Chapter 4[**]

Trauma

Trauma is the new legal buzzword, and the way trauma affects children as clients (and therefore the lawyer-client relationship) is paramount to everything else we discuss in this book. We most commonly discuss trauma outside the legal context when discussing war veterans and post-traumatic stress disorder (PTSD). Trauma, however, comes in a variety of forms. There are also multiple definitions of trauma. Most importantly, this chapter will focus not only on what trauma is and how prevalent it is but also on the resilience research beginning to emerge.

The other way to describe trauma is toxic stress. Much of the child welfare world has historically used the phrase toxic stress, and in some ways, it is the more pertinent phrase because trauma often is used more colloquially. Here, however, we use trauma to describe toxic stress as well because the definition we decide upon is the one that exists in the nervous system, and you could even call our use of the word *trauma* a "term of art."

Definitions of Trauma

There is no single definition of trauma, but this section will try to make some sense of the varied definitions. Different definitions of trauma affect how your clients receive services but should not affect your representation of your client.

Merriam Webster provides three separate definitions:[1]

> a: an injury (such as a wound) to living tissue caused by an

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[**] Excerpted from Chapter 4, Stahl, RM and Stahl PM, *Representing Children in Dependency and Family Court: Beyond the Law*, ABA Family Law Section, 2018.

[1] Merriam Webster, https://www.merriam-webster.com/dictionary/trauma (last visited Oct. 31, 2017).

extrinsic agent

b: a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury

c: an emotional upset

In this definition, the important piece to remember is that trauma can be physical or emotional, and often they go together. A child falling off a bicycle can be traumatic. Rebecca recently had a client who, when asked about the issues involved in the case, seemed to be uninvolved because the allegations involved her brother allegedly molesting their younger siblings, but she was also shaking. Upon further inquiry, Rebecca discovered she had been in a terrible car accident a year previously, and it was affecting her in her life and in terms of how she was responding to the case at hand. The conversation changed once that information was provided. Thus, it is important to remember that trauma in your clients is not limited to the trauma you hear about from the case in which you are involved.

The American Psychological Association website defines trauma as "an emotional response to a terrible event like an accident, rape or natural disaster."[2] Interestingly, from the psychological standpoint, trauma here is defined only as the emotional response to a traumatic event, which can include physical forms of trauma. The *Diagnostic and Statistical Manual-5* (*DSM-5*) does not really provide a definition of trauma; instead, it provides a diagnosis for PTSD. It defines the effects of trauma and, within that definition, defines the types of events that qualify as precursors to PTSD.

The *DSM-5* redefined trauma from the *DSM-IV-TR*. Where PTSD used to be

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<FN>[2] American Psychological Association, Trauma, www.apa.org/topics/trauma/ (last visited Oct. 31, 2017).

defined as an anxiety disorder, the *DSM-5*, which was released in 2013, now has a category called "Trauma and Stressor-Related Disorders," which "include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion."[3]

The *DSM-5* redefined what a traumatic or stressful event is. The *DSM-IV-TR* defined trauma as "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others."[4] The *DSM-5* added to the definition of a traumatic event.[5] The additions include adding sexual violence as a form of traumatic event and changing the definition of *exposure* to include learning the events happened to a close friend or family member or being exposed to repeated or extreme details of the event, as is the case with vicarious trauma.[6] The *DSM-5* requirements, therefore, limit the definition of trauma to that which the *DSM-5* writers objectively believed is traumatic. It did not consider the subjectivity of traumatic experiences. In the *DSM-5*, there must be at least a threat of harm or actual harm.

Dr. Peter Levine, who has spent the past 35 years studying trauma, says that defining trauma is still "a challenge."[7] But he does provide some clues. First, he says trauma is subjective, not objective. He states, "[w]e become traumatized when our

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<KT>[3] DSM Library, https://dsm.psychiatryonline.org/doi/abs/10.1176/appi.books.9780890425596.dsm07 (last visited Oct. 31, 2017).

[4] European Society for Traumatic Stress Studies, DSM IV PTSD Definition, https://www.estss.org/learn-about-trauma/dsm-iv-definition/ (last visited Oct. 31, 2017).

[5] Laura K. Jones & Jenny L. Cureton, *Trauma Redefined in the DSM-5: Rationale and Implications for Counseling Practice*, The Professional Counselor, http://tpcjournal.nbcc.org/trauma-redefined-in-the-dsm-5-rationale-and-implications-for-counseling-practice/ (last visited Oct. 31, 2017).

[6] *Id.* Note that we will discuss vicarious trauma in Chapter 11.

<FN>[7] PETER A. LEVINE, HEALING TRAUMA: A PIONEERING PROGRAM FOR RESTORING THE WISDOM OF YOUR BODY 9 (Sounds True, Inc. 2005).

ability to respond to a *perceived* threat is in some way overwhelmed."[8] The word *perceived* is the piece left out by the *DSM-5* definition. The second part of this definition states that the system is overwhelmed. The human nervous system, like all animal nervous systems, has the ingrained ability to resolve trauma. This is where the definitions for trauma and toxic stress overlap. The body is designed to deal with stress, but stress becomes problematic when it becomes toxic stress. When the system is overwhelmed, trauma gets stuck in the nervous system and manifests problematically.

