

Gentling

A Practical Guide to Treating
PTSD in Abused Children
Second Edition



William E. Krill, Jr. LPC
Foreword by Marian K. Volkman, CTS

Praise for *Gentling*:
A Practical Guide to Treating PTSD in Abused Children

“William Krill reminds us that ‘gentleness is free’, but the methodology and philosophy he puts into designing a protocol for treating stress disordered children is priceless. In this book Krill directly addresses identifying stress symptoms, diagnosis and assessment tools, behavioral interpretation and a specific course of treatment to gently guide children from a place of panic, fear and defensiveness to one of a self-empowered transcendence that engages a child's natural impulse to learn. In this world where children are often disenfranchised in trauma care—and all too often treated with the same techniques as adults—Krill makes a compelling case for how to adapt proven post-trauma treatment to the world of a child.”

—Michele Rosenthal, HealMyPTSD.com

“William Krill’s *Gentling* is one of the most remarkable books I've ever read. The author's approach to treating PTSD in abused children employs a common sense oriented treatment that will not only help the child but will direct the clinician through the ‘where do I go next?’ question. This book is so needed in the world of PTSD and provides step-by-step understanding and treatment of the battered child. A must read and apply for all counselors, clinicians or anyone who is presented with the painful question, ‘What can I do to help this child?’”

—Marjorie McKinnon, Author of
*Repair for Kids: A Children’s Program for Recovery from Incest and Childhood
Sexual Abuse*

“Congratulations to Krill when he says that ‘being gentle’ cannot be over-emphasized in work with the abused. *Gentling* paired with tolerance on the one hand and clear boundaries on the other will give a victim the space to begin recovery. The former emphasizes non-threatening and the latter promotes safety.”

Andrew D. Gibson, PhD
Author of *Got an Angry Kid? Parenting Spike, A Seriously Difficult Child*

“William Krill’s book is greatly needed. PTSD is the most common aftermath of child abuse and often domestic abuse as well. There is a critical scarcity of mental-health professionals who know how to recognize child abuse, let alone treat it. The same goes for PTSD. I am relieved that someone is filling this gaping void.”

—Fr. Heyward B. Ewart, III, Ph.D.
St. James the Elder Theological Seminary

“*Gentling* breaks new ground on the subject of treating abused children. William Krill has created that rare thing: a book on an important topic that goes well beyond conventional thinking and opens up new possibilities for positive treatment outcomes. All too often in the case of abused children, the victim gets blamed for bad behavior, for withdrawing, for resisting treatment. Krill not only makes it clear that the helping professional must meet the child where he or she lives, he shows us how.”

Marian Volkman, CTS, Certified TIR Trainer
Editor of *Children and Traumatic Incident Reduction*
Author of *Life Skills: Improve the Quality of Your Life*

“Krill believes that victims of child abuse have their own version of PTSD. If this child does not receive appropriate treatment, the behaviors can become worse, more embedded and harder to treat. Therefore, I believe that it is essential that people who are involved with these children especially clinicians, parents, foster parents and teachers read *Gentling*. By doing so it will help them to recognize the behaviors and deal with the child more effectively.”

Paige Lovitt, *Reader Views*

I found Krill's presentation to be very straightforward and to the point. The use of the case studies throughout the book was a wonderful way to illustrate and drive home the main points of the book. *Gentling: A Practical Guide to Treating PTSD in Abused Children* is a very thorough and comprehensive guide. I believe any mental health professional, physician, parent, or foster parent would benefit from reading this book and following the approach and techniques outlined within.”

Kam Aures, *Rebecca's Reads*

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William E. Krill, Jr. LPC

Forewords by Marjorie McKinnon and Marian K. Volkman

New Horizons in Therapy Series

Loving Healing Press

Gentling: A Practical Guide to Treating PTSD in Abused Children, 2nd Edition
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From the New Horizons in Therapy Series

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Cover photo: W.A. Krill / Fighting Chance Photography

Library of Congress Cataloging-in-Publication Data

Krill, William E. (William Edwin), 1958-

Gentling : a practical guide to treating PTSD in abused children / by William E. Krill, Jr. ;
foreword by Marjorie McKinnon. -- 2nd ed.

p. cm. -- (New horizons in therapy)

Includes bibliographical references and index.

ISBN 978-1-61599-106-8 (pbk. : alk. paper) -- ISBN 978-1-61599-107-5 (hardcover : alk.
paper)

1. Post-traumatic stress disorder in children--Treatment. 2. Post-traumatic stress disorder
in adolescence--Treatment. 3. Abused children--Mental health. 4. Abused teenagers--
Mental health. I. Title.

