave badly and it just seems lazy, but something's going on for a kid is getting your attention that you're going to give them that odd label.

Participant 7 also stated, "It's real hard to tell if you got ADHD on your hands or developmental trauma. And if there was anything that made that easier, that would be amazing." Participant 9 stated:

> Yeah. So, this is probably not politically correct to say, but I don't think a lot of children have GAD. It's just, you know, the same thing with ADHD, which I think is a horrible diagnosis, you know, I think the medication that we make is just mind-boggling to me, how many kids are diagnosed with ADHD and it might be trauma.

Some of the participants shared they do not like to diagnose, but when they do, they look for what matches best with what the child is presenting. Some cautioned some children have been misdiagnosed with ADHD or ASD when in fact the child has developmental trauma.

Adapting

Asking the participants about interventions they used to help treat children who exhibited developmental trauma, all nine (100%) mentioned their intervention modalities varied. They recognized being able to have multiple tools, or interventions, to help the child learn to cope with their traumatic experiences was invaluable. Participant 4 mentioned:

> Lifespan Integration and sand tray, for sure. And sometimes other kinds of play or art therapy and you should be including the parents that I can kind of get in

> support there. The kids that are really up for that, some of the kids just kick their parents out.

Participant 6 stated:

> A lot of play therapy, a lot of play therapy. That was probably the most thing we do. There was art therapy involved too, but a lot of play therapy. We did, we ran groups as well. I did individual and group work. The groups were always no more than five kids per group usually two therapists per group. One was a behavioral specialist so that the therapist could focus on the internal dynamics and the relational dynamics and the behavioral specialist could work on behavioral skills, social skills.

Participant 3 shared:

> My primary modality and lens from which I operate is Synergetic Play Therapy. I also bring in other therapeutic modalities including EMDR Therapy, Theraplay, Internal Family Systems, and many more expressive and mind-body therapies. I also bring in Animal Assisted Therapy and have a trained service dog that is designed in my state for facility intervention work.

All of the participants shared they do not just use one modality of therapy. Many of the modalities can be intertwined with others to be beneficial for the child. The participants are always adapting to what the child needs.

Attuning

One of the things discussed was recognizing what treatment to use with a child who had developmental trauma. All nine (100%) participants recognized the importance of meeting the child where they are. Participant 3 stated:

Basically, I'm always assessing and looking at what the child is responding to, and what is needed therapeutically. As a synergetic play therapist, we're looking at where the child is at in their therapeutic stage. The child will orient quickly, often within the first session (using SPT) and then go into a working phase where they work on many layers and levels to their healing process. While this process can be as little as 9-15 sessions for a child that does not have early trauma, for children with developmental trauma, as I said earlier, this process can be ongoing and therefore therapeutic breaks are needed where the child does a chunk of work (25–30 sessions), takes a break and returns at a later time to address another aspect. It closely relates to their developmental stage. As children grow, they naturally experience challenges. When a child has experienced trauma and early trauma, each normal developmental stage can be met with increased challenge for the child. For example, a typical 8-year-old can exhibit tantruming, anger and be highly critical of themselves or others. A child with developmental trauma can exhibit the same behaviors, but 10-fold, making parenting them much more challenging. This is when a child may need to return for treatment. We need to be aware of this as therapists, however, because ultimately it becomes too easy to over-therapeutize children with developmental trauma- every normal challenge can seem over the top and at some point, we do a disservice to the parent-child relationship by not allowing parents and children to struggle in the relationship and have ruptures and repairs if there is an over-reliance on the child getting help in therapy. I practice and off-and-on pattern of treating and supporting children with developmental trauma.

Participant 1 mentioned:

> You know, we're looking at the way they're playing again, we're looking at the way they look physically, and all of those are clues back to what part of them had a rupture at that particular emotional age. So that then we use that information to guide us, to be attuned, and to then intervene at that age to help them catch up so that their emotional age and their developmental age are closer together.

Participant 6 stated:

> I think that was a big challenge. Yeah, because again, it was coming from the best place, best intentions that all the adults that worked in our organization had the best, they wanted the best, they were really hoping for the best, but sometimes that blinded them to how compromised a certain child or certain family system really was. And then what happens is that then it, you run the risk of creating shame for the kid or for the family, because if you're expecting them to do something and they can't do something, then they often feel worse about themselves. And I saw that happen a lot, again, with the best of intentions from teacher and from therapists.

Participant 4 said: "Almost any of the techniques I try to kind of tailor to fit what works for that kid and parents or grandparents."

When asked how observing and watching the child informs treatment, Participant 1 shared:

> Because it's letting me know what their emotional age is, and then that informs number one, how I speak to this child so that I can be more emotionally attuned to their actual emotional age, or developmentally where they're stuck. It influences

> the type of interventions I have. So for example, if I have a 10-year-old who very clearly is, you know, and I'm assessing that from the different clues that I'm given, well, if I'm creating an activity or if we're in play, I'm gonna play with them at the level of a two-year-old, not at the level of a ten-year-old. So it helps with my attunement. It helps with me meeting them where they are in where the rupture took place, so that we can work on healing that integrating so we can grow up.

All of the participants shared although in therapy they attune to where the child is at emotionally and find what the child needs, they recognize the need to slow down for some severely disorganized children and when a therapeutic break might be necessary.

Modifying

Another way in which developmental trauma impacts treatment is the need for modification. All nine (100%) of the participants recognized the need to modify treatment at times. The participants might bring in other specialists to help, change the level of stimuli due to the level in the window of tolerance, and make sure what they are doing is always developmentally appropriate. Participant 6 mentioned:

> So that's something we talk a lot about in our trainings. We actually have a whole model it's called the (facility) personality spectrum. We have 10 different cycles, biological capacities that we're assessing our clients or so that we really understand the interventions are the same, but how you apply the interventions are going to be different depending on where the person falls in terms of their capacity level.

Participant 1 stated:

> I find in those situations is that, sometimes those moments mean that I need to bring in another resource. For example, it's time to bring in an occupational therapist to work along with me, or it's time to bring in more family work.

Participant 5 shared:

> Depending on how disorganized they are will inform me how slow or how few of queues, how many repetitions I'm going to do a severely disorganized child. I'm going to attune to them. We're going to play games. We're going to be on the floor. I'm going to move slow. Maybe I'll get a couple of timelines and that will happen organically.

Participant 8 mentioned:

> So the lovely thing about synergetic play therapy too, is that it is very easily layered with any other kind of play therapy or interventions that you want to use, because it is so much about paying attention to the nervous system, offering regulation, modeling regulation. So in that you can really use it with anything.

Participant 7 shared:

> Well, some of it's like training, like I didn't do LI's specific training, but I've assisted with other trainings and talked a few times to some of the senior therapists. And, they're real clear that it's all about modifying with LI and in kids and like definitely more of a play orientation and we already have the dolls and there's Legos all the time and kids are drawing and stuff, you know, a lot of times there'll be like art material or a whiteboard or something. And they're just giving you the data all the time. And with LI, the therapy at the end of the day is like, yes, there's the thing. And we're okay. And we're here now. And the timeline

> would be a little bit of story kind of visual cortex stuff in between. But with kids I'm mostly going, yes, there's the thing. And here's a little bit of your story and, you know, we're here the whole time talking about it because you're safe and you're okay. And your body is, if you can believe it, trying to help you telling you a bad thing happened, but yeah, it's very modified and its tough work for kids too. So, you know, I'm not expecting to get like a whole 45 minutes or hour of therapy. I'm just kind of, you know, there with the brake and the gas, trying to be with them at their pace. And then, you know, they'll give you a really clear thing. They're done, and that's enough for the day and the whole time with LI, right. We're trying to stay in the window of tolerance. So with kids, especially, it's just very like, "Hey, how much are you up for today?'

Participant 1 stated:

> When asked about having the availability of modification, Participant 1 shared, Yes. And in fact, its' necessary. I feel like if we're not attuning, and even if there's a protocol, if we're not making sure that protocol is done in a way that meets where the child's at or doesn't mean only child, adults too. I feel like we gotta meet the client where they're at.

Participants expressed modification is most always necessary for children with developmental trauma. Modification may be determinant on the window of tolerance the child has, then looking at what might developmentally appropriate other resources might be brought in such as other therapists or other specialists.

Summary

To summarize, this chapter shared the participant pool and the process of analyzing the data. how the researcher sought to obtain reliability and credibility was discussed. The chapter shared the themes derived from the interviews given. There were nine participants, seven women, and two men. All participants had their master's degrees, seven had masters' in counseling, and two had a master's in social work. Eight (88.9%) of the nine participants had over 10 years of experience working with children who were observed to have developmental trauma. The ninth participant had between 5–10 years of experience. Eight (88.9%) participants are in private practice with one being in community mental health. The participants each answered 17 questions to help the researcher ascertain their understanding of developmental trauma and the impact it has on treatment with children who exhibit developmental trauma.

Once the interviews were completed, the transcripts, video recordings, notes, and observations of each of the interviews were read through for the researcher to use for data. The researcher looked for commonalities in what was said and also observed how some of the participants showed emotion when talking about their pediatric clients. The researcher listened to what the participant found valuable and important to share. The valuable and important data points became the themes to answer the three overarching research questions. The themes were then shown to the participants for reliability and validity.

There were three overarching research questions for this study; the lived experiences of clinicians working with children who exhibit developmental trauma, their understanding of developmental trauma, and how knowing a child has developmental

trauma how does is impact treatment and implementation. Seventeen questions altogether were asked of the participants to gather information, thoughts, feelings, and develop themes from the data.

Themes for the lived experiences of the participants who work with children who exhibit developmental trauma were Challenging, Rewarding, and Triggering. Challenging was experienced through either the abusive environment the child is still involved with or the push for progress from the system in which the participant worked. Rewarding was described as seeing the small steps the child makes in healing, a past client coming back, and helping a child to recognize "felt-safety" when working with children who exhibit developmental trauma. Triggering for participants was in having memories, thoughts, or feelings of the participant's past come to the surface during sessions with children who have developmental trauma. The participants recognized times when the child was not moving forward in therapy and took a step back, reflecting on what was happening in the session. When asked what they wanted students or new clinicians to know about working with children exhibiting developmental trauma, the participants went to lengths to normalize what the students and new clinicians might experience and feel.

Themes presented for understanding developmental trauma were Lack of Graduate Training in Trauma, the Pervasive Nature of Trauma, and the Dysregulation Effects of Trauma. Eight (88.9%) of the participants shared they did not have coursework specific to developmental trauma and what to do when they saw the symptoms and behavior. The pervasive nature of trauma is based on the overwhelming stressors on the child due to traumatic experiences. One participant stated the "child has no port in the

storm." The dysregulation effects of trauma theme recognized the child responds to different stimuli with extreme emotions or behaviors. The emotions exhibited are extreme because the child does not know what to do with the intensity of the emotion.

Themes for developmental trauma impacts treatment and its implementation includes Assessing, Observing, Diagnosing, Adapting, Attuning, and Modifying. Many of the participants shared their assessment of the child with developmental trauma is ongoing. Participants discussed how they are observing not only physical, emotional, and behavioral changes in the child with developmental trauma but also what the child is trying to communicate with others. Diagnosing for the participants was both in what they felt they could diagnose with, but also the problem with misdiagnosing a child with something as ADHD or ASD when it might be developmental trauma. The participants discussed they do not have just one modality of therapy they use, they are always adapting to the child and what the child needs. This then brought up the theme of Attuning which was recognizing they have to meet the child where he's at in therapy. When a modification is needed, the participants shared bringing in other resources, changing what is offered, and shortening session times as a few options they have taken.

In the next chapter, the researcher presents her interpretation of the findings through the lens of hermeneutic phenomenology and discuss both the implication for future studies and how graduate programs can provide better insight for those who might desire to work with children who have developmental trauma is demonstrated.

Chapter 4: Discussion

Previous studies have demonstrated how children with developmental trauma need treatment, the necessity for awareness of how the trauma manifests itself, and potential interventions for this population. What other studies neglected to provide or discuss was the experience of working with the population itself, the understanding of developmental trauma, and the implications of treatment is what the researcher wanted to deliver.

There were three research questions posed in the study; the lived experiences of clinicians working with children who have trauma histories, the understanding of developmental trauma and the impact developmental trauma has on treatment and its implementation. The themes for the lived experiences of the participants were Challenging, Rewarding, and Triggering. When noticing no forward movement in therapy, participants took a reflecting stance to determine what might be the issue. They wanted to give students and new clinicians normalizing advice in working with children with developmental trauma.

The themes for understanding developmental trauma were a Lack of Graduate Training in Trauma, the Pervasive Nature of Trauma, and the Dysregulating Effects of Trauma. Many of the participants shared their graduate program lacked specific coursework dedicated to developmental trauma. The pervasive nature of trauma was determined by when the child does not know how to feel safe in themself. The dysregulating effects of trauma was about how children with developmental trauma show emotional and behavioral dysregulation.

Assessing, Observing, Diagnosing, Adapting, and Attuning were themes relating to the implications developmental trauma have on treatment. Participants expressed how they assess the child based on what they see the child present in terms of behavior and emotion. The presentation of behaviors and emotions are constantly being observed, thus allowing for a potential diagnosis. With behaviors and emotions being monitored frequently, it may be necessary to adapt and change interventions. Participants recognized the need to be attune to the child and meet them where they are as very important to the therapeutic relationship.

Peoples (2021) said the discussion chapter is intended to make connections between the literature review and the results through the lens of the chosen phenomenology philosophy. In this case the lens is through the hermeneutic framework. The dasein, foresight, and hermeneutic circle were used for interpretation of the results section. To interpret the findings, the researcher looked at the *dasein*, foresight, and the hermeneutic circle from the perspective of the researcher, but also the participants.

Interpretation of the Findings

Using the Heideggerian theoretical framework, both the researcher's process and participants' experiences were used for understanding the *daesin*, foresight, and hermeneutic circle to discuss the findings. For the *dasein*, the process of understanding the researcher's "being in the world" and its impact on the research. Foresight was about any preconceived knowledge about experiences or situations on the part of the researcher. The hermeneutic circle allowed for the researcher to use the new information given to change preconceived ideas or thoughts. As previously mentioned, Heidegger recommended the researcher's biases be made known and as the thoughts and feelings of

the participants are based on their experiences, the researcher used her own experiences to help interpret the findings (Peoples, 2021).

The participants' experiences will be discussed through the same hermeneutic lens. Interpretation of the *dasein* will be about how participants found themselves in situations or circumstances not of their own making and how they experience "being-in-the-world" with others. Foresight with the participants will be recognized by their own preconceived ideas and what if anything changed during their experiences. The hermeneutic circle encompasses the revisions made due to their new experiences and understanding. Each research question will be discussed through these two dynamics along with previous research available to give an understanding of the lived experiences of clinicians in ways of their experiences, knowledge and treatment of children who exhibit developmental trauma.