Dr. Levine takes an even broader approach and states:[9]

> In short, trauma is about loss of connection—to ourselves, to our bodies, to our families, to others, and to the world around us. This loss of connection is often hard to recognize because it doesn't happen all at once. It can happen slowly, over time, and we adapt to these subtle changes sometimes without even noticing them. These are the hidden effects of trauma, the ones most of us keep to ourselves. We may simply sense that we do not feel quite right, without ever becoming fully aware of what is taking place; that is, the gradual undermining of our self esteem, self confidence, feelings of well-being, and connection to life.
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> Our choices become limited as we avoid certain feelings, people, situations, and places. The result of this gradual constriction of freedom is the loss of vitality and

[8] *Id.* (emphasis in original).
[9] *Id.*

potential for the fulfillment of our dreams.

Bessel van der Kolk states:[10]

> For human beings the best predictor of something becoming traumatic seems to be a situation in which they no longer can imagine a way out; when fighting or fleeing no longer is an option and they feel overpowered and helpless.

Neither of these last definitions requires an event. Both of them can be slow, but they are about the human loss of control and connection. Taken together, trauma is an overwhelm of the system and a loss of wholeness. Our system, when whole, functions well, but when the system fractures and breaks apart, the result is a feeling of isolation, which results similarly to all of the definable forms of trauma provided by the literature. Humans are pack animals, and they thrive in communities. That sense of community, as we will discuss later, is one of the greatest predictors of resilience against the effects of trauma. Thus, the broadest definition of trauma can be defined as a separation from ourselves and those around us. This can happen over time and be barely noticeable at first, but it can be the most damaging.

What is interesting about this definition is how it works directly with the work you do with your child clients. Whether you are in family or dependency court, you are working with children who have been taken from a structure of normalcy in their life,[11] had that shattered, and often are disconnected from those they love the most. In family court, it can happen as a separation of their parents, where they live in a different family

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<FN>[10] PAT OGDEN, TRAUMA AND THE BODY: A SENSORIMOTOR APPROACH TO PSYCHOTHERAPY 21 (W. W. Norton & Company, Inc. 2006).

<FN>[11] Or in the case of infants, what would be normal absent their abuse/neglect experiences.

structure than before. In dependency, they are often removed from one or both of their parents. This lack of connection begins the case and, in some ways, is the ultimate definition of what trauma is for humans.

For our nonclinical purposes, trauma is a subjective situation, which is important for us to remember when representing children. Whether we believe our clients have experienced trauma is not the issue; the real issue is whether they are affected by their life experiences in ways that feel traumatic to them and that affect their daily lives and, by extension, their relationship to us and the legal situation.

In addition to these definitions of trauma, the National Childhood Traumatic Stress Network (NCTSN) provides a definition of "complex trauma," which "describes both children's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure."[12] Further, the NCTSN states, "These events are severe and pervasive, such as abuse or profound neglect. They usually begin early in life and can disrupt many aspects of the child's development and the very formation of a self. Since they often occur in the context of the child's relationship with a caregiver, they interfere with the child's ability to form a secure attachment bond. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability."[13]

Complex trauma, therefore, is often what our clients experience. Notice this definition adds neglect as a form of complex trauma. Neglect leads to an overwhelm of the system because, as we will see in Chapter 5 regarding attachment, the system

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<FN>[12] The National Child Traumatic Stress Network, Complex Trauma, www.nctsn.org/trauma-types/complex-trauma (last visited Oct. 31, 2017).
[13] *Id.*

learns to regulate through the responsiveness of attentive caregivers. When the infant does not have responsive and attentive caregivers, the result is traumatic for the young nervous system. Frequently, neglect as a form of trauma is one of the most difficult for lawyers to understand because without understanding its effect on brain development and its effect on attachment relationships, the long-term consequences can sometimes go unnoticed.

In addition to these definable traumas in this lifetime, there is epigenetic trauma, which is trauma passed from generation to generation. Epigenetic research is new, and while indigenous cultures and Eastern religions have discussed it for millennia, the scientific research into exactly what is passed down in DNA is just beginning to be discovered. But science now confirms that epigenetic trauma plays a key role in someone's ability to respond to trauma and stress in this lifetime. The specific science behind epigenetics is beyond the scope of this book, but we have provided some resources about it in the Appendix. What is important for you to know, however, particularly in family and dependency law, is that the trauma your client has experienced is not just in his lifetime. Many times, the families involved in these systems are repeat offenders over generations. Children who grow up in the dependency system have their children removed. Children of high-conflict divorce or children of domestic violence grow up and act in similar ways, thus perpetuating the cycle. What is important to know is this is not just because of learned behavior; it is because of the trauma being passed through generations through DNA.

Now that we have a working definition of trauma and what kinds of trauma your clients are likely to experience, the rest of this chapter will describe the way trauma

manifests in your child clients and some of the resilience research.

Physiological Changes Resulting from Subjective Trauma

Trauma affects your clients' daily lives, and noticing the trauma when it shows up is vital to your ability to represent your clients effectively. This section outlines the changes to the nervous system that occur with trauma and how trauma looks to the outside observer so you can notice what your clients are experiencing and, in turn, work with them more effectively.

Autonomic Nervous System (ANS)

Trauma, like stress, is a natural part of life. Birth itself is traumatic. Bodies and nervous systems are designed to respond to trauma and to resolve it from getting stuck in the system. Everyone's nervous system has a window of tolerance for resolving trauma. As long as the trauma does not overwhelm a particular person's window of tolerance, the trauma will not get stuck in the nervous system. All mammals have this ability to resolve trauma, and in wild mammals, we see them literally shake off their trauma. They are far less likely to have PTSD-like symptoms because their nervous systems are rarely extended beyond their window of tolerance. But similarly to chronic stress, when we have chronic trauma, or even one trauma from which we never fully heal, it can begin to dominate how we act and interact in the world.