RJ506.P55K75 2011

618.92'8521--dc23

2011026370

Distributed by Ingram Book Group, Bertrams Books, New Leaf Distributing.

Published by
Loving Healing Press
5145 Pontiac Trail
Ann Arbor, MI 48105

www.LHPress.com
info@LHPress.com
Tollfree 888-761-6268
Fax 734-663-6861



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Foreword

As a survivor of incest, while going through recovery, I read countless books on the subject. I attended retreats, seminars, watched video clips, listened to speakers and maneuvered my way through anything available to heal my soul from childhood sexual abuse. W. E. Krill's book, *Gentling: A Practical Guide to Treating PTSD in Abused Children*, intrigued me. If there is one term not yet included in any writing on child sexual abuse recovery it's "gentling." I had never given it much thought before, but as I read this page-turner I realized that the author was on to something unique that the rest of the world had neglected.

He grabbed me with his first sentence, "What would the world be like without gentleness?" Every page in this book touched a nerve, brought exhilaration. It was as if Mr. Krill knew exactly what goes on in the mind and the heart of a child sexual abuse victim.

He explains that the term PTSD was born after the Vietnam War, but over the years has changed to include victims from all walks of life, from young children to elders with delayed onset of PTSD. His career has placed him in position to care for children who have been neglected, physically abused, sexually abused, and emotionally abused. As a result he has studied their behavior patterns, located the source and totality of their pain and decided on what they needed to heal. He points out that these children may spend years with the wrong diagnosis and ineffective treatment.

An abused child will not respond to pointed questions, to games directed at climbing inside their head, to hints that the clinician knows everything already. But they will respond to patience and gentling. The author says, "It is amazing to me how the child is sometimes the only one who 'knows' what their diagnosis is".

This book, while directed at clinicians, should be read by anyone attempting to maneuver their way through the murky waters of child sexual abuse. It addresses every area of recovery with intelligence, sensitivity, and compassion. The innovative Child Stress Profile (CSP), and Quick Teach handouts such as "Fostering an Abused Child" and "Stress Signs in Children with PTSD," are just a few of the techniques the author utilizes. Mr. Krill's book is a jewel in the hands of anyone trying to heal, either themselves or others.

—Marjorie McKinnon,
Author of *REPAIR Your Life*, *REPAIR For Kids*, and *REPAIR For Toddlers*
Founder of *The Lamplighters*, a movement for recovery from incest and
childhood sexual abuse

Foreword to the 2nd Edition

A few times in a lifetime, you may encounter a book that can change the world. This is one of them. As someone with a great interest in child development and long experience in working with the effects of trauma and its resolution, I have no hesitation in commending this valuable book to your notice. In today's world of trauma-informed treatment, you might assume that an understanding of the effects of trauma and abuse would be at the center of any population of traumatized persons. The treatment of children lags considerably behind that of adults in this regard.

I will intersperse some quotations that you'll uncover later in this book:

It is just common sense that when a child has been traumatized by abuse, a gentle approach is indicated.

In his patient, sensible and forthright fashion, William Krill shows us how to actually, effectively help traumatized, abused children. You may read, as I did, with consternation about some of the methods thought to be acceptable or even advisable in working with these small and vulnerable persons. So much of conventional wisdom about handling troubled children Krill demonstrates as counter-productive. With story and example, with deep wisdom and practical actions, he shows us the way out of the nightmare that is an abused child's world.

Children who have experienced abuse that has resulted in post traumatic stress behaviors have a right to be angry. How arrogant and foolhardy to aggressively work at extinguishing that rage! Any approach that targets emotional regulation as a primary or singular objective to control resultant PTSD behaviors and uses purely behavioral techniques to do this is doomed to failure.

It is possible to resolve traumatic stress, not just regulate its symptoms. This is the hope that can sustain people working with trauma. *Gentling* includes a sample treatment plan with measurable objectives and expected outcomes.

Adult attitudes toward and frustration with troublesome children, while understandable, are also counter-productive.

Adults often tend to ignore using gestures of respect for children that they demand to be given to themselves. Many adults hold a double standard for the amount, quality, and duration of respect that they will offer to the child as opposed to what they expect back from the child. There is an enacted belief that children somehow deserve less respect and dignity than fellow adults. Hogwash!