When appropriate information from previous studies was compared alongside the data collected here. However, the themes for the first research question regard the thoughts and feelings of the participants and as such will be allowed to stand for themselves.

Participants' Lived Experiences

Participants were asked about their experiences working with children who exhibit developmental trauma. Themes which came out of the interviews were Challenging, Rewarding, and Triggering. When thinking about when a child is not progressing, they shared they were more in a Reflecting way of trying to see what might be causing the breakdown in therapy. Participants related their own experiences to give a Normalizing awareness to students and new clinicians who might consider working with

this population. Each of these themes had subthemes. The theme Challenging had subthemes of Emotionality, Success Rate, Ongoing Abuse, and the Expectations of Others. Rewarding had five subthemes in which there was Privilege, Small Movements, Beautiful, Meaningful, and Rich. Triggering had two subthemes; Own Abusive History, and Painful Events. Reflecting's subthemes were the Opportunity to Learn, Self-Reflection, and If the Right Intervention Was Being Used. Normalizing had four subthemes of which were Difficult Work, Counseling for Self, the Need for Supervision and/or Consultation, Self-Care, and the Potential for Burnout.

Working With Developmental Trauma Has Many Challenges

Challenges such as emotionally, dealing with the expectations of others, the success rate, and the possibility the child may experience ongoing abuse can occur when working with children who have developmental trauma. Shea (2015) mentioned social workers interviewed in their study expressed feelings of helplessness and hopelessness. Many of the participants in the current study, looked off to the side, smiled, took in a deep breath and reflected on what they wanted to say. Working with children who display developmental trauma means clinicians are on a constant shift between emotions. Emotions may arise from the stories heard, the interactions with the child, and from the difficulty of the work itself. Clinicians may experience many emotions such as frustration when children with developmental trauma do not meet outcomes they hope for.

Shea (2015) discussed how budget cuts impacted the level of care government agencies were able to provide to children with trauma histories, not unlike what Participant 6 expressed. When there is a push to progress or to garner a desired outcome for continued money to be received, therapists might feel pressure to perform. The

success rate of helping children according to Participant 6 was low when looking at the study by Farnfield and Onions (2021) after 2 years in residential care children exhibited worse emotional regulation, which seems to agree with Participant 6's point of view. Participants 4 and 6 discussed how children may still be in an abusive environment due to parenting plans or placement instability. Shea (2015) expressed similar reservations as to how to help children with placement instability, and family-related issues.

My perspective on this theme is in agreement with the participants and the findings in the study. Hearing stories of the children who have developmental trauma does bring up many emotions. Anger and frustration are a few of the emotions expressed along with sadness that some children experience trauma in the form of abuse and or neglect to that extreme. There does appear to be pressure from kinship care parents, or the parent bringing the child for treatment to "fix the solution." There was some foresight on my behalf due to also working with this population before conducting this research. As for the hermeneutic circle no new understandings were established but a sense of camaraderie for other clinicians was experienced.

Based on the responses of the participants many knew working with children exhibiting developmental trauma was going to be challenging emotionally. Participant 6 ended by leaving the agency in which he worked to become a trainer for those working with this population and do consulting work, due to pressures of the agency to use certain therapies and the push for a certain outcome. Another experience expressed by the participants about working with this population was rewarding.

Working With Developmental Trauma May Have Benefits

Conducting therapy with a child demonstrating developmental trauma can be rewarding in that it is a privilege to see the small movements forward in healing, which reflect the beautiful, meaningful, and the richest work a therapist can do. Working with highly traumatized clients was shown to have positive gains with a deeper understanding associated with clinicians (Coleman et al., 2018). Words used in the interviews about experiences working with this population were varied – “privilege,” “beautiful,” “the richest work a therapist can do,” “sacred,” and “meaningful.” These words used to express the thoughts of the participants show how meaningful work with children who exhibit developmental trauma can be.

Like the participants, I experienced a sense of privilege in witnessing the small movements forward in healing for children with developmental trauma. Working with children who have developmental trauma has been truly humbling and meaningful. Here again, there is agreement between the participants’ thoughts and those of the researcher.

With the answers expressed by the participants, it is apparent they enjoy the work they do with children with trauma histories. Participant 6 shared his story about the young man that saw him at the ATM. He said those moments meant so much to him because he also shared, they do not happen often. The participants expressed their thoughts and feelings based on what they have witnessed in working with children with traumatic experiences. Another expression of experience in working with children with developmental trauma is triggering.

Working With Developmental Trauma May Be Triggering

Working with children who demonstrate developmental trauma can bring up one's own abusive childhood or events or memories painful to remember. Working with children who have trauma histories can have a detrimental impact on clinicians (Coleman et al., 2018). Osofsky (2009) shared vicarious trauma, compassion fatigue, and burnout are part of the work in helping children with trauma histories. Clinicians have the potential to form vicarious trauma or secondary trauma when listening to the trauma stories of their clients (Andaházy, 2019; Sprang et al., 2011). Symptoms of vicarious trauma include post-traumatic stress disorder in the manner of reexperiencing the traumatic event, avoiding stimuli related to the event, increased arousal, and cognitive intrusions (Ivicic & Motta, 2017). Butler et al. (2017) interviewed 195 students attending clinical training and found about half (48.5%) reported having been traumatized during their fieldwork. Baird and Kracen (2006) did a meta-analysis investigating vicarious trauma. At the time of meta-analysis only 10 years had gone by where vicarious trauma was studied. What was found was having a history of trauma is linked to developing vicarious trauma as reported in six studies. The amount of exposure (client hours, amount of time on caseload, and overall exposure) to traumatic material did not increase the likelihood of vicarious trauma (Baird & Kracen, 2006). Coping strategies and self-care do not prevent vicarious trauma, but do offer a buffer (Jordan, 2018). Hearing trauma stories may lead to vicarious trauma. Unresolved issues may arise causing counter-transference to occur.

Counter-transference occurs when a clinician unconsciously transfers unresolved issues from their own past (Lowe, 2016). The client may trigger thoughts, feelings, and

emotions in the clinician resulting from past memories. Counter-transference may look different depending on what the clinician experienced in the past. Without insight, counter-transference may impact the therapeutic relationship. Awareness of the clinician's past experiences and attachment histories is important, as is being reflective on what is happening during therapy. Supervision and/or consultation can be used by the clinician to process thoughts and, feelings on past resolved issues, and how to recognize when counter-transference is taking place (Lowe, 2016).

Over half of the participants shared working with this population has been triggering for them. Three of the participants shared specifically they had been abused as children. Participant 5 shared a story of how one girl at camp triggered her so much she needed to go for swims to decompress from the pain she witnessed in the little girl, as well as something inside her had shattered. Participant 6 shared he consults and counsels social workers who are working tirelessly to help children because of their own past and working past the point of healthy boundaries. Lowe (2016) stated the clinician knowing of their prior experience can either enhance or interfere with the work they want to do. Awareness of those experiences and vulnerabilities can provide an opportunity to be more genuine, authentic and empathetic for the clinician with the client (Lowe, 2016).

Not unlike the participants, working with children with developmental trauma does trigger memories of past childhood abuse and neglect for me as well. Situations arise in therapy which do bring up past memories and need to be put aside until these memories can be processed properly. At times, however, it can be difficult to do so. This was one question was most important to ask and talk about. I was driven by a desire to know if other clinicians working with this population had similar stories.

It is important to look at and explore Participant 1's story with the hermeneutic framework. From the *dasein* perspective she found herself in a situation she did not want to be in when asked to meet with a child whose parents were going through a divorce; she was the same age when she experienced her own parents getting divorced. She had foresight to know this experience might bring up painful memories of that time in her life. She was right, but she also recognized she could help the child and later help her younger self. The new information allowed her the opportunity to continue to work with children.

Using the hermeneutic framework and the lens of countertransference, we can look at Participant 5's story about the young 6-year-old girl who had been raped a short time before camp. When Participant 5 witnessed the little girl sobbing, the participant instantly felt viscerally that she was "shattered." The participant recognized something inside herself was not alright and found time alone to process her thoughts and feelings with God. Participant 5 was aware of part of her story, but not all of it. Meeting that young little girl, opened up thoughts, feelings, and perhaps memories she had not dealt with or remembered, which offered a potential counter-transference. The little girl and her story changed how Participant 5 saw herself and who she was. The new information Participant 5 received about herself changed how she interacted the rest of the season at camp she mentioned. Another experience expressed by the participants was when pediatric clients do not move forward during therapy, they took time to self-reflect and ask themselves questions about what was holding up progress.

Treatment Does Not Go Smoothly

There are times when progress is not happening, where self-reflections are made and questions of is the right intervention being used. All of the participants expressed times when children are not moving forward and how this led them to reflect with many questions. Most of the questions expressed were from a stance of what the participant was doing or if the participant was the one with the reticence to move forward. They asked questions of the self, such as to “Am I holding it back somehow?” and, “Am I not naming something that needs to be named to like, what’s my contribution to the stuckness?” This line of questioning allowed the participants to explore their own feelings and thoughts about what was happening in the therapy session.

When a child is not progressing, self-reflection does occur for the researcher as well. The researcher has had similar questions when trying to figure out why a child is not progressing. Hearing from other clinicians they also experience times when their pediatric clients are not moving forward was encouraging and validating.

When the second request for member check was sent out, Participant 2 shared similar thoughts about how validating and normalizing it was for her to read how other clinicians worked with this population (see Appendix I). The new information did not necessarily give her a new way to think, but it validated and reassured her others working with this population felt at times the same way she did.

One thing to consider when a child is not making progress, there is a feeling for the clinician perhaps “nothing is happening” to note, something is still happening during the therapeutic relationship. The child may not have previously experienced an adult who could sit in uncomfortable silence. The child may not have had a chance to fully trust an

adult and seeing the adult regulate their own emotional discomfort without the fear of being abused may feel extraordinary and rare for the child. Participant 1 mentioned she recognized she needed to be present with the child in her office. Being present in the stuckness is also very important for the child to witness to add to their sense of safety. The participants wanted to share some normalizing advice for students and new clinicians when they might feel uncertain.

Participants Imparted Normalizing Advice to Students and New Clinicians

Participants wanted to share some thoughts to those considering working with children with developmental trauma talking about the work being difficult, perhaps having counseling for self, receiving supervision or consultation, discussed the potential of burnout, and the importance of self-care. In his study, Shea (2015) study, caseworkers were expressing feelings of hopelessness, helplessness, anger and frustration sometimes mirroring the child who wanted to avoid or disengage. Shea (2015) reported many of the social workers expressed feelings of helplessness from lack of engagement from the foster parent and trying to maintain a high level of attunement between foster parent and child. As Participant 9 mentioned, sometimes the parent or foster parent has their own trauma history is causing their own dysregulation and cannot meet the needs of the child.

Counseling for the clinician can be very helpful. Some graduate programs require a certain number of counseling sessions for their counseling students. This provides future clinician to have insight as to what it feels like being in therapy, but may also allow for opportunities to process thoughts, feelings, and painful memories. Lowe (2016) mentioned supervision and counseling are not the same thing. It is imperative to have good boundaries around what to bring to supervision versus having therapy.

Supervision and/or consultation is necessary for a clinician to feel confident in themselves and the modalities in which they use. Clinicians felt confident in using evidence-based modalities when paired with regular consultation and supervision by the agencies (Kim et al., 2018; Osofsky, 2009) in which they worked, as well as proper training and the openness by the clinician (Kim et al., 2018). A supervisor understands both the theories and modalities used by the supervisee and how to help the supervisee best meet the needs of his or her clients (Lowe, 2016). Regular supervision is important for those who work with trauma (Damra et al., 2014; Osofsky, 2009). The supervisor can also give recommendations on self-care, issues with counter-transference, how to avoid or deal with burnout (Coleman et al., 2018; Osofsky, 2009) vicarious trauma (Colman et al., 2018; Jordan, 2018; Osofsky, 2009), and the overall impact client work has on the clinician (Coleman et al., 2018). Four of the participants (44.4%) shared they are either consultants or supervisors for areas of modalities of therapies, or clinical supervisors of an agency. The experience of being a supervisor gave them the agency and candidness to share the importance of supervision or consultation.

Receiving supervision while working with clients has been very beneficial for me as well. A recent event happened where I had to mandate report two young boys being unattended at a college baseball game for over 10 hours. Due to a very neglectful childhood, this event emotionally, mentally, and physically exhausted me. Talking in supervision about the event allowed for a decompression and a way to accept what had happened during my childhood and a recognition of aligning with the two young boys. Supervision allows a chance for me to ask questions of stuckness (when I feel I am not

moving forward with a child), or options for modification as the supervisor knows the therapies, I use for the clients I see.

Burnout was a topic three (33.3%) participants discussed they felt was important for students or new clinicians to know about and understand. With psychological distress discussed by Harker et al. (2016) clinicians may not be at their best when meeting with clients. There are steps or skills one can use when wanting to prevent or alleviate burnout. La Mott and Martin (2019) stated compassion fatigue can happen to any clinician. Positive attitudes towards evidence-based modalities and their own confidence in modalities used were protective factors against burnout (Kim et al., 2018). Self-care may be a way to decrease the impact of burnout, emotion exhaustion, or compassion fatigue (La Mott & Martin, 2019; Osofsky, 2009). La Mott and Martin (2019) stated low self-care was associated with a greater risk of burnout. High levels of resilience and mindfulness predicted lower levels of burnout (Harker et al., 2016). Higher age was found to have a negative correlation with burnout (Harker et al., 2016; Sprang et al., 2011). Other ways to confront burnout are to have support, in the manner of self-care and supervision and/or consultation.

Discussion about burnout has occurred over the years between my supervisor and myself, including how to balance things out when work/life balance is especially problematic. Talk about clients, how many client hours, and how or what I am doing to prevent burnout has been continual.

The participants discussed burnout from the perspective of seeing it happen in others. They did not mention if they had ever experienced burnout personally. Participant 6 shared he had been doing therapy with others who had been burned out. Participants 3

mentioned she saw clinicians start off really excited to work with this population, but soon became burned out. Participant 8 shared what she shared with her supervisees about the importance of a work/life balance to be sustainable in the field including the need for self-care.

Self-care is of great import to those working in the field of mental health. Self-care can provide respite from the mental intrusions which come with hearing trauma stories. Andaházy (2019) shared self-care can help the clinician be at their best. Self-care may provide growth and thriving beyond client work (Coleman et al., 2018). Trainings should be conducted for students in graduate school to learn how to have self-care (Butler et al., 2017; La Mott & Martin, 2018) as vicarious trauma may occur during coursework or during field work (Butler et al., 2017). La Mott and Martin (2018) believed if students found benefits of self-care early in their career, they would incorporate the learned skill into their future and perhaps extend their career.