To this end, Dr. Peter Levine describes trauma not in the experience as the *DSM-5* does, but in the nervous system.[14] The nervous system stores the trauma until it is released. Trauma, like stress, shows up in the fight, flight, or freeze response,

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<FN>[14] Peter Payne, et al., *Somatic Experiencing: Using Interoception and Proprioception as Core Elements of Trauma Therapy,* FRONTIERS IN PSYCHOL. (2015), *available at* https://www.frontiersin.org/articles/10.3389/fpsyg.2015.00093

functions of the autonomic nervous system (ANS). The fight-or-flight response has become common parlance with regard to stress, but the discussion often misses a key component—freeze. The ANS activates in response to trauma similarly to how it activates in response to stress.[15]

Simply put, the fight and flight responses activate the sympathetic nervous system. Imagine you are walking down a street at night and you hear a noise behind you. What is your reaction? Most people jump and either turn toward the sound or start to run away. The heart rate increases, muscles tense, and blood flows to the limbs and away from the internal organs. Nonessential bodily functions shut down because they are not necessary to help a person fight or flee from danger.

Once the person realizes it is some children playing in the trees, the system relaxes and goes into a parasympathetic response. In this normal "window of tolerance" description, the parasympathetic response is often described as the "rest and digest" response. This parasympathetic response brings blood back to the internal organs, allows the muscles to relax and heal, slows down the heart rate, and slows down the breath. Then the nonessential bodily tasks return, and the body quite literally, can rest and digest.

The ANS can also respond to danger through parasympathetic means in the freeze response. This is when the body goes into such a "relaxed" state it shuts down. The freeze response is also a normal, healthy response to a traumatic event. It exists in all mammals. Many people liken the freeze response to a deer in the headlights. There are videos of gazelles being chased by predators and "playing dead," going into the

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<FN>[15] We will discuss the flow between sympathetic and parasympathetic responses in Chapter 12 on vicarious trauma, but here we discuss the effects when they are outside someone's window of tolerance.

freeze response; as soon as the predator gives up, the gazelle stands up, shakes itself, and goes back to normal.[16] The animal shakes itself to bring its body out of that extreme freeze response and then can function normally.

Humans, like all mammals, have a freeze response, and when it works appropriately, humans can release the freeze from the system and go back to a more normal, regulated state. When coming out of freeze, the sympathetic nervous system must turn on sufficiently to bring the body out of the freeze but not so much that it becomes over activated. The system can, however, get stuck in these responses even in forms of acute, defined trauma. You see this in your clients when they tell you they feel numb, they have a very flat affect, and they seem as though they are not quite present when you are talking to them.

The fight, flight, and freeze responses are the body's survival instinct. Problems arise in two ways: (1) there has not been sufficient time to come out of one of these states, such as shock, which we describe later in this chapter, or (2) the process gets stuck. In the foreword to Peter Levine's book *Trauma and Memory*, Dr. van der Kolk explains what happens when trauma gets stuck::[17]

> Post-traumatic actions do not only consist of gross behaviors such as blowing up at anyone who offends you or becoming paralyzed when you are scared, but also in imperceptibly holding your breath, tensing your muscles, or tightening your sphincters. [Levine] showed me that the entire

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<FN>[16] Gazelle's escape, https://www.youtube.com/watch?v=IlwzPIUtRPc&index=1&list=PLKt47oQNSAs5AQSZtMt5Pv5oPXTkEJIl7.

[17] PETER A. LEVINE, TRAUMA AND MEMORY: BRAIN AND BODY IN A SEARCH FOR THE LIVING PAST: A PRACTICAL GUIDE FOR UNDERSTANDING AND WORKING WITH TRAUMATIC MEMORY xiv (North Atlantic Books 2015) [hereinafter TRAUMA AND MEMORY].

organism—body, mind, and spirit—becomes stuck and continues to behave as if there is a clear and present danger.

Thus, when these natural processes get stuck, the body and the nervous system believe the danger continues to exist, and they respond accordingly.

The reason trauma gets stuck in the body is because usually the incident or incidents that create the trauma are so overwhelming for the emotional system they cannot resolve in the normal course of the ANS. So, the trauma gets stuck in one or more aspects of the ANS. Everyone has a limit to how much stress and trauma he can handle before it gets stuck. Up until that point of overwhelm, the system can recover. But once that point of overwhelm is reached, the system cannot recover on its own, and it needs intervention, which we will discuss below. As we will discuss later in this chapter and in Chapter 5, children need the help of a loving, caring adult to resolve the trauma in their nervous systems; unfortunately, the children with whom you work in the dependency and family court systems often live in this state of overwhelm, and one of their parents is rarely capable of being that supportive, healing presence. If they were, they would not be your clients. Thus, most of your clients are stuck in these unresolved processes. Being stuck in the sympathetic response can lead to hyperactivity, panic, rage, hypervigilance, and elation or mania. Being stuck in the freeze response can lead to disconnection, depression, deadness, and exhaustion.

Trauma does not have to get stuck in the nervous system. Wild animals that go into a state of deep freeze, or “play dead,” come out of that state, shake it off, and walk away. They do not experience PTSD the way humans do. Humans attempt to resolve trauma similarly. Often human instinct is to cry or rock or tremble. The problem is that

society views these actions as weakness. We prefer to believe "whatever does not kill us only makes us stronger." Instead of feeling the pain of the trauma—and therefore being able to move it through the body to move toward wholeness and wellness—we expect people just to get over it. That prohibits the body from going through the natural resolution process. Instead of experiencing the event or events, responding appropriately to them, and healing from them, society asks us to halt the process and pretend everything is okay. This works until the trauma we never resolved comes back, and we act from that traumatized place.