Without a doubt, it takes enormous compassion and patience to deal with troubled children, especially those who express their pain in defiant and destructive ways. It takes more than that; it takes real knowledge and skills based in that knowledge. Lacking the necessary knowledge and skill, people who take an adversarial stance in relation to a damaged child are going to get more of the behaviors and attitudes that they most do not wish to see. Labels such as “Oppositional Defiant Disorder” or “Conduct Disorder” illustrate adversarial attitudes on the part of adults, and further the destructive idea that traumatized children could control their bad behavior “if they wanted to”. Such labels can obscure PTSD as the real cause of the problem. Given the extent of the damage to some children and the violence of their acting out, we can’t be surprised that many adults eventually throw up their hands in despair and label a child as unreachable, untreatable, or just plain bad. There is abundant evidence of this in the multiple placements in various homes that many foster children endure. As you will see, William Krill never throws up his hands.

The people who work with abused children deserve respect, admiration, and support. Many of these people instinctively do the right things with the children they care for. Some become frustrated, get “burned out” and quit the field. Probably the majority work hard to do what they think are the right things, with mixed results. This book is a boon to everyone who works with children in any capacity, especially those, including therapists, teachers and foster parents, who care for children who have been abused.

From well-informed theory to the immediate and practical, Krill gives a real alternative to more of the same old behavioral approach. He shows how children respond to overwhelming trauma. Children’s defenses can look quite different to adult defenses. He shows how a stress episode can build toward an explosion, and how it can be defused. He gives tables and charts for tracking patterns of behavior and keeping track of progress. Numerous “Quick Teach” sheets provide vital information in a concise form for busy care-givers.

Finally I will leave you with one of my favorite quotations from *Gentling*:

Filling up the child's hunger for nurturing is not indulgent; it's feeding a starving child.

September 2011

Marian K. Volkman, CTS, Certified TIR & AEF Trainer
Editor, *Children and Traumatic Incident Reduction*

Introduction

Like most books, this one has been long in the making. Not just the writing and publishing, but the roots of the book have been in formation for decades. The experiences of my life including my childhood, my education, my professional career, and those who have mentored and influenced me along the way, all played a part in this final fruit. Like the survivors that we mental health professionals treat, we are all the sum total of our life experiences, and our experiences, both good and bad cannot be forgotten or ignored.

The idea to write about the way that I approach and treat children who have had traumatic abuse events in their lives came to me a few years ago. I discovered that I perhaps was “on to something new” when others began to notice that I was having some success in relieving symptoms in children with PTSD. My search for specific approaches to small children only yielded articles describing the signs of trauma, and citations that “more study is needed” to test efficacy of various treatments. Most material concerning treatment described efforts with adult victims, and suggested adaptations of those methods to apply to children. While pre-adolescent and adolescent children may be approached more or less successfully with adapted adult methods, there remains no real articulated approach to young children suffering from stress disorders.

I cannot help but believe that there are countless clinicians out in the field that feel as frustrated as I did when I went searching for specific interventions and treatment plans to help these children. Since every recognized clinical approach needs to start somewhere, this book is an effort to put forth a practical approach to treatment of children with stress disorders. The approaches described are admittedly “untested” and a purely anecdotal account of what has worked for me. The method has developed largely by intuition as well as trial and error. The approach that I have developed has been largely intuitive. By paying close behavioral attention to the children, I have learned volumes from them.

In the past few years, I began to find that colleagues in the treatment of children were seeking me out to consult because I was becoming known as the guy who was having some success with stress disordered children. This forced me to consider how to articulate what it was that I was doing. This effort to organize the approach led

me to produce one-page descriptions that I called “Quick Teach“ sheets (see Appendix D) for fellow workers, including behavior specialists, mobile therapists, therapeutic support staff, teachers, and foster parents. These became the seeds for this book.

Although the original purpose of *Gentling* was to serve as a guide for clinicians working with traumatized children, the book has found a much wider audience. In this second edition, common psychological terms are defined in the text and glossary so as to make it more accessible to parents, teachers, judges, clergy, and others concerned with the well being of children.

Preface To The 2nd Edition

It has been over five years since I started formulating the framework for *Gentling*, and much has happened in my professional life since then. I have given up my Mobile Therapy position to take an office and practice outpatient therapy with a group of other clinicians whom I greatly respect. Though I still work with some of the tougher cases of children who have PTSD, I do not have as many of those cases as I once had. The work, as you may well know, is exhausting in so many ways, and I needed the break from the intensity of it. I have been led to begin to work more with adult couples, and am finding that there is a very high proportion where one or both partners have a stress disorder from having been abused as a child. I guess I am just expanding upon the things I have learned.