Self-care was introduced to me during my interview for graduate school. The question posed was, “What do you do for self-care?” At the time, I had no concept of self-care, but learned during the course of the program I needed to make sure I had time for myself. In turn not unlike Participant 9, I have worked self-care into my schedule. I decided 4 years ago, when I opened my practice to have every Monday off and every other Friday off as well. This allows for longer weekends and opportunities to visit my family and/or friends. It also allows for time for me to relax and decompress from perhaps a trauma heavy week in sessions.

The importance of self-care was discussed by three (33.3%) participants. Participant 3 said the modality of therapy she uses allows her to take care of herself and

feels very invaluable to her. Participant 9 is a cancer survivor so self-care is of extreme import and so she only works so many hours during the day and has only a few clients. This allows her to take care of herself while still providing the families she works with the care they need. Working with children who have trauma histories can be difficult to navigate and the second research question was about how clinicians understand developmental trauma.

Understanding of Developmental Trauma

Participants were asked about their understanding of developmental trauma. The researcher asked questions about trauma training in graduate school, and about their knowledge of what happens with a child who exhibits developmental trauma. The overall themes were the Lack of Graduate Training in Trauma, the Pervasive Nature of Trauma, and the Dysregulation Effects of Trauma. The subthemes of lack of training meant no specific or some specific course work in trauma. The subthemes for the pervasive nature of trauma were Early Stressors, Needs Not Met, and the Impact to Self. Subthemes for the dysregulation effects of trauma were Angry Outbursts, Emotional and Behavioral Dysregulation.

No Course Work on Developmental Trauma for Many Participants

Most participants, eight (88.9%) out of nine, shared they had no specific coursework on children with developmental trauma. The one participant who did have course work had a professor whose practice entailed working with children exhibiting developmental trauma. This agrees with previous research by Weir et al. (2008) stating less than half of marriage and family programs surveyed 48% had coursework related to adoption and foster care, 16.3% of the social work programs had coursework in adoption,

and 22.1% had coursework in foster care. Trauma-informed care is essential in curriculum due to exposure to trauma and stress it invokes in working with children who have developmental trauma (Butler et al., 2017). These programs might not have focused on what happens to a child who has been a victim of abuse and/or neglect and how to help the child.

In both undergraduate and graduate school, I had courses in which one could understand abuse and or neglect. In undergraduate school, family violence was a course offered as well as a course on attachment. These two courses discussed what abuse could look like with abusive relationships. Family violence explained how abusive relationships impact the victim/survivor. Attachment explained what abuse and/or neglect could look like in the form of attachment styles the infant/child would form. Graduate school offered a course which was an elective to receive a master's degree and the course was on child and elder abuse. What was not discussed was what happens to the child internally when exposed to abuse and/or neglect and how to help the dysregulated child. Hearing responses of the participants allowed for a feeling of validation, as I was not alone in feeling certain things were left out. The responses also allowed for insight as to what trainings I might want to undertake in the future, and feeling there is still a lot more to learn about treating developmental trauma.

The lack of specific coursework in graduate school forced participants to undertake the daunting task of finding tools to help them treat children with developmental trauma. One participant shared she developed a new modality of therapy to help the clinician regulate their emotions while working with a child. She said she felt this was a missing piece of the puzzle for her in her training. Another participant has

studied multiple variations of play therapy and other modalities to be able to adapt to what the child may need. From the responses given by participants, it would appear even though their experience in graduate school lacked proper trauma training, they found other measures to best serve this vulnerable population. Children with developmental trauma experience stress early in life which impact how they see themselves.

The Pervasive Nature of Trauma Felt by Children Have Early Stressors

Children who are victims of abuse and/or neglect experience their needs not being met, and impact to their sense of self. Previous research stated a child's caregiving environment had an impact on their brain development (Afifi & MacMillan, 2011; Blair & Raver, 2016; McLaughlin et al., 2015; Tottenham, 2018; Vela, 2014). Child maltreatment occurs generally in the context of both family dysfunction and a troubled parent-child relationship (Dubowitz et al., 2019). The family dysfunction in an abused and/or neglected child might be their needs are not being met emotionally, physically, mentally, and relationally. These needs include receiving food when hungry, drink when thirsty, clothing and shelter for warmth and safety, which allows the child to observe, learn, and practice healthy coping skills and establish a healthy response under stress (Blair & Raver, 2016; Kertes et al., 2009; Perry, 2009; Scott et al., 2011; Shonkoff et al., 2011; van der Kolk, 2005). Farnfield and Onions (2021) found children who were exposed to abuse and/or neglect failed to learn about their bodies and feelings and how to make sense of their world.

The participants' responses were in alignment with previous research and expressed their views as to how abuse and/or neglect impacted the children they treat. From what participants recognized in working with those children, they were in unison as

to what brings about developmental trauma and one of the ways in which the children were impacted.

Listening to responses given by the participants, I gained a better understanding of what I experienced growing up in an abusive and neglectful environment. The responses were validating to hear and brought a feeling of gratitude I was not alone in my experiences. These responses added depth and breadth in terms of offering me a new awareness of how to process thoughts and memories of the past at a later time. Previously, I mentioned recently, I had to report two young boys being unsupervised. That experience brought up memories of me riding a city bus to attend church in the evening without a parent. After this experience with the two boys, nightmares followed the next two evenings, and I processed the experience in supervision. The depth of hurt and pain came back was excruciating. Not unlike Participant 5, who shared a story of being shattered when she engaged the 6-year-old little girl and felt the need to get things right with God, I had a similar experience recognizing God was protecting me during those rides on the city bus and throughout my childhood.

The Effects of Trauma Were Expressed by Dysregulation

Expressions of dysregulation consisted of angry outbursts, and both emotionally and behaviorally. Previous studies discussed how abuse and/or neglect causes severe stress on the child's system leading to potential long-lasting effects on brain development, impacting negative emotions and bringing about maladaptive behaviors (Burns et al., 2004; McWey, 2004; Morales-Munez et al., 2018). Children with abuse and/or neglect histories often display behavioral dysregulation (York & Jones, 2017). This display can be in the form of explosive anger (Cook et al., 2005; D' Andrea et al.,

2012) and destructive behaviors such as kicking, biting, and spitting (York & Jones 2017). Impulsivity was found to be a developmental component to both internal and external behaviors (Wasserman et al., 2021). The participants all expressed to what level dysregulation they witnessed in children exhibiting developmental trauma. The responses all are in alignment to what has been documented in the scholarly literature.

Developmental Trauma Impacts Treatment

Participants were asked how developmental trauma impacts how they treat pediatric clients with developmental trauma. Participants discussed how some do not have formal assessments to gauge the level of developmental trauma. Participants shared what they observe when looking at a pediatric client who exhibits developmental trauma. The participants discussed what goes into diagnosing a child with developmental trauma and the potential of misdiagnosing. There was not just one therapeutic modality all the participants used, which allows for flexibility in interventions. The participants mentioned the importance of meeting the child where they are at, and the importance of making modifications when needed.

Understanding Developmental Trauma Informs Clinicians on Treatment

Knowing the impact developmental trauma has on a child who has been exposed to abuse and/or neglect can inform the clinician on how to assess, where they may not use formal assessments, they may use the emotional age, and continue to assess the child throughout treatment. According to Choi and Graham-Bermann (2018) based on the recent literature, a developmental psychopathology perspective is important to understand, assess, diagnose, and treat post-traumatic stress disorders properly. Most of the studies reviewed in Choi and Graham-Bermann's (2018) meta-analysis did not use

the DSM diagnostic criteria to assess the children for PTSD as young children only partially met the criteria and the PTSD criteria was oriented towards adult trauma survivors.

Most participants mentioned they did not perform formal assessments for their pediatric clients. Many stated they are continuously assessing the client throughout treatment. One participant shared she gets all the collateral information she needs, but does not do an official assessment. The participants found it more beneficial to continually assess as it allowed for the adaptation of treatment interventions based on the child's individual needs. Participant 1 shared she continually assesses the "emotional age" of the child.

When meeting the children and young adolescents at my internship, I gave an intake to the adopted and kinship parents of the children who were coming for therapy. In meeting with the families and then with each individual child or young adolescent, it was apparent the emotional age did not meet the chronological age of the client. Development had stopped emotionally, socially, and cognitively for clients at the age at which they were abused.

If using the hermeneutic circle to explain why Participant 1 uses the emotional age to assess the gap in development of a child, she does so to understand where the child is emotionally to know where to begin treatment. Participant 1 understands normal human development and the benchmarks which should be made by certain ages, which informs her foresight. The information Participant 1 gleans from establishing the emotional age of the child, allows her to develop a timeline of milestones to be

addressed. The new information changes the participant's perspective of the child and what their needs are.

When Assessing Developmental Trauma Changes Are Observed

Physical, behavioral, and emotional changes are observed to give the clinician an indication of where the developmental gap occurred. Previous research mentioned how trauma impacts the daily functioning of a child, including language and relational difficulties (Chambers et al., 2010; McLaughlin et al., 2015; Newman & Mares, 2007; Shonkoff et al., 2011), and the emotional world of the child (Chambers et al., 2010; Finzi et al., 2001; Newman & Mares, 2007). Children with trauma histories have difficulty in controlling their emotions, especially anger and anxiety (Bruce et al., 2009; Cook et al., 2005; Hughes, 2004; Shonkoff et al., 2012). Some children with trauma histories display behavioral dysregulation (York & Jones, 2017), showing as explosive anger, and inappropriate affect (Cook et al., 2005; D' Andrea et al., 2012).

During my internship it was brought to my attention many of the children in my case load were either coming from foster care, adopted, or from kinship care. When angry, one child would do self-harming behavior and would throw a temper tantrum as a young child would, not as 14-year-old teenager would. Assessment for those clients showed them to be behaving at a level not age-appropriate.

Participants expressed what they are observing in children with developmental trauma. For some participants observations were behavioral and emotional changes, Participant 1 also looks for the physical change taking place when a child has been abused and/or neglected. She shared the story of the Russian orphan who was 17-years-old, but had the face of a 10-year-old. His physical development was stunted by the lack

of interaction with others. What changes the participants are noticing in children with developmental trauma provides support of previous research.

Participants Diagnose What They Observe in Abused Children

Participants shared they diagnose developmental trauma based on what is being presented to them, while others cautioned the potential for misdiagnosis. Currently developmental trauma is not a disorder mentioned in the DSM-V (American Psychiatric Association, 2013). Developmental trauma again, may be more parsimonious than giving numerous diagnoses (D' Andrea et al., 2012; DePierro et al., 2019; Gregorowski & Seedat, 2013; Spinazzola et al., 2018; Stolbach et al., 2013; van Der Kolk et al., 2019). In lieu of developmental trauma, clinicians diagnose patients with reactive attachment disorder (RAD; Barth et al., 2005) or oppositional defiant disorder (ODD**;** Harman et al., 2000).

Participants expressed how they came to diagnose the children exhibiting developmental trauma. A few looked at anxiety, depression and somatic symptoms and others looked to try and find a trauma diagnosis which fit what was being presented. However, Participant 3 shared the children did not meet the criteria of PTSD, in agreement with Choi and Graham-Bermann's (2018) meta-analysis. Participant 3 then looked to other specified trauma and stressor related disorder because the pieces fit better. The participants' responses fall in alignment with previous research.

Three participants shared the potential of misdiagnosis of attention deficit/ hyperactive disorder (ADHD), oppositional defiant disorder (ODD), and autism spectrum disorder (ASD) instead of developmental trauma. Participant 3 shared the running joke at the community mental health clinic where she saw clients for some time, about finding a

child with ADHD, and asking where the trauma is instead. Participants 7 and 9 shared how ADHD might be the wrong diagnosis for some children who were abused and/or neglected and should be assessed for developmental trauma. Participant’s 3 and 6 discussed how developmental trauma might be misdiagnosed as autism.

It is important to note, developmental trauma may never be admitted as a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*; however, clinicians need to have an awareness of how pediatric clients’ narratives plays a role in the fuller picture. Clinicians may observe depression and anxiety and when a full developmental timeline is placed alongside the child’s abuse history, a clinician should be able to understand how the narrative of the child falls hand in hand with developmental trauma. Once a diagnosis is made, treatment planning and implementation of intervention begins.

Modalities of Therapy Need to Be Varied for Developmental Trauma

Miller-Graff and Campion (2016) conducted a meta-analysis on 74 studies performed over the previous 15 years of treatments with children who have post-traumatic stress disorder (PTSD). The most used modality of treatment was cognitive behavioral therapy (CBT) and trauma-focused cognitive behavioral therapy (TF-CBT) with 16 studies with large effect sizes. Eye movement desensitization and reprocessing (EMDR) was used in two studies with a smaller effect size. Other modalities used to treat children with PTSD were trauma focused art therapy, grief and traumatic intervention (GTI), child-parent psychotherapy, child-centered psychotherapy, narrative therapy, group CBT, manualized group, child-centered play therapy, family therapy, and trauma adaptive recovery group education and training (TARGET). According to Miller-Graff

and Campion (2016) there are clear gaps in the empirical evaluation of treatments, and a gap exists in treatments for children younger than 8-years-old even though symptoms of PTSD are present at the younger ages. Perry (2009) suggested using a neurosequential model of therapeutics which is not an intervention but a clinical approach using neuroscience, bringing scaffolding to a child missing developmental milestones. Bambrah et al. (2018) used TF-CBT with 53 Canadian, parent-child dyads and found with the 36 dyads, at the **6**-month follow-up, symptoms of PTSD were reduced in the children, and the parents were able to better regulate their emotions.

At the beginning of this study, there was an awareness of different modalities available to use in treating trauma. I have had EMDR and LI training, and LI with youth and adolescents training, to use in treating people with trauma histories. In listening to the participants discuss the different modalities they use in working with children who exhibit developmental trauma, it has become more apparent there are more options available for study.

The majority of participants, eight (88.9%) out of the nine, have two or more modalities available to them to use when treating a child with developmental trauma, only one participant had only one method of intervention. Participant 3 shared she appreciates being up-to-date on modalities and has been trained in six different modalities and is a supervisor for two different play therapy modalities. Participant 9 shared the importance of learning and doing the work to be able to meet the child’s needs and meet them where he or she is at.

Attuning to the Child is Imperative to Gain the Child's Trust

A child who has been exposed to abuse and/or neglect may have difficulty in trusting. Forming a therapeutic alliance has the potential to bring about attunement (González et al., 2019). The therapeutic alliance offers support, acceptance, and validation for the client with a potential to bring a desire to be an active participant during therapy (Fernández et al., 2016). The participants' responses are in agreement with previous research about the desire to meet the child where they are, allowing for a reciprocal therapeutic relationship beneficial for the child.