Noticing when people are in these extreme states is important because one of the key aspects of overly active sympathetic and parasympathetic responses is what happens in the brain. Because these instincts are survival instincts, the brain reacts in a survival response.

Trauma and the Brain

For our purposes, the brain has three levels:[18] (1) the reptilian brain, (2) the limbic brain, and (3) the neocortex. The reptilian brain is the brain stem, and it controls all the unconscious aspects of our lives—breath, heartbeat, temperature, balance, and the execution of the ANS. The limbic brain controls the emotions required to connect to others, including attachment, and contains two very important parts of the brain—the amygdala, which regulates fear, and the hippocampus, which regulates memory. The limbic brain governs early affect states apparent in infants as well as emotions humans use to express and connect to others, such as compassion. Both the limbic and reptilian

<FN>[18] Certainly, brain science is much more advanced than what we are going to discuss here, but we want to discuss it enough so that you understand just how natural your clients' responses are; they may not be as in control as you would like to think because of how automatic the effects of the trauma are.

brain can speak through sensation and a felt sense within the body. This will become important to our discussion later in this chapter. Finally, the neocortex is the executive functioning of the brain. It is where thought intervenes and interrupts impulsive reaction; it also controls language, reasoning, and voluntary movement.

Without the impact of trauma, children's brains are already different from adult brains. The neocortex is not fully developed, and the prefrontal cortex, the reasoning center of the brain, can take until the mid-20s to develop fully. Thus, children already act more from an emotional and impulsive place than do adults. When trauma is added to the mix, and someone is stuck in a fight, flight, or freeze pattern, that chasm grows even wider. The amygdala can go into overdrive, and children can sense fear in a multitude of situations that otherwise should not induce fear.

When trauma is involved, the brain goes into survival mode. And as the saying goes, when a tiger is chasing you, there is no need for a neocortex. It shuts down. There is no time to analyze and reason as to whether you are going to run. You must act and act immediately, or you die. Remember that trauma feels to the person like a life-or-death situation; therefore, the brain goes into a life-or-death response. Because the ANS is governed by the reptilian brain and emotions are governed by the limbic brain, when the body is in fight, flight, or freeze, the neocortex shuts down. It is not necessary. There is no reason to think about multiplication tables when a tiger is chasing you. But if the body is stuck in that state, it can cause problems for your clients as well as your relationship with your clients.

If the neocortex shuts down, children act more on impulse than they would otherwise. They go into hyper- or hypo-aroused states where there is too much or too

little feeling, respectively. If they are very young, the higher brain may not develop language and reasoning abilities, or those abilities will be greatly impaired. If they are older, they may struggle in school both academically and socially. And if they are teenagers, the normal risks teenagers take as they grow into adulthood can become impulsive aggression and extremely high-risk behaviors, all because the neocortex is essentially impaired or shut down.

One interesting way these brain changes affect your representation is that when the neocortex is shut off, imagination becomes more difficult. Imagination is crucial to children generally, and it is crucial to being a lawyer because part of your job is to imagine possibilities with your clients, including safety plans for children you worry are in an unsafe situation. The only person who can tell us how a situation will truly affect the child is the child, so children must be part of the process of determining what happens to them. In that sense, you must be able to brainstorm and imagine a variety of possibilities with your clients. If the higher brain is offline, imagination disappears.

If your clients are absorbed by trauma, they will be less likely to see ways out of their situation. It becomes nearly impossible to imagine that life will be different than it is today. This causes multiple problems for children, but the two most important are that (1) they can become depressed and hopeless about their future and (2) they can find it too difficult to come up with ideas to move beyond where they are today.

Memory and Trauma

Memory is one aspect of life everyone thinks they understand, but often what we believe to be true is moderately to significantly false.[19] Memory is a confusing topic for

<FN>[19] In addition to what we are writing about in this chapter, in Chapter 11, we will be addressing the illusion of memory as it relates to bias.

neuroscientists, and neither of us are neuroscientists. This section, therefore, is not an overview of everything science knows about memory. It is an overview of how what we think we know about memory is often incorrect and how trauma affects memory.

First, and perhaps most importantly, memory consists of more than recalling events. In his book, *Trauma and Memory*, Dr. Peter Levine discusses different types of memories. The hippocampus, where we store many explicit event memories, comes online at about 18 months of age. Therefore, it is very unlikely someone can recall events that happened prior to that age in the colloquial sense of remembering an event. But the brain is making other forms of memory from birth (and perhaps before), and those memories have a potentially greater impact on us as we grow.

The memories we hold generally in our tissues are bodily implicit memories, whereas the memories we hold in our conscious memories are explicit. Levine states, "Implicit memories appear and disappear surreptitiously, usually far outside the bounds of our conscious awareness. They are primarily organized around emotions and/or skills, or "procedures"—things the body does automatically, sometimes called "action patterns."[20] You know the adage "You never forget how to ride a bicycle." This is true because it is a procedural memory; the body remembers even if you cannot consciously remember the last time you were on a bicycle. These implicit memories are the memories that cause children and adults to recoil in fear for reasons they do not consciously understand. Thus, if a young child has been exposed to trauma at the hands of someone frequently enough, that child may cry or stiffen around the perpetrator of that trauma despite there being no safety concerns in the moment.

<FN>[20] TRAUMA AND MEMORY, *supra* note 132, at 21.