Of course, the first edition of *Gentling* was published, a fact that I continued to be amazed at, since so many of the large publishers, while telling me I had a great book, refused to publish it because it appealed to too small of a niche market. And then Victor sent me an email and asked if I was willing to do a second edition of *Gentling* to address how it works with teens and include a chapter about attachment issues. Both Victor and Marian are people with a true heart for the work of treating stress disorders, and I am so deeply grateful to both of them; Victor for having the courage and will to publish books such as mine, and Marian for her tenacious willingness to enter lively conversation about the topic of stress disorders and the need for clarity for the reader.

I know that the first edition of *Gentling* has changed my life forever, and I have had good number of readers tell me that it has changed theirs for the better as well. Here's hoping the second edition helps even more children and teens to not only survive trauma, but survive with healing. And who knows, maybe there are the seeds of *Gentling for Adult Survivors of Child Abuse* already planted.

Acknowledgements

My life, like yours, has intersected with people who have experienced terrible traumatic events. Most everyone we work with as clinicians have had some difficult if not traumatic events in their lives. Our friends and family have not been immune. Both my father and father-in-law served in World War II, and each bears the scars of its psychological and emotional effects.

Each have taught me through their relationship with me how a person is able to survive their experiences while effective treatment for Post Traumatic Stress was not even developed yet. Their willingness to share their stories with me has honored me. The children I work with daily are a constant reminder of the suffering that stress disorders create. When they come to trust me enough to share their stories, I am honored by them as well.

There have been many teachers and healers who have influenced my clinical practice. I owe a great debt to all of the children who have allowed me the privilege to help them along their way in life. My heroes of healing have been people with a combination of gentleness, spirituality, assertiveness, and strength. The list includes people like Jean Vanier, Mother Teresa, Henri Nouwen, and Fred Rogers. My own parents raised me with a firm, kind gentleness that lives on through in my own parenting and work that I do daily with children.

I must give acknowledgement to Dr. Heide Sedwick, who has been a mentor, supporter, and cheerleader in my efforts with stress disordered children. At times I have felt that she has pumped up my ego far too much, as I know who real the expert in PTSD is. Her clinical direction, emotional support, and gentle but firm Franciscan supervision have motivated me to press ahead with this book.

1

Gentling



What would the world be like without gentleness? Gentleness is such a basic human characteristic that we often take it for granted. Gentleness appears to be so basic that even animals can be seen behaving in a gentle fashion following the birth of offspring. Some may argue that such behavior is simply instinctive for the animal mother; a measure to ensure the growth of the baby and thus the continuation of the species.

Certainly human beings bring *meaning* to what may be an instinctive behavior set. While gentleness may be instinctive, our experience of gentleness from others further teaches the subtleties of human kindness, and in turn, shapes how we are gentle with others. It would not be a stretch to say that a person's capacity for gentleness is an indication of civility; even a marker of what makes a human being *human* in the largest sense.

Hopefully, if the reader were to play a brief game of word association, they would soon list the word "mother" or "father" in association with gentleness. And, what could be more nurturing than a parent's gentleness? Unfortunately, not all people are able to make this association so easily; their mother (or father) has not been gentle in their lives; they have experienced abuse and trauma at the hands of their loved ones.

Most people will also associate healing with gentleness, even though healing may involve some discomfort. Even when healing is not a possibility, there is gentleness to ease the discomfort of pain, and even the transition to death. "Gentling" is the process of delivering the balm of gentle gestures.

These gestures are complex and even at times may appear paradoxical: gentleness involves a kind of strength and assurance in the giver, and the gentleness may be delivered in a firm and assertive fashion. Of course, gentling also includes a calming countenance, a safe tone of voice sometimes paired with eyes filled with compassion,

and an empathetic touch that can be as light as feather or as firm as a safe, encompassing hug.

Gentleness also may be easily associated with “spiritual”. Most of the major religions of the world have an expression of their deity that is compassionate. As a person whose degree is in Pastoral Counseling, compassion is a core value of my vocation, how I help others, and why I do what I do. Even the secular clinician will recognize the value of using gentleness as a tool in their approach to helping others, and perhaps has even experienced the “miraculous” movement forward for a patient when they have had their empathic efforts accepted and used by the patient.

Though this approach has many familiar components that are certainly not new to the compassionate and caring helper, it is different because it uses these components in a very intentional, specific, and timely fashion. “Gentling” as a treatment for stress disordered children has its didactics and techniques, just like other approaches to helping children, but the foundation on which it is built is a firm and abiding faith in the power of gentleness and compassion. In a world where everything has a price, where the costs of violence are truly expensive, where hundreds of thousands of children each day face the harsh realities of traumatic events, gentleness is free.