When meeting new pediatric clients, my initial questions are about getting to know them and what they like to do. If seeing a little boy, I ask questions about sports, about what sports they play, their position on the team, and what they like about it and if the sport is baseball, it surprises them when I share baseball is my favorite sport. If the new client is a little girl, there are questions about sports, and adding what she likes to do for fun. There are card games and board games in the office to allow for play as talking occurs, so the focus does not need to be on the child. The desire is to build rapport with the child and help them to establish the clinician in front of them is a safe person.

The participants all have ways to analyze how to meet the child where they are at and begin the attuning process. They mentioned the importance of having the attunement with the child. This attunement allows the child to feel safe with the clinician. Participant 6 shared not being attuned with the child might create shame for the child or the family, thus preventing nurturance from occurring. Using the new information given to him, Participant 6 recognized the need to be attuned to the child and their needs. Even with best intentions interventions sometimes need to be modified to fit what the child needs.

Modifications Sometimes Need to be Made

When therapy halts in progress sometimes modifications need to be explored by potentially bringing other specialists on board, changing the level of stimuli, and making developmentally appropriate changes. Algeria et al. (2010) stated mental health providers need to be able to tailor (modify) treatment to offer services to diverse populations. Tailoring treatment for foster and adoptive families is imperative (Chakawa et al., 2020; Lochman, 2021); however, suggestions about specific ways in which to do so are lacking (Chakawa et al., 2020). Chakawa et al. (2020) made modifications to parent-child interaction therapy (PCIT) not previously explored in PCIT research. Damra et al. (2014) made modifications to trauma-focus cognitive behavioral therapy (TF-CBT) for children and adolescents in Jordan which had not been previously explored for the Jordanian culture. There is a gap in the literature where therapy modifications are concerned. The participants interviewed, all stated they have had to make modifications during therapy with children who exhibit developmental trauma.

When participants recognize the child’s window of tolerance cannot hold anymore stimuli and/or emotion they understand a modification to therapy might be necessary. Participants shared ways in which they make modifications to help the child stay in the window of tolerance. Some participants shorten the session time others changed the number of toys offered to the child to take away the feelings of being overwhelmed for the child others bring in other support resources such as an occupational therapist and two have therapy animals to aid the child during sessions.

Therapy modification was not something really discussed in any of the trainings I attended learning different modalities of therapy. I asked participants about modifying

therapy because this has personally been an uncomfortable thought for me. Foresight came into play for me during this study because I wanted to explore how clinicians choose to make modifications. Hearing the participants speak boldly on how they modify and with no qualms or reservations, led me to find confidence in modifying interventions with developmental appropriateness in mind.

Limitations and Future Directions

This study was mainly focused on understanding the perspectives of clinicians who work with children who exhibit developmental trauma. It was limited to only nine participants from the mental health field (e.g., social workers, mental health counselors). Even though there were similarities in the responses, the findings cannot be generalized due to the methodology, which was designed with an open and explorative attitude to add to the limited research available on clinicians who treat children with developmental trauma (Berg, 2019). Future studies should incorporate other cultural populations and their approaches to working with children with developmental trauma. For example, all but one participant was from the United States, so future studies could be conducted to examine different experiences treating developmental trauma in other countries. One of the criteria was the participant had to have had 5 years after graduate school professional experience, findings might be different if the participants were just out of graduate school. All participants were also providers of mental health, no faculty members of graduate programs were interviewed, which might dramatically affect the findings.

There is little current research on modifying interventions, which is an area for fruitful research in the future. Two articles were found regarding modifying interventions. One by Darma and colleagues (2014) discussed the need to modify TF-

CBT for Jordanian children and youth who had suffered abuse. Chakawa and colleagues (2020) modified PCIT to help a foster adoptive family. Both studies mentioned this was the first time these modalities had been modified in the literature.

Implications for Graduate Training Programs

This study has various implications for how graduate programs can approach teaching future clinicians about the mental health needs of children with developmental trauma. A couple of suggestions are now presented:

- Provide coursework specific material for working with children who have developmental trauma (Weir et al., 2008). Coursework could include how the brain undergoes changes which impact behavioral and emotional regulation, and relational issues due to abuse and/ or neglect so students learn how to recognize developmental trauma in children. Understanding the difference between a singular event trauma versus chronic abuse and/or neglect is imperative for students who want to work with this vulnerable population. Faculty members can offer tools on how to assess the different ways in which developmental trauma manifests. A key aspect of curriculum could be the ramifications of treating ADHD with medication, or a diagnosis of being on the autism spectrum when the child has developmental trauma. Offer students options about different possible modalities of interventions which have been shown to be effective with children with developmental trauma, and offer concrete ideas about how to make modifications based on what the child needs.

- Discuss the impacts of working with children who exhibit developmental trauma on the clinician. As Participant 6 shared many of the professionals he counseled had trauma histories in their own past and did not understand how to have better work/ life balance to prevent burnout. Participant 3, also shared how many a new therapist started out strong and excited, then did not have the skills to take care of themself. Due to the nature of working with trauma, it is important to share with graduate students the need to engage in their own therapy or draw on supervision to process thoughts, feelings, or memories which come up for them. Having the mentor/mentee relationship is imperative for the mentee to be able to express thoughts, struggles, or stuckness while treating children with developmental trauma. Talk about the potential of burnout and how it can impact the effectiveness of the clinician. Explain the necessity of self-care and possible suggestions for the student to draw on throughout their career as a clinician.

Implications for Mental Health Professionals, Therapists, and Counselors

This study has various implications for mental health professionals and how they approach treating children with developmental trauma. A few of the suggestions are provided below:

- Understand developmental trauma is not a disease or an illness which can be easily fixed. As Participant 2 stated, “I may not be like any other clinicians, but I believe developmental trauma is not an illness. Like we can talk about mental health and we can talk about mental wellness, but this is no disease.” Mental health professionals, provide scaffolding for the child who exhibits

developmental trauma. They can offer support, acceptance, and validation of feelings is what the therapeutic alliance will give to the child (Fernández et al., 2016).

- Know triggers may arise when working with children with developmental trauma. Recognize if the triggers are traumas from the clinician's past, or if unresolved trauma injuries are bringing up countertransference, or secondary trauma. Understand which issues to bring to a supervisor versus a counselor.
- Be part of a consultation group or find a supervisor for support and accountability. Supervision and/or consultation should provide support on new modalities to gain confidence in using the intervention. Having supervision can allow for open conversation about struggles, thoughts, and insights and how the clinician experiences them.
- Find modalities of therapy which best fit the clinician's training and the client's needs. Inquire how effective the modality is from other clinicians, and if there are ways in which the intervention can be modified to fit the needs of a child whose window of tolerance is at its limits.
- Make self-care part of the routine. To be sustainable, self-care is imperative. Self-care allows time to refresh, decompress, and feel rejuvenated. Self-care can be a preventative measure against burnout.
- Know other mental health professionals are also experiencing the same thoughts, feelings, and doubts when working with children who exhibit developmental trauma. Participant 2 shared in the second member check, "This is amazing!! Not only was it validating and normalizing to read other

therapists' responses, it felt inspiring that this many people have clear ideas on how to support children in really tough situations."

- The *Diagnostic and Statistical Manual of Mental Disorders,* may never add developmental trauma as a diagnosis. A clinician should, however, be able to learn and parcel out whether the child is presenting symptoms of developmental trauma or another diagnosis based on the child's narrative and history of abuse and/ or neglect. The clinician with an understanding of developmental trauma should be able to build a case for diagnosing developmental trauma. Once the diagnosis has been concluded, the clinician then can focus on what interventions best meet the need of the child they are seeing.

Conclusion

Caregiving impacts a child's brain development. According to the Child Abuse Prevention and Treatment Act (CAPTA) of 1974, an unhealthy environment such as maltreatment encompasses five subcategories of physical abuse, emotional abuse, physical and emotional neglect, sexual abuse, and witnessing family violence. Abuse and/or neglect have been proven to negatively impact the trajectory of the brain's development. Developmental trauma affects areas of the brain related to emotional and behavioral regulation. The limbic system, which deals with arousal, is impacted, as well as the stress response system which helps to manage a potential threat. The stressors from abuse and/or neglect leave the child with a fragile sense of self and difficulty with attachments. Children with developmental trauma showing difficulty regulating behaviors and emotions and with relational issues are brought to clinicians for treatment.

Clinicians working with children who have developmental trauma experience both the difficulty of the work and yet rewarding journey. One difficulty faced by many of the participants in the current study was a lack of education in graduate school regarding developmental trauma. Out of nine participants, only one participant had coursework specifically for developmental trauma. Based on previous research, education and training around developmental trauma have been lacking (Weir et al., 2008) and this study confirmed that finding. Education concerning symptomology of developmental trauma is necessary. Due to the potential of a misdiagnosis, an understanding of the differences in other disorders needs to be explained and explored. The confidence in using interventions and how, when, and where to make modifications are essential for working with children exhibiting developmental trauma and should be addressed during graduate school. Moreover, the impact on the clinician working with developmental trauma needs to occur during graduate school.

Rewarding, challenging, and triggering were some of the sentiments shared by participants in the current study. DePierro et al. (2019) asked clinicians about their pediatric clients with developmental trauma, but no questions were posed about the experience of working with the population itself. It was the current researcher's hope to fill the gap in the literature by providing the lived experiences of clinicians who work with this vulnerable population. Clinicians may experience triggers of past events and memories when working with children with developmental trauma.

Working with children with developmental trauma can be rewarding, but it may be overwhelming. Counter-transference, secondary trauma, and burnout may be experienced by clinicians working with children with trauma histories. Discussion around

supervision, consultation, and self-care needs to be explored for sustainability. More courses specifically focused on the impact abuse and neglect has on a child, how to help the child, and the impact on the clinician are needed. Developmental trauma impacts not only the child but also how the clinician assesses which treatment best meets the need of the child.

Developmental trauma impacts all aspects of the therapeutic relationship a clinician has with a child. From assessing, diagnosing, choosing the right intervention, and recognizing the need for modification, developmental trauma plays a major role in how clinicians engage with the pediatric clients they see. As of yet, developmental trauma has not been included as a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders.* Perhaps with future research and more clinicians who understand how developmental trauma impacts abused and neglected children more compelling arguments will be made to include this as a possible diagnosis. However, clinicians should be able to use a descriptive narrative of the child's abusive history to formulate an assessment and diagnosis, thus providing an optimal treatment plan and interventions until then.

References

Academy for Play Therapy Training. (n.d.). *How to become a play therapist*. https://www.trainingplaytherapy.com/how-to-become-a-certified-play-therapist/

Afifi, T. O., McTavish, J., Turner, S., MacMillan, H. L., & Wathen, C. N. (2018). The relationship between child protection contact and mental health outcomes among Canadian adults with a child abuse history. *Child Abuse & Neglect*, *79*, 22–30. https://doi.org/10.1016/j.chiabu.2018.01.019

Alegria, M., Atkins, M., Farmer, E., Slaton, E., & Stelk, W. (2010). One size does not fit all: Taking diversity, culture, and context seriously. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(1-2), 48–60. https://doi.org/10.1007/s10488-010-0283-2

Allen, B. (2011). The use and abuse of attachment theory in clinical practice with maltreated children, part II: Treatment. *Trauma, Violence, & Abuse*, *12*(1), 13–22. https://doi.org/10.1177/1524838010386974

Allen, B. (2016). A RADical idea: A call to eliminate "attachment disorder" and "attachment therapy" from the clinical lexicon. *Evidence-Based Practice in Child and Adolescent Mental Health*, *1*(1), 60–71. https://doi.org/10.1080/23794925.2016.1172945

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author. https://doi.org/10.1176.appi.books.9780890425596

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174–186. https://doi.org/10.1007/s00406-005-0624-4

Andaházy, A. (2019). Tuning of the self: in session somatic support for vicarios trauma-related countertransference. *Body, Movement and Dance in Psychotherapy, 14*(1), 41–57. https//doi.org/10.1080/17432979.2019.1577758

Applegate, J. S., & Shapiro, J. R. (2005). *Neurobilogy for clinical social work: Theory and practice*. W. W. Norton & Company.

Bambrah, V., Mastorakos, T., Cordeiro, K.M., Thornback, K., Muller, R. T. (2018). Parent-child discordance and child trauma symptomatology throughout therapy: correlates and treatment response. *Journal of Family Violence, 33*(2018), 281–295. https://doi.org/10.1007/s10896-017-9948-x

Barth, R. P., Crea, T. M., John, K., Thoburn, J., & Quinton, D. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child and Family Social Work*, *10*(4), 257–268. https://doi.org/10.1111/j.1365-2206.2005.00380.x

Becker-Weidman, A. (2006). Treatment for children with trauma-attachment disorders: Dyadic developmental psychotherapy. *Child and Adolescent Social Work Journal*, *23*(2), 147–171. https://doi.org/10.1007/s10560-005-0039-0

Belsky, J., & de Haan, M. (2011). Annual Research Review: Parenting and children's brain development: the end of the beginning. *Journal of Child Psychology and Psychiatry*, *52*(4), 409–428. https://doi.org/10.1111/j.1469-7610.2010.02281.x

Berg, H. (2019). How does evidence-based practice in psychology work? – As an ethical demarcation. *Philosophical Psychology*, *32*(6), 855–875. https://doi.org/10.1080/09515089.2019.1632424

Blair, C., & Raver, C. C. (2016). Poverty, stress, and brain development: New directions for prevention and intervention. *Academic Pediatrics*, *16*(3), S30–S36. https://doi.org/10.1016/j.acap.2016.01.010

Boris, N. W. (2003). Attachment, aggression and holding: A cautionary tale. *Attachment & Human Development*, *5*(3), 245–247. https://doi.org/10.1080/14616730310001593947

Boyce, W. T., & Ellis, B. J. (2005). Biological sensitivity to context: I. An evolutionary–developmental theory of the origins and functions of stress reactivity. *Development and Psychopathology*, *17*(02), 271–301. https://doi.org/10.1017/S0954579405050145

Boyd, D., & Bee, H. (2015). Physical and cognitive development in early childhood. In D. Boyd, & H. Bee, *Lifespan development* (7th ed., pp. 161–178). Pearson.

Breedlove, S. M., & Watson, N. V. (2013a). Attention and higher cognition. In S. M. Breedlove & N. V. Watson, *Biological Psychology: An introduction to behavrioal, cognitive, and clinical neuroscience* (7th ed., pp. 561–596). Sinauer Associates.