Declarative memories, by contrast, are a form of explicit memories. These are usually the only types of memories people are referring to when discussing memory in general. “Declarative memories are relatively orderly, neat, and tidy, like the highly structured cerebral cortex that they use for their hardware and operating system.”[21] No feeling or emotion is attached to them. Episodic memories are another form of procedural memory, but they “are often infused with feeling tones and vitality, whether of positive or negative valence, and richly encode our personal life experiences.”[22]

What might be most interesting about episodic memories, those infused with emotion, is how they change as they are recalled.[23] This has its advantages; the memory becomes a narrative that can influence how you feel about yourself as it grows and changes with each recollection.[24] These episodic memories generally begin for people around age 3, but they can occur earlier.[25] The mutability of memory is crucial to our growth in that it allows us to learn with each new experience we have. When a memory is mutable, “our present feeling state may be the major factor determining what and how we remember a particular event.”[26] This means we do not need to get fixated on the memory and it does not need to become overwhelming to us. Instead, it can grow and change and help us learn. What is important to remember is that our current emotional state influences the memory, so the memory changes with our emotional states.

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[21] *Id.* at 16
[22] *Id.*
<FN>[23] Mark Fischetti, *Why Do Our Memories Change*, SCIENTIFIC AMERICAN, Feb. 10, 2017, https://blogs.scientificamerican.com/observations/why-do-our-memories-change-video/.
[24] TRAUMA AND MEMORY, *supra* note 132, at 19.
[25] *Id.* at 20.
[26] *Id.* at 3.

Levine describes two types of implicit memories—emotional and procedural. Emotional memories help us remember emotional experiences and seek out those experiences again. If you have a wonderful experience at a party with friends and later your body feels the same way, your understanding of that new event is that it is safe like the party. There has been research on where specific emotions appear in the body, and people indicate similar experiences.[27] Procedural memories, like emotional memories, are a felt sense rather than a conscious recollection of an event. They consist of learned motor actions, emergency responses, and fundamental responses such as avoidance or approach.[28]

Even very young children can experience the effects of traumatizing events because the memory of that event is stored in the body memory even if the child has no conscious memory something bad happened. These memories can affect them later in life in how they react to the person or people who caused the trauma as well as in response to others in their lives. In addition, even when a child is not in the room when traumatic events happen, the fallout from that trauma can affect them on numerous levels. First, they can feel it happening even if they are asleep and cannot hear it in the moment. [29] Second, caregivers who experience trauma act differently, and that affects the children's relationship with the caregivers.

Trauma can also affect explicit memory recall. Instead of memories being mutable and part of a coherent narrative of someone's life, traumatic memories appear

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[27] Lauri Nummenmaa et al., *Bodily Maps of Emotions*, PROCEEDINGS NAT'L ACAD. OF SCI. U.S.A (2013), *available at* www.pnas.org/content/111/2/646.full.

<FN>[28] TRAUMA AND MEMORY, *supra* note 132, at 25.

[29] See, e.g., California Attorney General's Office, *First Impressions: Exposure to Violence and a Childs Developing Brain*, https://www.youtube.com/watch?v=O4zP50tEad0.

as overwhelming fragments filled with emotion and other sensory input. Levine explains:[30]

> In sharp contrast to gratifying or even troublesome memories, which can generally be formed and revisited as coherent narratives, "traumatic memories" tend to arise as fragmented splinters of inchoate and indigestible sensations, emotions, images, smells, tastes, thoughts, and so on. For example, a motorist who survived a fiery car crash is suddenly besieged by a racing heart, stark terror, and a desperate need to flee when he catches a whiff of gasoline while filling his tank at a service station. These jumbled fragments cannot be remembered in the narrative sense per se, but are perpetually being "replayed" and re-experienced as unbidden and incoherent intrusions or physical symptoms. The more we try to rid ourselves of these "flashbacks," the more they haunt, torment, and strangle our life force, seriously restricting our capacity to live in the here and now.

Memory is, therefore, more than the conscious recall of an event that happened in the past. It lives in the emotions and feeling states of both our past and present. In addition, if the event was overwhelming at the time, the memories can be fragmented pieces without any coherent narrative, causing someone to react to current situations in

[30] TRAUMA AND MEMORY, *supra* note 132, at 7–8.

ways that make little sense in the moment. For children, who are already more emotion- and feeling-oriented than adults, these problems with memory become even more difficult parts of your job.

Think about the 3-year-old during a forensic interview who cannot recall the event of the day but squirms and curls into a ball while trying to remember the sex abuse the interviewer asks about. Then think about the 7-year-old child who can give you a very specific narrative of what happened during what should have been an incredibly traumatic experience. She can tell you where she was every minute for over an hour. The first example does not necessarily mean the abuse happened, and the second does not necessarily mean it did not. What it means is you need to ask more questions—and not necessarily questions of the child—because conscious recall of an event can have a multitude of meanings. Knowing that memory, particularly traumatic memory, is deeper than conscious awareness and often shows up as emotional states will help you better understand your clients and the words they say to you. Moreover, with preverbal, or nonverbal children, these understandings of how memory leads to instinctual actions can help you better interpret what these children are saying without words.

Long-Term Effects of Trauma

We would be remiss if we were to discuss trauma and not the Adverse Childhood Experiences Study. It helps put into perspective the importance of understanding trauma not only for your current relationship with your client but also for its long-term effects on her life. Kaiser Permanente, the largest healthcare provider in California, did a study on adverse childhood experiences (ACEs), asking participants about their

adverse experiences prior to their eighteenth birthdays. The ACE study consists of ten questions regarding specific types of childhood trauma,[31] including:[32]

> 1. Did a parent or other adult in the household often or very often . . . Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
> 2. Did a parent or other adult in the household often or very often . . . Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
> 3. Did an adult person at least years years older than you ever . . . Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
> 4. Did you often or very often feel that . . . No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
> 5. Did you often or very often feel that . . . You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

<FN>[31] Centers for Disease Control and Prevention, Adverse Childhood Experiences (ACEs), https://www.cdc.gov/violenceprevention/acestudy/.