2

Trauma



A trauma is an event that has happened to a person that has had a profound and life changing effect. The event may have resulted in the person having ongoing and uncomfortable symptoms. The symptoms might include re-experiencing (memories), avoidance, numbing, detachment, relationship problems, and alterations in the way that they view the world and physical symptoms that are similar to panic attacks.

Trauma affects everyone, either directly or indirectly. We all have people in our lives that have had difficult, and perhaps terrible things happen to them. Many times a day, we likely come into contact with people that we least expect to have had very traumatic experiences, and yet, they do.

In recent months, I have come to learn more about a friend and colleague's life before I met her, and her life story could not be guessed from her current life. Each of us has had events in our own lives that have traumatized us and have caused us discomfort as a result. While one person's experience at having had a dog bite them may not be as dramatic or life-altering as a person who has survived a hurricane, torture, or rape, the process and discomfort are no less real.

Since trauma is all around us on a daily basis, and is what makes media headlines to catch viewers' attention, it is easy to become numb to it. Certainly the "newsworthy" traumas beg for our attention, but there are countless private, quiet traumas that occur daily as well. On the nightly news we hear of young men and women who have died in the Global War on Terrorism, and see their grieving families.

Each day there are hundreds, if not thousands of children who are being neglected and abused in their families, by neighbors, strangers, or by the effects of war. Many of these children survive, for better or worse. Some do not survive. Sometimes survivors who gain healing go on to productive and happy lives, while others descend into lifelong pain, dysfunction, and may become perpetrators of trauma themselves.

Trauma always affects body, mind, emotions, and spirit. It stands to reason that a person who has had a physical trauma, such as a motorcycle accident, will have difficult emotions surrounding his or her misfortune. When a person is a victim of a psychological and emotional trauma, such as in the case of witnessing a loved one assaulted or abused, they may develop physical symptoms as a result of chemical changes in their body that occurred at the time of the assault. In situations where a child has been sexually abused, their body, mind, emotions, and spirit are altered and damaged. When viewed in this way, trauma can be seen for what it is: an all encompassing and profoundly life-altering disability.

To most of us, the reason why one person becomes symptomatic following a critical incident and another does not is often a mystery. New research is beginning to demonstrate that in fact people who suffer symptoms for a long time after a trauma may have a brain chemistry that is prone to developing these symptoms. It does appear (and stands to reason, with their still developing brains) that young children may be more vulnerable to developing acute stress or post-traumatic stress.

Preconditions such as mental health disorders or high levels of everyday stress are also likely to be a factor. Children who live in marginal family situations with parents who have their own daily struggles to survive, or have mental health issues may also be more susceptible to developing symptoms. Children who, by circumstance, have poor ego strength may be more vulnerable to the effects of trauma and stress. By ego strength, it is meant the natural and developed internal resources to cope with changing environments and situations, including stressful ones.

In families with intergenerational histories of domestic abuse, not only is abuse “inherited”, but also stress disorders as well. However, the question of discerning the biophysical and genetic possibilities of connections between domestic abuse, child abuse, and PTSD are beyond the scope of this book.

Some children live in conditions with their biological families that are highly volatile, abusive, uncertain, and chaotic. These children may not have one single traumatic event that can be pinpointed as the source of their stress signs and symptoms. In their lives, the constant high level of stress may create behavioral effects in them that look very much like the ones seen in children who have survived other, more specific trauma. The diagnostic and treatment community needs to recognize and codify this kind of traumatic stress as just as valid as acute and post-traumatic stress. The sources of specific symptoms, study of how symptoms develop for some people but not others, alternate treatment approaches, and treatment outcomes of trauma are far from complete.

A child may suffer for many years without the proper diagnosis. In some cases, the critical incident(s) may be unknown to the adults around the child. In situations where the child has been sexually perpetrated upon, the child may be holding the

secret quite closely. If the child is very young (age six or below), the trauma may have occurred at a time before verbal memory was fully developed; even if they want to tell you about the trauma, they may have a difficult time in recalling enough details of the event or be able to articulate what they are feeling. Though some anecdotal examples exist of people being able to recall memories at early ages, for the practical purposes of the Gentling approach, this is often moot. In this clinician's experience, recall is not very effective in settling the stress reactions in the present moment that abused children are experiencing.