Breedlove, S. M., & Watson, N. V. (2013b). Behavior, Functional neuroanatomy: The nervous system and behavior. In S. M. Breedlove & N. V. Watson, *Biological Psychology: An introduction to behavrioal, cognitive, and clinical neuroscience* (7th ed., pp. 23–57). Sinauer Associates.

Breedlove, S. M., & Watson, N. V. (2013c). Functional neuroanatomy: The nervous system and behavior. In S. M. Breedlove & N. V. Watson*, Biological Psychology: An introduction to behavrioal, cognitive, and clinical neuroscience* (7th ed., pp. 23–58). Sinauer Associates.

Breedlove, S. M., & Watson, N. V. (2013d). Language and hemispheric asymmetry. In S. M. Breedlove & N. V. Watson, *Biological Psychology: An introduction to behavrioal, cognitive, and clinical neuroscience* (7th ed., pp. 597–633). Sinauer Associates.

Brown, J. M. (2015). Therapeutic moments are the key: foster children give clues to their past experience of infant trauma and neglect. *Journal of Family Therapy*, *37*(3), 286–307. https://doi.org/10.1111/j.1467-6427.2012.00606.x

Bruce, J., Fisher, P. A., Pears, K. C., & Levine, S. (2009). Morning cortisol Levels in preschool-aged foster children: Differential effects of maltreatment type. *Developmental Psychobiology*, *51*(1), 14–23. https://doi.org/10.1002/dev.20333

Bruce, M., Young, D., Turnbull, S., Maki, R., Chadwick, G., Young-southward, G., Minnis, H., & Haig, C. (2019). Reactive attachment disorder in maltreated infants and young children in foster care. *Attachment & Human Development*, *21*(2), 152–169. https://doi.org/10.1080/14616734.2018.1499211

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(8), 960–970. https://doi.org/10.1097/01.chi.0000127590.95585.65

Butler, L. D., Carello, J., Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological, Trauma, Theory, Research, Practice, and Policy, 9*(4), 416–424. https://doi.org/10.1037/tra0000187

Carliner, H., Gary, D., McLaughlin, K. A., & Keyes, K. M. (2017). Trauma exposure and externalizing disorders in adolescents: Results from the National Comorbidity Survey Adolescent Supplement. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(9), 755–764.e3. https://doi.org/10.1016/j.jaac.2017.06.006

Carrion, V. G., Weems, C. F., Watson, C., Eliez, S., Menon, V., & Reiss, A. L. (2009). Converging evidence for abnormalities of the prefrontal cortex and evaluation of midsagittal structures in pediatric posttraumatic stress disorder: An MRI study. *Psychiatry Research: Neuroimaging*, *172*(3), 226–234. https://doi.org/10.1016/j.pscychresns.2008.07.008

Cassidy, A. R. (2016). Executive function and psychosocial adjustment in healthy children and adolescents: A latent variable modelling investigation. *Child Neuropsychology*, *22*(3), 292–317. https://doi.org/10.1080/09297049.2014.994484

Chaffin, M., Hanson, R., Saunders, B. E., Nichols, T., Barnett, D., Zeanah, C., Berliner, L., Egeland, B., Newman, E., Lyon, T., Letourneau, E., & Miller-Perrin, C. (2006). Report of the APSAC Task Force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment*, *11*(1), 76–89. https://doi.org/10.1177/1077559505283699

Chakawa, A., Frye, W., Travis, J., & Brestan-Knight, E. (2020). Parent-child interaction therapy: Tailoring treatment to meet the sociocultural needs of an adoptive foster child and family. *Journal of Family Social Work, 23*(1), 53–70. https://doi.org/10.1080.10522158.2019.1681336

Choi, K. R., & Graham-Bermann, S. A. (2018) Developmental considerations for assessment of trauma symptoms in preschoolers: A review of measures and diagnoses. *Journal of Child and Family Studies, 27*(2018), 3427–3439. https://doi.org/10.1007/s10826-018-1177-2

Chambers, M. F., Saunders, A. M., New, B. D., Williams, C. L., & Stachurska, A. (2010). Assessment of children coming into care: Processes, pitfalls and partnerships. *Clinical Child Psychology and Psychiatry*, *15*(4), 511–527. https://doi.org/10.1177/1359104510375932

Coleman, A.M., Chouliara, Z., & Currie, K. (2018). Working in the field of complex psychological trauma: A framework for personal and professional growth, training, and supervision. *Journal of Interpersonal Violence, 00*(0), 1–25. https://doi.org/ 10.1177/0886260618759062

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautuad, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, *35*(5), 390–398. https://doi.org/10.3928/00485713-20050501-05

Cowell, R. A., Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2015). Childhood maltreatment and its effect on neurocognitive functioning: Timing and chronicity matter. *Development and Psychopathology*, *27*(2). https://doi.org/10.1017/S0954579415000139

Cuffe, S. P., & Shugart, M. (2001). Child abuse and psychic trauma in children. In H. B. Vance & A. Pumariega (Eds.), *Clinical Assessment of Child & Adolescent Behavior* (pp. 329–357). John Wiley & Sons.

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry*, *82*(2), 187–200. https://doi.org/10.1111/j.1939-0025.2012.01154.x

Damra, J. K. M., Nassar, Y.H., & Ghabri, T. M. F. (2014). Trauma-focused cognitive behavioral therapy: Cultural adaptations for application in Jordanian culture. *Counseling Psychology Quarterly, 27*(3), 308–323. https://doi.org/10.1080/09515070.2014.918534

De Bellis, M. D., Nooner, K. B., Scheid, J. M., & Cohen, J. A. (2019). Depression in Maltreated Children and Adolescents. *Child and Adolescent Psychiatric Clinics of North America*, *28*(3), 289–302. https://doi.org/10.1016/j.chc.2019.02.002

De Brito, S. A., Viding, E., Sebastian, C. L., Kelly, P. A., Mechelli, A., Maris, H., & McCrory, E. J. (2013). Reduced orbitofrontal and temporal grey matter in a community sample of maltreated children. *Journal of Child Psychology and Psychiatry*, *54*(1), 105–112. https://doi.org/10.1111/j.1469-7610.2012.02597.x

DePierro, J., D'Andrea, W., Spinazzola, J., Stafford, E., van Der Kolk, B., Saxe, G., Stolbach, B., McKernan, S., & Ford, J. D. (2019). Beyond PTSD: Client presentations of developmental trauma disorder from a national survey of clinicians. *Psychological Trauma: Theory, Research, Practice, and Policy*. https://doi.org/10.1037/tra0000532

Dozier, M. (2003). Attachment-based treatment for vulnerable children. *Attachment & Human Development*, *5*(3), 253–257. https://doi.org/10.1080/14616730310001596151

Dozier, M., Albus, K., & Fisher, P. A. (2002). Interventions for foster parents: Implications for developmental theory. *Development and Psychopathology*, *14*(2002), 843–860. https://doi.org/10.1017.S0954579402004091

Dubowitz, J., Roesch, S., Metzger, R., Arria, A., Thompson, R., & English, D. (2019). Child maltreatment, relationship with father, peer substance use, and adolescent marijuana use. *Journal of Child & Adolescent Substance Abuse, 28*(1), 1–10. https://doi.org/10.1080/1067828X.2019.1667285

Farnfield, S., & Onions, C. (2021). The role of affect regulation in deveopmental trauma: An empirical study of children in residential care. *Journal of Child Psychotherapy, 47*(3), 470–490. https://doi.org/10.1080/0075417x.2021.2015421

Feeney, B. C., Cassidy, J., & Ramos-Marcuse, F. (2008). The generalization of attachment representations to new social situations: Predicting behavior during initial interactions with strangers. *Journal of Personality and Social Psychology*, *95*(6), 1481–1498. https://doi.org/10.1037/a0012635

Fernández, O.M., Krause, M., & Pérez, J.C. (2016). Therapeutic alliance in the initial phase of psychotherapy with adolescents: Different perspectives and their association with therapeutic outcomes. *Research in Psychotherapy: Psychopathology, Process and Outcome 2016, 19*, 1–9. https://doi.org/10.4081/ripppo.2016.180

Ford, J. D., Spinazzola, J., van der Kolk, B., & Grasso, D. J. (2018). Toward an empirically based developmental trauma disorder diagnosis for children. *The Journal of Clinical Psychiatry*, *79*(5), 628–639. https://doi.org/10.4088/JCP.17m11675

Foster, A. L., D/Andrea, W. D., Fehertoi, N., Healy, C. J., & Miller, A. (2019). Assessing the validity and clinical utility of a developmental trauma diagnosis in ethnic minority adolescents. *Journal of Child & Adolescent Trauma,* 12(2019), 479–488. https://doi.org/10.1007/s40653-019-00272-2

Fujisawa, T. X., Shimada, K., Takiguchi, S., Mizushima, S., Kosaka, H., Teicher, M. H., & Tomoda, A. (2018). Type and timing of childhood maltreatment and reduced visual cortex volume in children and adolescents with reactive attachment disorder. *NeuroImage: Clinical*, *20*, 216–221. https://doi.org/10.1016/j.nicl.2018.07.018

Gardenhire, J., Schleiden, C., & Brown, C. C. (2019). Attachment as a tool in the treatment of children within foster care. *Contemporary Family Therapy*, *41*(2), 191–200. https://doi.org/10.1007/s10591-018-09487-1

Gokten, E. S., & Uyulan, C. (2020). Prediction of the development of depression and post-traumatic stress disorder in sexually abused children using a random forest classifier. *Journal of Affective Disorders*, *279*, 256–265. https://doi.org/10.1016/j.jad.2020.10.006

Gold, A. L., Sheridan, M. A., Peverill, M., Busso, D. S., Lambert, H. K., Alves, S., Pine, D. S., & McLaughlin, K. A. (2016). Childhood abuse and reduced cortical thickness in brain regions involved in emotional processing. *Journal of Child Psychology and Psychiatry*, *57*(10), 1154–1164. https://doi.org/10.1111/jcpp.12630

González, O. F., Pérez, J. C., & Krause, M. (2019). The relation between the therapeutic alliance and communicative intentions in therapeutic interaction during the initial phase of adolescent therapy. *Research in Psychotherapy: Psychopathology, Process and Outcome 2019, 22*, 189–198. https://doi.org/10.4081/ripppo/1019.356

Greeson, J. K. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake III, G. S., Ko, S. J., Gerrity, E. T., Steinberg, A. M., Howard, T. H. M. L., Pynoos, R. S., & Fairbank, J. A. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network. *Child Welfare*, *90*(6), 91–108.

Gregorowski, C., & Seedat, S. (2013). Addressing childhood trauma in a developmental context. *Journal of Child & Adolescent Mental Health*, *25*(2), 105–118. https://doi.org/10.2989/17280583.2013.795154

Harker, R., Pidgeon, A. M., Klaassen, F., & King, S. (2016). Exploring resilience and mindfulness as preventative factors for psychological distress burnout and secondary traumatic stress among human sesrvice professionals. *Work, 54*(2016), 631–637. https://doi.org/10.3233/WOR-162311

Haugaard, J. J. (2004). Recognizing and treating uncommon behavioral and emotional disorders in children and adolescents who have been severely maltreated: Dissociative disorders. *Child Maltreatment*, *9*(2), 146–153. https://doi.org/10.1177/1077559504264311

Hoemann, K., Xu, F., & Barrett, L. F. (2019). Emotion words, emotion concepts, and emotional development in children: A constructionist hypothesis. *Developmental Psychology*, *55*(9), 1830–1849. https://doi.org/10.1037/dev0000686

Hughes, D. (2004). An attachment-based treatment of maltreated children and young people. *Attachment & Human Development*, *6*(3), 263–278. https://doi.org/10.1080/14616730412331281539

Hughes, D. A. (2003). Psychological interventions for the spectrum of attachment disorders and intrafamilial trauma. *Attachment & Human Development*, *5*(3), 271–277. https://doi.org/10.1080/14616730310001596142

Hunter, A. L., Minnis, H., & Wilson, P. (2011). Altered stress responses in children exposed to early adversity: A systematic review of salivary cortisol studies. *Stress*, *14*(6), 614–626. https://doi.org/http10.3109/10253890.2011.577848

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). Skill integration, decisional counseling, treatment planning, and relapse prevention. In *Intentional Interviewing and Counseling: Facilitating Client Development in a Multicultural Society* (8th ed., pp. 351–393). Brooks/Cole.

Ivicic, R., & Motta, R. (2017). Variables associated with secondary traumatic stress amng mental health professionals. *Traumatology, 23*(2), 196–204. https://doi.org/10.1037/trm0000065

Jedd, K., Hunt, R. H., Cicchetti, D., Hunt, E., Cowell, R. A., Rogosch, F. A., Toth, S. L., & Thomas, K. M. (2015). Long-term consequences of childhood maltreatment: Altered amygdala functional connectivity. *Development and Psychopathology*, *27*(402), 1577–1589. https://doi.org/10.1017/S0954579415000954

John, S. G., Brandt, T. W., Secrist, M. E., Mesman, G. R., Sigel, B. A., & Kramer, T. L. (2019). Empirically-guided assessment of complex trauma for children in foster care: A focus on appropriate diagnosis of attachment concerns. *Psychological Services*, *16*(1), 120–133. https://doi.org/10.1037/ser0000263

Jonkman, C. S., Oosterman, M., Schuengel, C., Bolle, E. A., Boer, F., & Lindauer, R. J. L. (2014). Disturbances in attachment: Inhibited and disinhibited symptoms in foster children. *Child and Adolescent Psychiatry and Mental Health*, *8*(1), 1–7. https://doi.org/10.1186/1753-2000-8-21

Jordan, K. (2018). Trauma-informed counseling supervision: Something every counselor should know about. *Asia Pacific Journal of Counseling and Psychotherapy, 9*(2), 127–142. https://doi.org/10.1080/21507686.2018.1450274

Kelly, P. A., Viding, E., Wallace, G. L., Schaer, M., De Brito, S. A., Robustelli, B., & McCrory, E. J. (2013). Cortical thickness, surface area, and gyrification abnormalities in children exposed to maltreatment: Neural markers of vulnerability? *Biological Psychiatry*, *74*(11), 845–852. https://doi.org/10.1016/j.biopsych.2013.06.020

Kim, J. J., Brookman-Frazce, L., Gellatly, R., Stadnick, N., Barnett, M. L., & Lau, A. S. (2018). Predictors of burnout among community therapists in the sustainment phase of a system-driven implementation of multiple evidence-based practices in children's mental health. *Professional Psychology: Researcher and Practice, 49*(2), 132–141. https://doi.org/10.1037/pro000182

Kliewer-Neumann, J. D., Zimmermann, J., Bovenschen, I., Gabler, S., Lang, K., Spangler, G., & Nowacki, K. (2018). Assessment of attachment disorder symptoms in foster children: Comparing diagnostic assessment tools. *Child and Adolescent Psychiatry and Mental Health*, *12*, Article 43. https://doi.org/10.1186/s13034-018-0250-3