[32] The Adverse Childhood Experiences Study: A Springboard to Hope, www.acestudy.org/the-ace-score.html.

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Did a household member go to prison?

Every yes answer equals 1 point. What the ACE study ultimately showed was those who had a higher ACE score were more likely to have physical illnesses and social problems later in life. Specifically, an ACE score of 6 or more leads to significantly higher risks of many physical diseases later in life, including, but not limited to, heart disease, diabetes, and chronic obstructive pulmonary disease (COPD). It further leads to an approximately 20 year decrease in life expectancy.[33]

The idea that emotional trauma could have such lasting impacts on us physically has been the most important finding of the ACE study. It was a reminder to the medical community that we must look to emotional reasons for some, if not most, physical ailments. As Peter Levine has found, trauma exists in the nervous system just as stress does, and its effects, therefore, are just as profound on our health as having a stressful

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<FN>[33] Carina Storrs, *Is Life Expectancy Reduced by a Traumatic Childhood?*, SCIENTIFIC AMERICAN, Oct. 7, 2009, https://www.scientificamerican.com/article/childhood-adverse-event-life-expectancy-abuse-mortality/.

life. Therefore, we know the trauma our clients experience will likely have a lasting impact on them if we do not help them find ways to mitigate the harmful effects of the trauma. Moreover, as we will discuss in Chapter 12, these issues affect your own life and health as well.

By definition, children involved in the dependency or family court system have an ACE score of at least 1 because the ACE questions list most of the reasons a child would enter the court system. If they are provided a lawyer in a high-conflict custody case, they often have a much higher score, and certainly children involved in child welfare cases frequently have scores higher than 1. What the ACE study does not cover is the trauma of being involved in the court system itself. The ACE study does not ask about removal from primary caregivers, most likely parents, and it does not ask about being interviewed numerous times by several different strangers about preference between parents or about topics society generally tells children they should not discuss with strangers, especially when the children's caregivers have told them to keep these issues secret.

Child clients, therefore, have many more indicators of trauma than the ACE study contemplates, but the findings of the ACE study are what should interest us. It teaches us that the effects of trauma last long past the end of the case, and they manifest as more than just emotional issues. As professionals in the system, and the ones working with the children directly, you can help find ways to counteract the trauma your clients experience.

Manifestations of Trauma

Now that you know what trauma is, how it affects the nervous system, body, and

brain, and its long-term effects, the rest of this chapter will focus on how it manifests and why it matters to the work you do with your clients. This is in no way a complete overview of every form of trauma manifestation, but we hope to increase your awareness of what children are saying when they are speaking verbally and when they are speaking in ways you, as lawyers, are less trained to see.

In his book on stories of complex trauma in children, *The Boy Who Was Raised as a Dog*,[34] Dr. Bruce Perry provides examples of what happens when children are severely neglected or severely traumatized. These include stories of the children who were freed prior to the FBI destroying the Waco complex, a little girl who had been sexually abused and believed all adult men were sexual predators, a 3-year-old girl who watched her mother get murdered, a little boy who was adopted from a Russian orphanage, and a little boy who, quite literally, was raised in a cage like a dog because that's the only type of mammal his caregiver knew how to raise. Dr. Perry describes his work with these children and others and explains how we can begin to help children who have been severely traumatized.

Dr. Perry describes how these types of trauma manifest in children. For example, a young 7-year-old girl crawls into Dr. Perry's lap and tries to undo his zipper because, in her world, men existed only in a sexualized way. He described how a child with "intermittent care" from his parents resulted in his sociopathy and in him committing murder. Dr. Perry described this child as being left home alone for entire days while his mother was out on walks with her older son. Tragically, Dr. Perry writes, "Receiving no consistent, loving response to his fears and needs, [he] never developed the normal

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<FN>[34] BRUCE D. PERRY & MAIA SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG (Basic Books 2006).

association between human contact and relief from stress. What he learned instead was that the only person he could rely on was himself."[35]

One story Dr. Perry recounts is a good reminder that you, as the child's lawyer, may see the trauma very differently than the children do. Dr. Perry worked with the children who were rescued from Waco, Texas, prior to the FBI raid that destroyed the Branch Davidian compound. To the children who were removed from that complex, the FBI and the ever-increasing number of well-meaning professionals who entered their lives, not their parents, were the danger. When one child saw Dr. Perry arrive, she calmly asked, "Are you here to kill us?"[36] "These children did not feel as though they had just been liberated. Instead, because of what they'd been taught about outsiders and because of the violence they'd survived, they felt like hostages."[37]

This example of the children from the Davidian compound is an important reminder about the work we do. As outsiders to these children's families, we may believe they have been traumatized. We may see all forms of abuse, neglect, and problems in parenting, but to the child, that life is normal. You may believe the child has been rescued from a dangerous situation, whether it be abusive parenting or an alienating parent, but from the child's perspective, the legal system is the danger, not the abuse you see. It is important never to lose sight of the fact that the lives these children lead are their normal, that it can take time to readjust their thinking, and that sometimes you cannot. The fear of the outsider, you included, may never shift in your clients even though you know or think you know the interventions being taken are

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<FN>[35] *Id.* 113.
[36] *Id.* at 64.
[37] *Id.*

appropriate. Further, there is a long history in the United States and around the world, of the dominant culture attempting to "save" people who have a different culture. What you may view as traumatizing may be normal to the child's culture. Where you draw that line, as discussed in Chapter 1, is critical to your work with children, and it must be navigated by considering the effect your choices have on the child's nervous system functioning.