In other situations, the adult caregivers simply do not connect the dots between the critical incident and the child's behaviors. This is especially true in chaotic families that have a long history of domestic violence and varieties of abuse. In these families, the child's behaviors are the norm, and the family only becomes aware of a problem when the child enters school.

What is Post Traumatic Stress Disorder (PTSD)?

The rudiments of a modern understanding of PTSD are reflected in the medical literature as early as the American Civil War, when surgeon Jacob Mendes Da Costa identified what came to be called "soldier's heart", a grouping of symptoms that looked like heart disease, but revealed no physiological abnormalities of heart problems. It came to be understood in the medical field as a grouping of symptoms indicating a severe anxiety reaction associated with battle experience.

By the time of World War I, the popular label for PTSD becomes "shell shock", a reasonable description considering the heavy artillery barrages of that war. Films from the era show soldiers in states of dissociation or uncontrolled trembling, as well as cases of apparent leg and arm paralysis, or sudden, unexplained blindness. In World War II, "battle fatigue" became the phrase for the collection of signs and symptoms. The disorder was still highly misunderstood by most lay people, with soldiers continuing to associate the symptoms as a proof of being a "coward", a word that carried much weight for soldiers of that day. Subsequent examination and research of the Holocaust survivors of Nazi concentration camps and the bombing survivors of throughout Europe and Japan revealed extremely similar effects on non-combatants. Not much progress on the issue appears to have been made during the Korean War years.

Many courageous but damaged veterans of the Viet Nam War pressed the mental health community (not to mention the US government) into consideration of the symptom and behavioral sign clusters as something more than a simple and passing anxiety or adjustment to post-battle life. The psychological community traditionally formulates new or adapted diagnoses as a result of a large body of clinical experience, and this appears to be the case for the eventual formulation of 'PTSD' first

introduced in the Diagnostic Statistics Manual III (DSM-III) in 1980. It certainly can be argued that there may have been significant political forces at work as to why it took so long after Viet Nam to recognize PTSD, but that is beyond the scope of the present work.

Interestingly, even anecdotal accounts of war-related PTSD symptoms appear to have differences in expression throughout the previously discussed wars, suggesting that present culture may greatly impact the expression of the symptoms and signs of the disorder. It would appear that our understandings of PTSD are still in a stage of adolescence, and are not yet fully mature. I have certainly come to the conclusion that child abuse victims have their own unique expression of PTSD.

The progress of mental health care, treatment, and early intervention in the past thirty years has come to recognize that it is not just war veterans who can develop painful signs and symptoms. Police officers, firefighters, victims of natural disasters, victims of domestic abuse and crime can all suffer from post-traumatic stress. In particular, the last ten to fifteen years of recognition, research, and treatment expansion for stress disorders has progressed significantly.

Indeed, the controversy in the mental health community over the PTSD diagnosis continues with suggestions that developmental trauma (abuse), though not having one single point of critical incident, qualifies for a PTSD diagnosis.

It is likely that any human being, when exposed long enough to repeated critical incidents, will take on a classic acute or post-traumatic stress profile of behaviors. Furthermore, I believe that any person, at any time, may become acutely reactive if an incident occurs at an emotionally vulnerable time and the event has emotional value to them. While the event and circumstance may not be evident to the observer as traumatic, it is the subjective experience that counts the most. We are all vulnerable.

PTSD and Children

Anyone who works closely with victims can tell you how contagious the stress is. Even the most experienced clinicians may experience an emotional toll, have intrusive dream content, and have moments in treatment when they become overwhelmed with grief, fear, and deep sadness (secondary PTSD). Part of the clinician's job is to remember to take care of themselves as well as the victim. I use the word "victim" rather than "survivor" because abused children *are* victims of a crime, and the effects of PTSD, left under and untreated, continue to *keep* them victims for years, even decades. For many, time is a second perpetrator. A child can only become a survivor when someone recognizes their PTSD and has effective means to begin to help them to heal.

My career has placed me in position to care for children who have been neglected, physically abused, sexually abused, and emotionally abused. Many of these children have been removed from their families and live with foster parents, who struggle to care for them despite the behavioral effects of post-traumatic stress. My experience with children has led me to understand that children have their own unique behavioral expressions that do not necessarily match the adult victim's behaviors. As such, many children with Acute Stress Disorder or PTSD may spend years with the wrong diagnosis and ineffective treatment.

Just as in the treatment of physical trauma, both immediate treatment and long-term rehabilitation are needed in psychological trauma. The healing process is not always comfortable, and the healer may need to help the patient tolerate the discomfort of treatment through encouragement and gentle nursing. While some pain is expected and perhaps even necessary for healing, the overriding key to stress disorder treatment in children is the application of the balm of gentleness.