Knefel, M., Lueger-Schuster, B., Karatzias, T., Shevlin, M., & Hyland, P. (2019). From child maltreatment to ICD-11 complex post-traumatic stress symptoms: The role of emotion regulation and re-victimisation. *Journal of Clinical Psychology*, *75*(3), 392–403. https://doi.org/10.1002/jclp.22655

La Mott, J., & Martin, L. A. (2019). Adverse childhood experiences, self-care, and compassion outcomes in mental health working with trauma. *Journal of Clinical Psychology, 2019*(75), 1066–1083. https://doi.org/10.1002/jclp.22752

Lehmann, S., Breivik, K., Monette, S., & Minnis, H. (2020). Potentially traumatic events in foster youth, and association with DSM-5 trauma- and stressor related symptoms. *Child Abuse and Neglect*, *101*(January), Article 104374. https://doi.org/10.1016/j.chiabu.2020.104374

Lieberman, A. F., Chu, A., Van Horn, P., & Harris, W. W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology*, *23*(2), 397–410. https://doi.org/10.1017/S0954579411000137

Lilienfield, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, *2*(1), 53–70. https://doi.org/10.1111/j.1745-6916.2007.00029.x

Lochman, J. E. (2021). Tailoring of evidence-based group intervention with children with disruptive behavior: Implications for therapists and researchers. *Salud Mental, 44*(6), 257–260. https://doi.org/10.17711/SM.0185-3325.2021.033

Lowe, C. (2016). The professional's influence within the client system: Exploring counter-transfernce and adult attachment within the therapeutic relationship with children experiencing abuse and their caregivers. *Journal of Social Work Practice, 30*(1), 59–68. https://doi.org/10.1080/02650533.2015.1035236

Luby, J., Belden, A., Botteron, K., Marrus, N., Harms, M. P., Babb, C., Nishino, T., & Barch, D. (2013). The effects of poverty on childhood brain development: The mediating effect of caregiving and stressful life events. *JAMA Pediatrics*, *167*(12), 1135–1142. https://doi.org/10.1001/jamapediatrics.2013.3139

Luke, M. A., Maio, G. R., & Carnelley, K. B. (2004). Attachment models of the self and others: Relations with self-esteem, humanity-esteen, and parental treatment. *Personal Relationships*, *11*(2004), 281–303. https://doi.org/10.1111/j.1475-6811.2004.00083.x

McCrory, E., De Brito, S. A., & Viding, E. (2010). Research review: The neurobiology and genetics of maltreatment and adversity. *Journal of Child Psychology and Psychiatry*, *51*(10), 1079–1095. https://doi./10.1111/j.1469-7610.2010.02271.x

McCrory, E. J., De Brito, S. A., Kelly, P. A., Bird, G., Sebastian, C. L., Mechelli, A., Samuel, S., & Viding, E. (2013). Amygdala activation in maltreated children during pre-attentive emotional processing. *British Journal of Psychiatry*, *202*(4), 269–276. https://doi.org/10.1192/bjp.bp.112.116624

McLaughlin, K. A., Sheridan, M. A., Tibu, F., Fox, N. A., Zeanah, C. H., & Nelson, C. A. (2015). Causal effects of the early caregiving environment on development of stress response systems in children. *Proceedings of the National Academy of Sciences*, *112*(18), 5637–5642. https:// doi.org/10.1073/pnas.1423363112

McLean, S., Riggs, D., Kettler, L., & Delfabbro, P. (2013). Challenging behaviour in out-of-home care: use of attachment ideas in practice. *Child & Family Social Work*, *18*(3), 243–252. https://doi.org/10.1111/j.1365-2206.2012.00825.x

McWey, L. M. (2004). Predictors of attachment styles of children in foster care: An attachment theory model for working with families. *Journal of Marital and Family Therapy*, *30*(4), 439–452. https://doi.org/10.1111/j.1752-0606.2004.tb01254.x

Mercer, J., Samer, L., & Rosa, L. (2003). *Attachment Theapy on Trial: The Torture and Death of Candace Newmaker*. Greenwood Publishing Group.

Mercer, J. (2013). Holding therapy in Britain: Historial background, recent events, and ethical concerns. *Adoption & Fostering, 37*(2), 144–156. https://doi.org/10.1177/0308575913490498

Messman-Moore, T. L., Walsh, K. L., & DiLillo, D. (2010). Emotion dysregulation and risky sexual behavior in revictimization. *Child Abuse and Neglect*, *34*(12), 967–976. https://doi.org/10.1016/j.chiabu.2010.06.004

Mikulincer, M., & Shaver, P. R. (2005). Attachment theory and emotions in close relationships: Exploring the attachment-related dynamics of emotional reactions to relational events. *Personal Relationships*, *12*(2005), 149–168. https://doi.org/10.1111/j.1350-\4126.2005.00108.x

Mikulincer, M., Shaver, P. R., Bar-On, N., & Ein-Dor, T. (2010). The pushes and pulls of close relationships: Attachment insecurities and relational ambivalence. *Journal of Personality and Social Psychology*, *98*(3), 450–468. https://doi.org/10.1037/a0017366

Miller, A. B., Esposito-Smythers, C., Weismoore, J. T., & Renshaw, K. D. (2013). The Relation Between Child Maltreatment and Adolescent Suicidal Behavior: A Systematic Review and Critical Examination of the Literature. *Clinical Child and Family Psychology Review*, *16*(2), 146–172. https://doi.org/10.1007/s10567-013-0131-5

Miller-Graff, L.E., & Campion, K. (2016). Interventions for posttraumatic stress with children exposed to violence: Factors associated with treatment success. *Journal of Clinical Psychology, 72*(3), 226–248. https://doi.org/10.1002/jclp.2238

Monin, J. K., Feeney, B. C., & Schultz, R. (2012). Attachment orientation and reactions to anxiety expression in close relationships. *Personal Relationships*, *19*(3), 535–550. https://doi.org/10.1111/j.1475-6811.2011.01376.x

Moors, A. C. (2020). Research methods in psychology: A feminist exercise to facilitate students' understanding of operational definitions, observation, and inter-rater reliability. *Psychology of Women Quarterly*, *44*(2), 266–270. https://doi.org/10.1177/0361684319900349

Morrison, J. (2014). *The first interview* (4th ed.). Guilford Press.

Newman, L., & Mares, S. (2007). Recent advances in the theories of and interventions with attachment disorders. *Current Opinion Psychiatry*, *20*(2007), 343–348.

O'Connor, T. G., & Zeanah, C. H. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development*, *5*(3), 223–244. https://doi.org/10.1080/14616730310001593974

Oshri, A., Gray, J. C., Owens, M. M., Liu, S., Duprey, E. B., Sweet, L. H., & MacKillop, J. (2019). Adverse childhood experiences and amygdalar reduction: High-resolution segmentation reveals associations with subnuclei and psychiatric outcomes. *Child Maltreatment*, *24*(4), 400–410. https://doi.org/10.1177/1077559519839491

Osofksy, J. D. (2009) Perspectives on helping traumatized infants, young children, and their families. *Infant Mental Health Journal, 30*(6), 673–677. https://doi.org/10.1002/imhj.20236

Pearce, J. W., & Pezzot-Pearce, T. D. (2001). Psychotherapeutics approaches to children in foster care: Guidance from attachment theory. *Child Psychiatry & Human Development*, *32*(1), 19–44. https://doi.org/10.1023/A:1017555529166

Pears, K. C., & Fisher, P. A. (2005). Emotion understanding and theory of mind among maltreated children in foster care: Evidence of deficits. *Development and Psychopathology*, *17*(1), 47–65. https://doi.org/10.1017/S0954579405050030

Peoples, K. (2021). *How to write a phenomenological dissertation: A step-by-step guide*. SAGE Publications.

Perry, B. D. (2009). examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss and Trauma*, *14*(4), 240–255. https://doi.org/10.1080/15325020903004350

Raby, K. L., & Dozier, M. (2018). Attachment across the lifespan: Insights from adoptive families. *Physiology & Behavior*, *176*(1), 139–148. https://doi.org/10.1117/12.2549369.Hyperspectral

Roos, L. E., Kim, H. K., Schnabler, S., & Fisher, P. A. (2016). Children's executive function in a CPS-involved sample: Effects of cumulative adversity and specific types of adversity. *Children and Youth Services Review*, *71*. https://doi.org/10.1016/j.childyouth.2016.11.008

Saldana, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). SAGE Publications.

Schalinski, I., Teicher, M. H., Carolus, A. M., & Rockstroh, B. (2018). Defining the impact of childhood adversities on cognitive deficits in psychosis: An exploratory analysis. *Schizophrenia Research*, *192*, 351–356. https://doi.org/10.1016/j.schres.2017.05.014

Scott, S., Briskman, J., Woolgar, M., Humayun, S., & O'Connor, T. G. (2011). Attachment in adolescence: Overlap with parenting and unique prediction of behavioural adjustment. *Journal of Child Psychology and Psychiatry*, *52*(10), 1052–1062. https://doi.org/10.1111/j.1469-7610.2011.02453.x

Scozzaro, C., & Janikowski, T. P. (2015). Mental health diagnosis, medication, treatment and placement milieu of children in foster care. *Journal of Child and Family Studies*, *24*(9), 2560–2567. https://doi.org/10.1007/s10826-014-0058-6

Seidman, I. (2019). *Interviewing as qualitative research* (5th ed.). Teacher's College Press.

Shaver, P. R., Mikulincer, M., & Shemesh-Iron, M. (2010). A behavioral systems perspective on prosocial behavior. In M. Mikulincer & P. R. Shaver (Ed.) *Prosocial motives, emotions, and behavior*: *The better angles of our nature* (pp. 73–91). American Psychological Association. https://doi.org/10.1037/12346-004

Shea, S. E. (2015). Finding parallels: The experiences of clinical social workers providing attachment-based treatment to children in foster care. *Clinical Social Work Journal*, *43*(1), 62–76. https://doi.org/10.1007/s10615-014-0488-z

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., Garner, A. S., McGuinn, L., Pascoe, J., & Wood, D. L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), e232 LP–e246. https://doi.org/10.1542/peds.2011-2663

Shrivastava, A. K., Karia, S. B., Sonavane, S. S., & De Sousa, A. A. (2018). Child sexual abuse and the development of psychiatric disorders: A neurobiological trajectory of pathogenesis. *Industrial Psychiatry Journal*, *26*(1), 4–12. https://doi.org/10.4103.ipj.ipj_38_15

Smith, A. L., Cross, D., Winkler, J., Jovanovic, T., & Bradley, B. (2014). Emotional dysregulation and negative affect mediate the relationship between maternal history of child maltreatment and maternal child abuse potential. *Journal of Family Violence*, *29*(5), 483–494. https://doi.org/10.1007/s10896-014-9606-5

Smith, M., Cameron, C., & Reimer, D. (2017). From attachment to recognition for children in care. *The British Journal of Social Work*, *47*(6), 1606–1623. https://doi.org/10.1093/bjsw/bcx096

Spall, S. (1998). Peer debriefing in qulaititative research: Emerging operational models. *Qualitative Inquiry*, *4*(2), 280–292. https://doi.org/10.1177/107780049800400208

Spinazzola, J., van der Kolk, B., & Ford, J. D. (2018). When nowhere is safe: Interpersonal trauma and attachment adversity as antecedents of posttraumatic stress disorder and developmental trauma disorder. *Journal of Traumatic Stress*, *31*(5), 631–642. https://doi.org/10.1002/jts.22320

Sprang, G. (2009). The efficacy of a relational treatment for maltreated children and their families. *Child and Adolescent Mental Health*, *14*(2), 81–88. https://doi.org/10.1111/j.1475-3588.2008.00499.x

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare, 90*(6), 149–168.

Stolbach, B. C., Minshew, R., Rompala, V., Dominguez, R. Z., Gazibara, T., & Finke, R. (2013). Complex trauma exposure and symptoms in urban traumatized children: A preliminary test of proposed criteria for developmental trauma disorder. *Journal of Traumatic Stress*, *26*(4), 483–491. https://doi.org/10.1002/jts.21826

Szilagyi, M. A., Rosen, D. S., Rubin, D., & Zlotnik, S. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*, *136*(4), e1142–e1166. https://doi.org/10.1542/peds.2015-2656

Takiguchi, S., Fujisawa, T. X., Mizushima, S., Saito, D. N., Okamoto, Y., Shimada, K., Koizumi, M., Kumazaki, H., Jung, M., Kosaka, H., Hiratani, M., Ohshima, Y., Teicher, M. H., & Tomoda, A. (2015). Ventral striatum dysfunction in children and adolescents with reactive attachment disorder: functional MRI study. *BJPsych Open*, *1*(2), 121–128. https://doi.org/10.1192/bjpo.bp.115.001586

Tarren-Sweeney, M. (2013). An investigation of complex attachment- and trauma-related symptomatology among children in foster and kinship care. *Child Psychiatry & Human Development*, *44*(6), 727–741. https://doi.org/10.1007/s10578-013-0366-x

Teicher, M. H., Anderson, C. M., & Polcari, A. (2012). Childhood maltreatment is associated with reduced volume in the hippocampal subfields CA3, dentate gyrus, and subiculum. *Proceedings of the National Academy of Sciences*, *109*(9), E563–E572. https://doi.org/10.1073/pnas.1115396109

Tottenham, N., Hare, T. A., Quinn, B. T., McCarry, T. W., Nurse, M., Gilhooly, T., Millner, A., Galvan, A., Davidson, M. C., Eigsti, I.-M., Thomas, K. M., Freed, P. J., Booma, E. S., Gunnar, M. R., Altemus, M., Aronson, J., & Casey, B. J. (2010). Prolonged institutional rearing is associated with atypically large amygdala volume and difficulties in emotion regulation. *Developmental Science*, *13*(1), 46–61. https://doi.org/10.1111/j.1467-7687.2009.00852.x

van Der Kolk, B. (2005). Developmental trauma disorder: Toward a rational disgnosis for children with complex trauma histories. *Psychiatric Annals*, *35*(5), 401–408. http://www.ncbi.nlm.nih.gov/pubmed/21538300

van Der Kolk, B. A. (2019). Developmental trama disorder. *Annals Developmental Trauma*. *December*.

van Der Kolk, B., Ford, J. D., & Spinazzola, J. (2019). Comorbidity of developmental trauma disorder (DTD) and post-traumatic stress disorder: findings from the DTD field trial. *European Journal of Psychotraumatology*, *10*(1), Article 1562841. https://doi.org/10.1080/20008198.2018.1562841

van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Routledge Taylor & Francis Group.