The stories in the book *The Boy Who Was Raised as a Dog* are some of the most intense trauma imaginable. And while you may not see such extensive trauma in your work, you often see children who have experienced what we would objectively define as less trauma, but that does not mean it affects children less. It cannot be overstated here that the "level" of trauma is not what matters; what matters is how the trauma affects the nervous system and, therefore, how it affects the child's daily functioning. We do not believe in relative suffering.

People may respond to traumatic experiences in ways that seem counterintuitive. In *The Body Keeps the Score*, Bessel van der Kolk stated that children who suffer abuse respond in ways that make the trauma worse and leave it within the body's system longer:[38]

> Most of them suffer from agonizing shame about the actions they took to survive and maintain a connection with the person who abused them. This was particularly true if the abuser was someone close to the child, someone the child depended on, as is so often the case. The result can be confusion about whether one was a victim or a willing participant, which

<FN>[38] BESSEL VAN DER KOLK, THE BODY KEEPS THE SCORE: BRAIN, MIND, AND BODY IN THE HEALING OF TRAUMA 13 (Viking Penguin Group 2014).

in turn leads to bewilderment about the difference between love and terror; pain and pleasure.

As van der Kolk points out, the response to trauma is sometimes traumatic for the person as well, and you have the opportunity to normalize, if not condone, peoples' behaviors, including those that cause them shame. If a child believes he was a willing participant in the trauma, then he might believe it is his fault the trauma occurred. This can be exacerbated in children who have younger siblings, as they believe they need to take care of their younger siblings and prevent the abuse from harming their siblings.[39] Then the problem arises wherein the victim is less able to process the trauma because he believes he is a co-creator of the trauma.

The more common types of trauma our clients experience, such as exposure to domestic violence, neglect due to drug use or mental health issues, physical abuse, sexual abuse, and emotional abuse, are still detrimental to the development of our young clients and the behavior of our older clients. It can be too easy to believe one client's trauma is not as bad as another client's, making it more difficult to understand why a child is acting in a certain way. But all nervous systems are different, and what matters is the subjective experience of the child and how her daily life is affected. Therefore, in the rest of this section, we will discuss how you can notice these minor—and major—manifestations of trauma.

Recognizable Manifestations of Trauma

DSM-5 Manifestations

Although as children's representatives your job is not to diagnose PTSD,

[39] See Chapters 5 and 9 regarding parentified children.

knowing its diagnostic criteria can help you understand how best to interview your clients about their symptoms and better understand whether their behaviors are a result of the trauma they experienced. As a result, you can help them receive the services they need and better understand what they are trying to express to you. As you read about the symptoms, consider clients you have met who experienced or demonstrated some of these behaviors.

First, the *DSM 5* requires the person experience trauma, as defined by the *DSM 5*.[40] As stated above, that requires exposure to "death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence" through direct exposure, by witnessing the trauma, by learning that a relative or close friend was exposed to the trauma, or through "[i]ndirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)."[41]

Once there has been a determination the person has experienced a traumatic event as defined by the *DSM 5*, a PTSD diagnosis requires a combination of symptoms falling within the PTSD diagnosis. First, the person must re-experience the traumatic event in one of the following ways: (1) intrusive thoughts, (2) nightmares, (3) flashbacks, (4) emotional distress after exposure to a traumatic event, or (5) physiological reactivity after exposure to the traumatic event.

"Intrusive thoughts" means the person cannot shake the repetitive thoughts about

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<FN>[40] In this chapter, we have taken the position that trauma can be anything that subjectively feels overwhelming to the system, but we are including the *DSM 5* requirements as a baseline. It is important to remember that the *DSM* serves a purpose for the insurance industry as much as it does for the therapeutic community. For our purposes in this book, therefore, we look at trauma in a broader perspective, but the requirements of the *DSM* are important to understand because children involved in the court system are often on Medicaid or can only receive therapy through insurance, which require diagnoses.

<FN>[41] U.S. Department of Veterans Affairs, PTSD: National Center for PTSD, PTSD and DSM-5, https://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp.

the traumatic experience. The person can be thinking about something unrelated, and then without warning, the person is thinking about the traumatic event. These are the children who continuously bring the conversation back to the trauma or tell you they cannot concentrate at school because they are constantly thinking about the trauma. Physiological reactivity means the body responds as though it is experiencing the event again even if it is not. Imagine you are walking in the woods, are bitten by a snake, and you almost die. The next time you go walking in the woods and you accidentally step on a stick. but it *feels to you* like the snake bite, your body can respond with all the fear associated with almost dying from the snake bite without any objective reality to the fear because stepping on a stick is not dangerous. The body, however, responds as though it was just bitten by a snake again.

Second, the person must have one form of avoidance of trauma-related stimuli after the event—either avoidance of thoughts or feelings about the event or avoidance of trauma-related reminders. Third, negative thoughts and feelings must begin or worsen in at least two ways. These can include (1) an inability to recall key features of the event, (2) overly negative assumptions about oneself or the world, (3) negative affect, (4) decreased interest in activities that used to be enjoyed, (5) feelings of isolation and detachment from friends and family, and (6) difficulty in feeling positive affect.

Affect generally refers to how emotions show up for someone. It can refer to "the conscious subjective aspect of an emotion considered apart from bodily changes" or to "a set of observable manifestations of a subjectively experienced emotion."[42] As

<FN>[42] Merriam Webster, https://www.merriam-webster.com/dictionary/affect (last visited Oct. 31, 2017).

children's representatives, you can notice a child's affect. People are often described as having a flat affect if their external emotional state does not appear to change between joy and sadness or anger and contentment. A child with a flat affect will tell a very traumatic story with the same outward appearance as telling a story about winning an award at school. A child who has difficulty feeling positive affect can go from external appearances of sadness to more of a flat affect but rarely, if ever, demonstrates external joyful emotional states.