Children, in fact, may experience trauma differently than adults do, and so then the treatment may also call for a different approach than what is used for adults. Adults who experience their critical event as adults naturally have much more history behind them and many more positive healthy ego experiences. As such, the adult survivor has a "well of resources" to draw from in order to begin to make sense of their traumatic event. They have the ability to make comparisons of their life before the events as opposed to after the event.

Small children who have experienced chaotic lives and multiple traumas since birth have no such wellspring to draw from. A child who has lived their entire life in the midst of a war, for example, has nothing to compare their experience to; no safe and comforting memory to retreat to when the time comes that they need to "go somewhere else" in their head to escape the intensity of the moment.

In traditional adult treatment of trauma, the patient is strongly encouraged to get right to the processing of the traumatic events and memories. The adult is encouraged to detail the events and articulate their corresponding emotions. This process may also be effective when used with a child of adolescent age. It can be assumed that the adult or adolescent has a fair understanding and ability to quickly develop trust in the clinician as a helper.

The idea of "counselor" is quite ingrained in most cultures as a positive concept. But what if the child is five or six years old, has an intellectual disability, and has a severe speech impediment? Or what if the child has had multiple adult perpetrators of violence against them?

Young children often have difficulty in articulating their experiences effectively, even if they are not traumatic experiences. Their self-awareness of internal processes is extremely limited, not because of their trauma, but simply because of their devel-

opmental stage. It becomes obvious that the treatment approaches for adults and teens becomes awkward at best when applied to young children.

Traumatic *stress reactivity* is a disease. Stress reactivity is the neurological and biological effects on the individuals body (and by extension, psyche) when a cue or trigger of their trauma comes about. The definition of a disease is something that affects the body that is destructive and progressive. Left untreated, many victims indeed get worse. The brain-body stress reactivity can become hyper-sensitive and stress reactions can become more frequent, intense, and habituated.

When too many critical incidents or stress reactivity episodes happen, the victim gets pushed over the edge to a realm of mental health disorder that they cannot easily come back from. Those who decide to cope with drugs and alcohol begin to suffer the effects from such abuse, sometimes including death. Victims of physical or sexual trauma may begin to live lifestyles that ensure their continued victimization. People can die in any number of ways due to their history of traumatic events.

Some lucky few victims of trauma happen upon ways to heal themselves. These lucky few are victims who have a solid history of an adequate ego strength development. In the case of soldiers, such as my own father, they may have among their resources an intensely strong faith that acted as their lifesaver. Or, as in the case of my father-in-law, an extremely sharp and intense intellect kept trauma at bay.

Both of these fine men also had the unshakable knowledge that there were loved ones that were ready and willing to provide them with the support and affection that they would need to heal when they returned home. But even in these cases, there are residual signs and symptoms that are clearly scars that still ache.

The young child who finds himself suddenly in a foster home following the five years of his (entire) life spent in a trailer that doubled as a meth lab, neglected, physically and sexually abused is at a considerably greater disadvantage. Next, I'll proceed to articulate how a clinician might take on the daunting task of trying to help this child.

3

Signs and Symptoms Profile



The treating psychologist hands you a diagnosis: Post Traumatic Stress Disorder. Now what? Most clinicians will begin to take a closer look at the child's behaviors. What does the parent or foster parent say the child is doing? What treatment has been tried in the recent past? What worked, what did not?

In many cases, clinicians inherit PTSD cases from other clinicians. The sad fact is there are not enough well-trained clinicians who understand stress disorders, let alone stress disorders in children. I have received cases that have been in services for years and years, having had many therapists, and yet made no real discernable progress.

In review of the case file and past treatment plans, I often find that the clinician attacked the behavior problems in what might be termed a very generic fashion. The goals often center on "ending tantrums", "learning anger management techniques", or "gaining better social skills." While all of these areas may be important and valid, they often are not a sharp enough focus for children with a PTSD diagnosis. These areas are what I call "wide brushstrokes" of behaviors. The stress-disordered child needs a finer and more precise brush stroke in their treatment approach.

In a later chapter, I will outline a sample treatment plan. But for now, it is important to lay the groundwork for that plan. As alluded to earlier, each person has his or her own unique and subjective experience of a traumatic event. So too, each person has more or less a very individualized demonstration of their distress. While we can certainly make generalizations of signs and symptoms common to most victims, each victim will have a personal profile of signs and symptoms. This information has very important implications in treatment for several reasons.