Vasilevski, V., & Tucker, A. (2016). Wide-ranging cognitive deficits in adolescents following early life maltreatment. *Neuropsychology*, *30*(2), 239–246. https://doi.org/10.1037/neu0000215

Vela, R. M. (2014). The effect of severe stress on early brain development, attachment, and emotions. *Psychiatric Clinics of North America*, *37*(4), 519–534. https://doi.org/10.1016/j.psc.2014.08.005

Vinnerljung, B., Sundell, K., Löfholm, C. A., & Humlesjö, E. (2006). Former Stockholm child protection cases as young adults: Do outcomes differ between those that received services and those that did not? *Children and Youth Services Review*, *28*(1), 59–77. https://doi.org/10.1016/j.childyouth.2005.02.009

Vuilleumier, P. (2005). How brains beware: neural mechanisms of emotional attention. *Trends in Cognitive Sciences*, *9*(12), 585–594. https://doi.org/10.1016/j.tics.2005.10.011

Vyshedskiy, A., Mahapatra, S., & Dunn, R. (2017). Linguistically deprived children: meta-analysis of published research underlines the importance of early syntactic language use for normal brain development. *Research Ideas and Outcomes*, *3*, Article e20696. https://doi.org/10.3897/rio.3.e20696

Wasserman, A. M., Wimmer, J., Hill-Kapturczak, N., Karns-Wright, T. E., Mathias, C. W., & Dougherty, D. M. (2021). The development of externalizing and internalizing behaviors among youth with or without a family history of substance use disorder: The indirect effects of early-life stress and impulsivity. *Child Psychiatry & Human Development, 52*(2021), 978–993. https://doi.org/10.1007.s10578-020-01076-4

Weir, K. N., Fife, S. T., Whiting, J. B., & Blazewick, A. (2008). Clinical training of MFTs for adoption, foster care, and child development settings: A comparative survey of CACREP, COAMFTE, and CSWE accredited programs. *Journal of Family Psychotherapy*, *19*(3), 277–290. https://doi.org/10.1080/08975350802269517

Whittle, S., Dennison, M., Vijayakumar, N., Simmons, J. G., Yücel, M., Lubman, D. I., Pantelis, C., & Allen, N. B. (2013). Childhood maltreatment and psychopathology affect brain development during adolescence. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*(9), 940–952.e1. https://doi.org/10.1016/j.jaac.2013.06.007

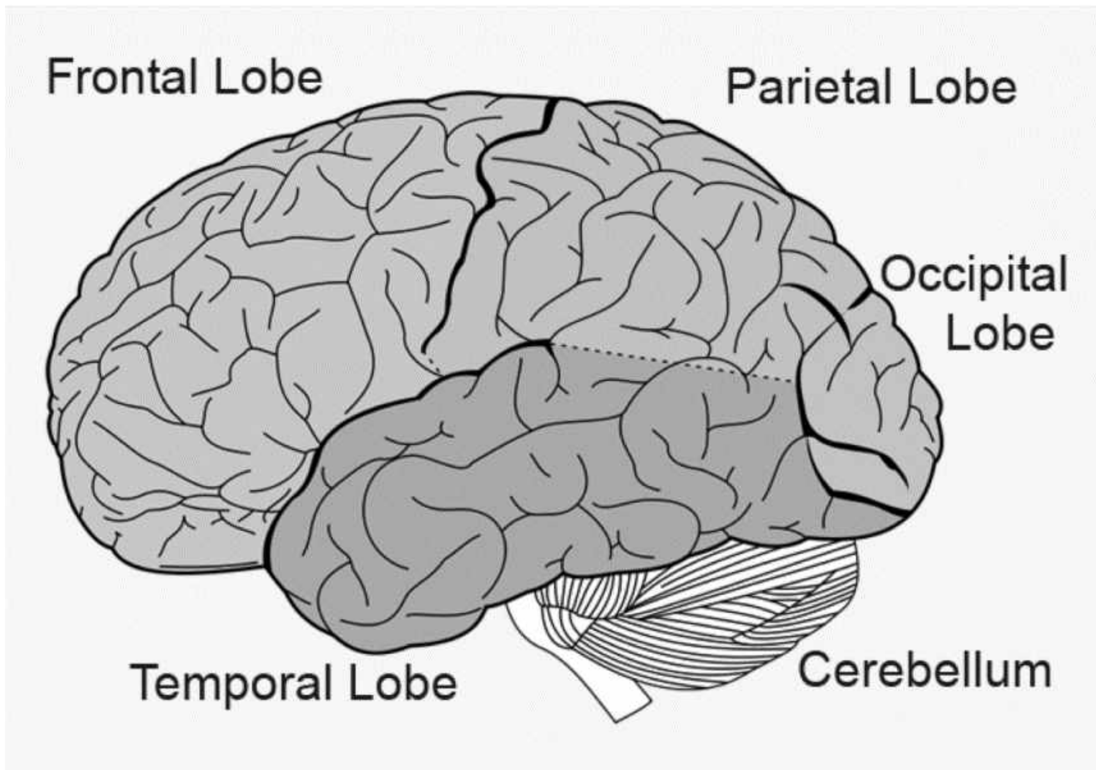
Wilson, K. R., Hansen, D. J., & Li, M. (2011). The traumatic stress response in child maltreatment and resultant neuropsychological effects. *Aggression and Violent Behavior*, *16*(2), 87–97. https://doi.org/10.1016/j.avb.2010.12.007

York, W., & Jones, J. C. (2017). Addressing the mental health needs of looked after children in foster care: The experiences of foster carers. *Journal of Psychiatric and Mental Health Nursing*, *24*(2-3), 143–153. https://doi.org/10.1111/jpm.12362

Zeanah, C. H., Chesher, T., Boris, N. W., Walter, H. J., Bukstein, O. G., Bellonci, C., Benson, R. S., Bussing, R., Chrisman, A., Hamilton, J., Hayek, M., Keable, H., Rockhill, C., Siegel, M., & Stock, S. (2016). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder and disinhibited social engagement disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, *55*(11), 990–1003. https://doi.org/10.1016/j.jaac.2016.08.004

Appendix A

Brain With Lobes Labeled



Appendix B

Developmental Trauma: The Implications of Treatment in Children With Trauma Histories

Northwest University
College of Social and Behavioral Sciences

Consent Form

Welcome to Developmental Trauma: The Implications of Treatment in Children with Trauma Histories, a research study that looks at understanding the impact of developmental trauma from a clinical point of view. This study is being conducted by Dodi Forgione at Northwest University.

To qualify for participation, you must be an adult age 18 years or older. Completion of this study typically takes approximately 2 hours and is strictly anonymous. Your responses will be treated confidentially and will not be linked to any identifying information about you. If you agree to participate in this study you will complete a screener questionnaire regarding demographic information age, gender, race, level of degree, years in practice, and working with children with traumatic experiences. An interview will follow if the inclusion criteria have been met. The 90-minute interview will contain questions about your experiences working with the population of abused and/or neglected children. Questions regarding developmental trauma and your experiences with this potential diagnosis will also be asked. No identifying questions of yourself or your clients will be asked. You may also stop your participation at any time.

After the analysis of the interview, you will be sent the transcript of your interview for your pursual and approval. This member checking allows for you to verify meanings and offer validity to the codes.

The Northwest University Institutional Review Board has approved the study. No deception is involved, and participation in this study poses minimal risk to participants. Although some participants may experience emotional distress when answering questions about children with trauma histories, if content of the questionnaire or the interview causes you significant distress, please call National Alliance on Mental Illness (NAMI), (800) 950-6264 or Mental Health America (MHA), (800) 969-6642. Participation in this study is voluntary, and you may elect to discontinue the questionnaire at any time and for any reason. You may print this consent form for your records. By submitting the questionnaire, you are giving permission to use your responses in this research study.

The results from this study will be utilized for dissertation, publication and/or conference dissemination and may be presented within a variety of psychological forums (formal and informal).

If you have any questions about this study, please contact Dodi Forgione at [redacted]. If you have further questions, please contact my faculty advisor Dr. Leihua Edstrom (dissertation chair) at [redacted]. You may also contact the Chair of the Northwest University IRB, Dr. [redacted], at [redacted]@northwestu.edu or at [redacted].

Before beginning the screener questionnaire, please read this consent form in full. If you understand all information contained in this form and agree to freely participate in this study, please click the "I Agree" button. You may exit the questionnaire at any time.

Thank you for considering participation in this study.

____
Digital Signature of Participant

Contact information for Dodi Forgione
[redacted]@northwestu.edu
Leihua Edstrom, PhD
Professor of Psychology
College of Social and Behavioral Sciences
[redacted]@northwestu.edu
[redacted] office

Appendix C

Screener Questionnaire

1. What is your age?
2. What is your gender?
3. What do you consider your race?
4. What is your level of degree, and credential?
5. How long have you been practicing post graduate school?
6. Did you feel prepared to work with children who were abused and/or neglected when leaving graduate school?
7. What trainings post graduate school have you done to work with trauma?
8. How long have you been working with children?
9. What is the setting in which you currently practice?
10. Have you worked with children who have had traumatic experiences due to abuse and/or neglect?

Appendix D

Interview Questions

1. How do you receive your pediatric clients? Parents, schools, CPS, court mandate
2. What courses do you remember in graduate school that dealt with children and trauma?
3. What made you decide to work with this population?
4. What trainings or certifications do you have to work with children and/or adolescents with trauma histories?
5. Please describe what your experience is like working with children who bring a trauma history with them?
6. How do you view developmental trauma? And how would you define it?
7. How do you see developmental trauma manifest?
8. How do you assess for developmental trauma?
9. How did these assessments help you develop a treatment plan for a child who has had a trauma history?
10. When diagnosing a child with trauma history how often are there comorbid diagnoses?
11. What therapies have you used in working with a child in healing from trauma experiences?
12. Have you had to modify interventions when working with a child who has had trauma experiences? And how so?
13. On average, how many sessions have you had with a child who has had trauma experiences?

14. Please describe a time when you felt you were not moving forward in therapy with a child.
15. Have you ever referred a child to someone else? If so, why?
16. As a clinician, is there anything you would want to share with new clinicians or students who are thinking of working with this population?
17. Has working with this population brought up anything for you?

Appendix E

First Member Check Request

Dear Participant,

Thank you again so much for your time. I am in the final stages, and I need your input. Please find the attached transcript with codes and memos. I need your feedback to continue to show validity and accuracy of your thoughts. Please read through the transcript with codes for any thoughts that might have gotten jumbled or maybe you have new thoughts as well. If I could have your feedback by February 13th, that would be wonderful.

Again, thank you.

Sincerely,
Dodi Forgione

Appendix F

Member Check First Responses

Hi Dodi,

Looks good. I don’t know what you meant by codes, but the transcript itself looks good.

Best to you in your process!

Hi Dodi!
Glad to see that you are moving forward in your work
. The transcription missed a few words here and there but I think you still get the gist. All the ums and likes are pretty embarrassing.
I think the "human bomb diffusing" was overly dramatic, probably more reflective of my recent experiences back then. Though, it is important to be precise with grounding and safe messages.
I would also have to disagree with myself about learning "nothing" about trauma in grad school, it's more that we didn't get presented the new somatic lens (as I mention later, the foundation of attachment and memory in the body) very much. There was one 3 day weekend training. They may have been talking about the same thing through the lens of the genogram/family tree though...
The whole field is fascinating, some of the big names Mate, Van Der Kolk, Porges, have the theory fairly accurately but still seem to be searching for the method.
I would also just add a tiny dash of projection if we were talking today, that I am even more convinced today that what I see in others is a reflection of my own experiences and state.
I appreciate the opportunity to share.

Hi Dodi,
Thank you for sending this along to me and I think it looks great. I got a good chuckle reading the numbers of "Ummms" I said in the interview- LOL. Thank you again and I hope that the interview is able to support your paper in the way you had hoped. If you need anything else please let me know.

Hmm I think I didn't understand the codes and so I didn't look at that part... I'm sorry! I haven't done this before and I haven't looked at qualitative research in so long that I don't remember a ton about it.
I will take another look at it when I have a little more time - but just reading the transcript part of it, I don't think there was anything that didn't come out how I wanted it to, I actually feel really proud of my ability to communicate about this topic after reading it. Although I do very much wish that I had less of a habit of saying "um..." haha.

Hi Dodi,
I have read through the transcript, fun to read… lots there.
Correction of names:
Will continue to review and respond. :-)

Hi Dodi,

Thanks for reaching out. How exciting to be almost done. It's a bit challenging to read through the transcript as it's every word I said literally and sometimes I think the translation didn't come quite through with some words. Not a big deal, but wondering if I could more review what you write vs. the transcript as I don't know what parts you're going to use or not use.

Hi Dodi,
I read through the transcript and enjoyed reliving our conversation! I don't have any edits or additions.
Let me know if I can help further.

Appendix G

Member Check Second Attempt

Thanks for your willingness again to help me with this last stage of my study. I am currently verifying my data and would truly appreciate your feedback. This will help the study to be more reliable and credible, thus, more likely to be used for future considerations. I have attached a document with the main themes in response to my research questions, gathered from everyone who participated in the interviews. There may have been some things you said that was not a major theme in other interviews, hence, not everything was included.

Please, read through the document and provide any comments and impressions you have. If there is a point that you want to be particularly emphasized or de-emphasized, please do let me know. **If I don't hear back from you by March 25th, I will assume that everything looks good and move on with these results.**

Thank you so much again for participating in this study. The information you provided would be beneficial in helping mental health professionals understand the impact of developmental trauma on children and implementing proper treatment.

Thank you.

Dodi

Appendix H

Member Check Second Responses

Wonderful Paper! looks good to me.

Wow Dodi!
This is amazing!! Not only was it so validating and normalizing to read other therapists' responses, it felt inspiring that this many people have clear ideas on how to support children in really tough situations. As for the research piece....I think you have done a beautiful job with the synthesizing.
Thank you so much for including me!!

Ah, ok now I understand. Looks great. Can I make some changes now that I see it from this bigger picture ...

Pg 11 - ~~And that's a~~ **The** beautiful process I have seen with these children is that they have been able
to attach **to** themselves despite what they've experienced, despite being in the boxing ring,
despite experiencing developmental trauma, they **can go through a process of connecting** ~~connect~~ with themselves. ~~They T~~hat's
~~just a~~ **the** beautiful process. (P3)

Pg. 15 - Absolutely. So that does happen. It's just part of the process.
Sometimes **we** ~~you~~ have to
reassess, and ~~you have to~~ look at what ~~we're doing, the modality,~~ **we're doing and what modality we're using. We might have to bring in other things into the child's work such as kickboxing or equine therapy or occupational therapy. Kickboxing offers a body visceral experience that can be quite empowering and really aid the therapeutic process. Sometimes children with developmental trauma hit a ceiling with their work and can't go any further. We need to honor the amazing work they've done up until that point and take a break. Integration requires a rest and digest period, as well as recognizing that healing takes all of childhood, adolescents and sometimes into adulthood for those that have experienced developmental trauma.** ~~maybe we need to bring~~
~~in, we need to bring into the process. Like maybe, you know, I've see seen a lot of amazing work happen. Like I said, when children, maybe we bring in kickboxing while they're doing therapy. Cause kickboxing is one of the things that has found to have a visceral kind of experience, a very empowering experience. Maybe the child participates in some equine therapy at the same time that they're doing this trauma work, maybe we look at some OT, some occupational therapy. If we just hit the ceiling where the child is,~~

~~like no, the child has done an amazing amount of work, and the child has made this much progress and now it's just time for a break.~~ (P3)

Pg. 19 - rewrote this a bit - "I'm a licensed clinical social worker and have a masters of social work. My program was a generalist program and there was not a focus on specialities or within mental health treatment."\

Pg. 20 - ... they see children with attachment, **or push/pull behavior**.

Pg. 21 - So, that void of not having ~~the~~ specific training and coming ~~into~~ **from** a generalist ~~mental health position~~ **background, along with realizing I needed more skills, drove me to find more training, more understanding, and additional ways of supporting children through a therapeutic process.** ~~and realizing I didn't have the skills that I needed, um, created, kind of prompted, drove me to find trainings.~~ (P3)

Pg 24 - ~~So, for example, instead of just avoidant, it's like, let's look at this dissociation and his that showing up? Let's look at the how these arousal symptoms are showing up, not just hypervigilance blaming a lot that you do see a lot of that sometimes presenting or exaggerated startle responses or anger outbursts, but like, what does the anger outbursts like click expand that, but that's what the DSM says right?~~ (P3) **Dysregulation shows up in a combination of hypo- and hyper-aroused symptoms happening simultaneously. The child that is showing up angry, anxious, or hypervigilant, is also struggling with avoidance, dissociation, and numbing. It's important to not just look at the arousal behavior/pattern that the child is presenting with (e.g., anger outbursts), but what's underneath (e.g., feeling powerless, helpless, sadness, lacking a sense of agency, etc.)**

Then take out on pg 25 - ~~They lack a sense of agency and control, and they feel very powerless. So, um, and they have a lot of behaviors, right. That we, um, sometimes get focused on. But instead, we have to look at what's going on behind the behavior.~~ (P3)

Pg. 29 - ~~So, most often I would say that I am using~~ My primary modality and the lens from which I operate is Synergetic Play Therapy. I also bring in other therapeutic modalities including EMDR Therapy, Theraplay, Internal Family Systems and many other expressive and mind-body therapies. I also bring in Animal Assisted Therapy and have a trained service dog that is designed in my State for facility intervention work. ~~I'm using EMDR therapy, I'm using therapy play, at least different kinds of aspects of their play. I use expressive arts. I also have a facility intervention dog that is a trained service dog in my state. (P3)~~

Pg 31 - ~~So, I'm typically looking at lots of different pieces, but I find that the foster parents are, you know, they see the child day in and day out, so they know how the child is sleeping. They know how the child is doing. The know, lots of different pieces. That's where I begin, but to me, assessment is ongoing. So, the assessment really continues as we treat.~~ **I'm assessing throughout the process and as I work with the child and their caregivers/parents. I begin with what the parents/caregivers/foster parents are seeing. They know the child from a perspective that I don't. And continuing to check in with them as it relates to the child's therapeutic process and what I'm seeing in the therapy room.** (P3)

Pg 33 - 34 ~~- But, I think like, if you look and if the child doesn't meet the criteria, then they do get F43.8, which is Other Specified Trauma and Stressor Related Disorder. Because what happens is once I started doing work with children, I start to see the criteria, and then they could get a diagnosis now, maybe they don't have a trauma diagnosis, but most of them do. And if they don't, maybe it is more focused on depression for them, or maybe it is more an anxiety related piece. But I will say most of the children, I work with have some level of trauma. They already experienced many of them, trauma abuse or neglect. So they already have that criteria met. And then oftentimes the symptoms emerge as we're doing treatment now, not always, you know if we do treatment and that child's still struggling with some attention issues. Okay. You know, well maybe we do need to look at a diagnosis of ADHD, but that's after extensive treatment because I also feel like you have to rule things out.~~ **Often children do not meet criteria for a PTSD diagnosis. It often starts with a diagnosis of Other Specified Trauma and Stressor Related Disorder because what they are presenting with are pieces of other diagnoses - depression, anxiety, mood dysregulation, attention issues, attachment, oppositional defiant, impulsivity, etc. Even autism spectrum (for this one, the Coventry Grid out of the UK does a beautiful job distinguishing the symptoms of ASD from developmental trauma). As therapy starts, symptoms emerge with more clarity. There is a need to rule out before just offering a diagnosis.** (P3)

Pg 36 - Basically, I'm always assessing and ~~I'm always like seeing you know,~~ **looking at** what~~'s~~ the child **is** responding to, **and what is needed therapeutically**. ~~I'm~~ **As** a synergetic play therapist, ~~like I said as my foundation, and we have a great way of assessing whether a child is in the working phase.~~ **we're looking at where the child is at in their therapeutic stage. The child will orient quickly, often within the first session [using SPT] and then go into a working phase where they work on many layers and levels to their healing process. While this process can be as little as 9 -15 sessions for a child that does not have early trauma, for children with developmental trauma, as I said earlier, this process can be ongoing and therefore therapeutic breaks are needed where the child does a chunk of work (25-30 sessions), takes a break and returns at a later time to address another aspect. It closely relates to their developmental stage. As children grow, they naturally experience challenges. When a child has experienced trauma and**

early trauma, each normal developmental stage can be met with increased challenge for the child. For example, a typical 8 year old can exhibit tantruming, anger and be highly critical of themselves or others. A child with developmental trauma can exhibit these same behaviors, but ten-fold, making parenting them much more challenging. This is when a child may need to return for some treatment. We need to be aware of this as therapists however, because ultimately it becomes too easy to over-therapeutize children with developmental trauma - every normal challenge can seem over the top and at some point we do a disservice to the parent-child relationship by not allowing parents and children to struggle in the relationship and have ruptures and repairs if there is an over-reliance on the child getting help in therapy. I practice an off-and-on pattern of treating and supporting children with developmental trauma. ~~A child in synergetic play therapy, doesn't need to time to get started. We are orientation.~~
~~Like our phase of getting started is in the first session. So the child engages within the first session, we don't need rapport building, that I used to find I would need in other modalities.~~ (P3)

Appendix I

Tables

Table I1

Coursework Specific to Children and Trauma

Coursework	P1	P2	P3	P4	P5	P6	P7	P8	P9
Lack of specific training on developmental trauma	X	X	X	X	X	X	X		X
Human development	X				X				
Attachment theory					X		X		
Had specific course work in developmental trauma								X	
My own research on Attachment theory in grad school									X

Table I2

Decision to Work With Population of Developmental Trauma

Reason	P1	P2	P3	P4	P5	P6	P7	P8	P9
I was abused				X	X			X	
Drawn to it			X		X				
Being a Christian					X				
Watched too many foster kids being bounced					X				
Internship/ needed hours	X					X			
Wanted to Intervene earlier		X							
Saw certain therapies not working									X
Research Article								X	
Professors								X	
Initially didn't want too	X								
My own stuff	X					X	X	X	

Table I3

Trainings or Certifications to Work with Children With Trauma Histories

Trainings/certifications	P1	P2	P3	P4	P5	P6	P7	P8	P9
Eye movement desensitization and reprocessing (EMDR)	X	X	X						
Lifespan integration (LI)				X	X		X		
International consultant (LI)					X				
Consultant (LI)							X		
Synergetic play therapy (SPT)	X	X	X					X	
Certified SPT supervisor			X					X	
Registered play therapist			X						
Play therapy supervisor			X						
Neuroscience based			X				X		
Attachment based			X				X		
Somatic therapies			X			X	X		
Dyadic developmental psychotherapy									X
Certified gestalt therapist	X								
Emotion focus therapy							X		X
Play therapy				X					

Table I4

Describe Your Experience Working With Children Who Bring a Trauma History With Them

Experiences	P1	P2	P3	P4	P5	P6	P7	P8	P9
Challenging		X	X			X			
Stirs up emotions		X							
Empowering of others			X	X					
Beautiful			X		X				
Getting to know myself	X								
Powerful	X								
Growth	X								
Heartbreaking					X	X			
Rich					X			X	
Holy ground					X				
Freely giving									X
Really hard						X	X		X
Rewarding			X				X		
Exhausting as a therapist			X						
Transformational			X						
Learn from them								X	
Meaningful						X			

Table I5

Define Developmental Trauma

Define developmental trauma	P1	P2	P3	P4	P5	P6	P7	P8	P9
Some stressors happen during early years	X	X	X	X	X	X	X	X	X
Impact sense of self	X		X		X	X		X	
Impact on daily life	X	X		X					
Developmental needs not met			X		X		X		X

Table I6

How Developmental Trauma Manifests

Developmental trauma manifests	P1	P2	P3	P4	P5	P6	P7	P8	P9
Anxiety		X	X	X					X
Depression	X			X					
Angry outbursts/Irritability	X	X	X	X			X	X	
Fearfulness				X					
Regression to earlier years	X								
Physical regression	X								
Emotional regression	X								
Defendedness					X			X	
Emotional dysregulation	X	X	X		X	X		X	
Behavioral dysregulation	X		X		X	X		X	
Hypervigilance			X						
Exaggerated startle response			X						
Negative self-concept						X			
Impacts academics		X							
Impaired stress response		X			X				
Interpersonal issues			X			X			

Table I7

Assessing for Developmental Trauma

Assessing for developmental trauma	P1	P2	P3	P4	P5	P6	P7	P8	P9
Adverse Childhood Experiences Scale		X							
No Real Standard Assessment	X	X	X						
Intake Interview		X							X
Developmental Timeline	X	X					X		
Checklist with Symptoms			X	X					
Clinical Observations	X	X			X				
Attachment Genogram									X
Collateral Information			X						
Ongoing Assessment	X		X					X	

Table I8

How the Assessment Impacts Treatment Planning

Assessment impact treatment planning	P1	P2	P3	P4	P5	P6	P7	P8	P9
Does treatment need to be more directive		X							
Education for parents		X			X		X	X	X
How slow to go with lifespan integration					X				
Helps to create a routine									X
Understand how the treatment plan changes throughout			X						
Attachment pieces			X						
Goals need to be appropriate	X		X						

Table I9

Developmental Trauma and Comorbid Diagnoses

Comorbid diagnoses	P1	P2	P3	P4	P5	P6	P7	P8	P9
Major depressive disorder		X							
Depression	X	X		X		X			
Generalized anxiety	X	X		X		X			X
Obsessive compulsive disorder		X							
Adjustment disorder		X					X		
Somatic symptoms				X					
Post-traumatic stress disorder (PTSD)			X	X		X		X	X
Attention issues	X								
Aggressive response	X								
Reactive attachment disorder					X				
Dissociation			X		X				
Misdiagnosed ADHD			X				X		X
Hyperarousal symptoms	X		X						
Avoidant			X						
Misdiagnosed oppositional defiant disorder			X				X		
Stress related disorder			X					X	
Misdiagnosed with forms of autism			X			X			

Table I10

Therapies Used to Treat Developmental Trauma

Therapies used for developmental trauma	P1	P2	P3	P4	P5	P6	P7	P8	P9
Wilderness therapy		X							
Group therapy		X				X			
Psychoeducation groups		X							
Eye movement desensitization and reprocessing (EMDR)	X	X	X						
Synergetic play therapy	X	X	X					X	
Directive artwork		X							
Mindfulness practices		X							
Dyad or family therapy	X	X	X						X
Sandtray				X					
Lifespan integration				X	X		X		
Play therapy			X		X	X			
Emotion focus therapy							X		X
Dyadic developmental psychotherapy (DDP)									X
Attachment interventions									X
Animal assisted therapy			X						X
Gestalt play therapy								X	
Family systems therapy						X			
Biofeedback			X						

Table I11

When Modifications Are Needed in Therapy

Modifications in therapy	P1	P2	P3	P4	P5	P6	P7	P8	P9
Shorter sessions		X					X		
Modify stimulation level		X							
Take breaks during session		X							X
Tailored to work				X					
Meet where the child is	X					X			
Always adapting					X				
Always assessing			X						
Look for small progresses			X	X					
Might change from nondirective to directive			X						
Might change modalities of therapy			X						
Moved to nondirective								X	

Table I12

Length of Therapy

Length of therapy	P1	P2	P3	P4	P5	P6	P7	P8	P9
Based on need of child	X								X
Average of a year		X				X		X	
They come back as more comes up		X							
Several years			X	X	X				
Every 6 months check-in				X	X				

Table I13

Experience in Not Moving Forward in Therapy

Experience in not moving forward in therapy	P1	P2	P3	P4	P5	P6	P7	P8	P9
Frustrating		X		X					
Sad		X							
Helpless		X							
Reflecting	X	X	X	X				X	
Heartbreaking					X				X

Table I14

Referring a Child Out

Reasons for referring out	P1	P2	P3	P4	P5	P6	P7	P8	P9
I am the one referred to					X				
Not enough child therapists in area			X						
Different intervention requested	X								
Financial situation changes	X								
More structure needed		X							
Child suicidal				X			X		
Higher level of care needed								X	
Behavioral specialists						X			

Table I15

Information for New Clinicians or Students Wanting to Work With This Population

Information	P1	P2	P3	P4	P5	P6	P7	P8	P9
DT is not a disease		X			X				
Do your own work		X	X	X		X	X	X	X
Be patient				X	X				
Go slow				X					
Get supervision/ consultation	X	X				X	X	X	
Fear is normal	X						X		
Activation is normal	X		X				X		
Feelings are normal	X								
It’s hard work			X			X			X
Want to learn			X						X
Lack of child therapists					X				
Self-care			X					X	X
Get a framework							X		
Super rewarding							X	X	
Let the client lead							X		
Possible to do long-term								X	
Keep boundaries								X	
Incredibly sacred						X			
Can burn out therapists			X			X		X	

Table I16

This Population Has Brought Up

Brought up	P1	P2	P3	P4	P5	P6	P7	P8	P9
What might have been for us						X			
Continued need for personal therapy		X		X	X	X	X		
Getting to know myself	X								
It was my life					X			X	
I would get triggered					X				
My own experience									X
Resiliency for children			X						
I find myself			X					X	
Allows me to sit with it								X	