First, when the clinician can accurately assess which behavioral signs and symptoms the victim has, a baseline view of behaviors develops that can be used later for comparison to determine what improvements have been made in treatment. Secondly, this data can help to focus the areas of treatment, and create a protocol of

what behavioral areas to treat first, second, and so on. Next, this information can be used directly with the victim to help sensitize them to the processes that go on inside their body and the behaviors that they engage in.

In many cases, children have lived so long with their stress behaviors; they do not even realize that they are abnormal. In addition, this list of signs and symptoms can be used to educate all of the adults in the child's life, such as parents, foster parents, teachers, therapeutic support staff, guidance counselors, ministers, lawyers, and judges. In cases where legal issues related to abuse are present, such clinical behavioral data becomes very important in demonstrating if and when the child is ready to return to their biological family.

A Child Stress Profile

In my clinical experience, I have noticed that children, while having many of the behavioral signs well-documented in adult PTSD victims, have either different expressions of these signs, or have unique signs only seen in children. Behavioral stress signs in children can range from quite dramatic to very subtle. A Stress Profile can help the clinician recognize some of these unique expressions as sourced in stress and not some other area. A brief example of this would be the common assessment that a child is behaving in an oppositional manner, when in fact they may be expressing defensive behaviors related to a trauma memory.

Gaining the ability to differentiate when a set of behaviors has its source in a traumatic event in history rather than a child simply misbehaving or demonstrating a "tantrum" is important in the daily care of the child. When pressure is applied to the (apparently oppositional) child with PTSD, the child's difficult behaviors often increase rather than decrease. Truly oppositional children, who are not acting in reaction to traumatic stress, will comply with pressure at some point. It is also important to the long term goal of easing the behavioral effects of PTSD, because when a child is given ordinary discipline to control PTSD behaviors, the PTSD behaviors are driven deeper, making them harder to treat.

The taking of a Child Stress Profile (CSP) should not be confused with an "assessment". An assessment leads to a diagnosis, and is completed by a psychologist. The CSP is a tool that a clinician uses following the diagnosis to begin to gain a clear picture of the child's stress related behaviors.

This becomes particularly important if the child has other issues that affect their behaviors, such a co-morbid mental health condition, or have lived in a household with inadequate discipline. Lots of children have had their stress symptoms confused with their lack of discipline. When the former is treated as if it were the latter, neither condition improves.

I developed the Child Stress Profile out of my desire to better understand, organize, and measure children’s stress behaviors and treatment outcomes. After having used it for two years, I was pleased to see that it demonstrated clear progress in the children I was treating. The CSP uses six sub-scales (or categories) of signs and symptoms, including the three classic symptom areas drawn from the DSM-IV: re-experiencing, avoidance-numbing-detachment, and psychobiological alterations.

The other three categories: personal relationships, psychological alterations, and self structure, have been taken from *Treating Psychological Trauma & PTSD* (Wilson, Friedman, and Lindy, 2001). Specific signs and symptoms were gleaned both from the DSM-IV and the work of Wilson, Freidman, and Lindy. I have placed a “spin” on many items so that they more accurately reflect what I have seen in children. Some items are the result of my own clinical experience of signs and symptoms common to children with stress disorders.

The resulting Child Stress Profile (CSP) tool has just over 100 items contained in six different sub-scales. The tool is designed for the clinician to conduct an interview with significant adults in the child’s life, preferably caretakers. If more than one person is being interviewed at the same time, I use a consensus method to determine the most accurate response. The interviewing clinician may need to give some further explanation for some of the items by giving examples. When completed, the clinician scores the responses.

Please turn to Appendix A of this book to review the actual questions contained in the CSP. The scoring block is reproduced below:

SCORING: Indicate the number of each response in each grouping

Range	Sub-scale	D	FN	NI	FI
Items 1-27	Allostatic process and load (27)				
Items 28-44	Re-experience (17)				
Items 45-60	Avoidance, numbing & detachment (16)				
Items 61-72	Personal relationships (12)				
Items 73-90	Psychological alterations (18)				
Items 91-102	Self structure (12)				
Totals					

Scoring the CSP is not difficult. The abbreviations may be decoded as:

- “D” is used to indicate that the symptom “does not appear”.
- “FN” is used to indicate that the symptom is “frequent, but not intense”.
- “NI” is used to indicate that the symptom is “not frequent but intense”.
- “FI” is used to indicate that the symptom is “frequent and intense”.