Finally, for a PTSD diagnosis, a person must exhibit at least two forms of trauma-related arousal and reactivity that began after the traumatic event or worsened because of it. These can include (1) irritability or aggression, (2) risky or destructive behavior, (3) hypervigilance, (4) heightened startle state, (5) difficulty concentrating, or (6) difficulty sleeping. For children under the age of 6, irritability or aggression may include extreme temper tantrums.[43] Hypervigilance and a heightened startle state are slightly different, but they often go together. Hypervigilance is when a person constantly looks around to understand her surroundings. A person who is hypervigilant may walk into your office and look at every corner. A person in this state also may try to sit with his back to a wall so as not to have space behind him where he cannot see what is happening.

A heightened startle state, by contrast, is an overly excessive response to otherwise benign stimuli, e.g., a door slamming or something falling on the floor. A person who exhibits a heightened startle response often turns toward the sound with a jerk of the head and possibly the body. This person may also have other signs of fight or flight manifest despite the fact there is no objective fear inducer. Babies who are raised

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<FN>[43] Matthew Tull, *Diagnostic Criteria for PTSD in Children*, verywell, Feb. 15, 2017, https://www.verywell.com/dsm-5-ptsd-criteria-for-children-2797288.

in violent homes often have a heightened startle state. It is a great question to ask about very young children. These PTSD requirements are an interesting starting point, but they are not the complete picture of how trauma will manifest in your clients.

Broader Manifestations of Trauma in Your Clients

Because trauma is in the nervous system, talking about traumatic events can bring up that trauma in children. This section discusses what you might see children do while you are talking to them that indicates the trauma is coming to the surface.

First, you may notice your clients discussing how their bodies feel. Compared to adults, children are more kinesthetic, so they often talk about their emotions through their body sensations. Bodily sensations include feelings of lightness, heaviness, and shakiness, for example. We have included a list of sensation words in the online materials. Children in family and dependency systems rarely describe feeling light and soft. Rebecca had one 7-year-old client describe, without provocation, a feeling of swirling in her belly. She described stress as “all the feelings inside me” and motioned to her stomach in quick circles. She further stated that when she feels stress, her legs go numb. While this was an unusual conversation, it exemplifies exactly how body- and sensation-based children are. When children do not remember a specific event, bringing them to the sensation of the event might help you understand how the event feels to them.

Children can also describe images and memories. When discussing events or telling you about a dream they had, they may tell you they see colors. It is always important to ask children how well they are sleeping. Sleep disturbances can indicate traumatic distress, but children often will tell you about their dreams and even their

nightmares. Children often can tell you what they heard and saw, but as we discussed earlier in this chapter, memory is not always accurate, particularly traumatic memories. Notice the fragmentation in the memory and how many other trauma manifestations appear while the child describes the memory.

Noticing how a child sits, gestures, and moves while you are talking is vitally important. Most of us do this unconsciously, and sometimes these movements are huge and obvious. For example, Rebecca has had multiple children literally turn around in a spinning chair so as not to look at her when discussing distressing events. One child got out of his chair and hid behind a couch when a person's was mentioned he did not want to discuss. Those are obvious actions by children. But often these cues are subtler, and they can be just as important.

Is the child looking around the room as though he is scared? Is he looking away from you? Is he fidgeting? Is he only talking while drawing or spinning? Is he stroking his arm or pulling/stroking on his hair while telling a story? These can be signs that a child is distressed about the conversation; they also can be ways a child soothes and calms himself. If a child is holding a stuffed animal while you are discussing something distressing for the child, encourage the child to notice the stuffed animal. Sometimes children will begin to shake nervously in your presence. That is often a sign they feel overwhelmed. Other behaviors such as rubbing their hands together, stroking their arms or legs, or even drawing and spinning around in circles are often signs they are mitigating the increased stress they are feeling in themselves while telling their stories.

Another very interesting but less well understood manifestation of trauma is a child's gait. Remember the discussion of how the reptilian brain affects balance. Dr.

Perry has noted that a child's "curious slanting gait" was the result of early childhood trauma "because coordinated walking relies on a well-regulated midbrain and brainstem."[44] We mention this because it is rare to think of these deep-seated physical issues as trauma manifestations. But once you understand how trauma effects development, and development affects every action humans take, you begin to see how trauma affects every aspect of your clients' lives, including potentially the way they walk.[45]

Children will also show emotions while speaking with you. These can be broader than those necessary for a PTSD diagnosis. You are probably well versed in understanding the emotions, or affect, your clients show. The most common affect not discussed above with the PTSD diagnosis is a flat affect. People with a flat affect appear disconnected from their emotions. These children do not laugh or cry and have a similar external state despite talking about issues as unrelated as sex abuse and their favorite puppy. This is generally a sign children are in a deep freeze state, as described earlier. You may, of course, see other emotions, including joy, sadness, anger, frustration, happiness, etc. One important fact about children, particularly those who are in a state of trauma, is that sometimes laughter is a nervous tick and not genuine laughter.

It can be beneficial to ask children about somatic issues. Biologically speaking, *soma* means "body." Somatic issues are different from sensations. The sensations are just that; somatic issues are the longer-term effects of what might be described as

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<FN>[44] Perry *supra* note 149, at 135.

[45] We do not mean to imply that trauma is the cause of every child with a strange gait, but we hope that these examples help you think outside the box on what causes different changes in your clients.

sensations. Trauma often manifests as somatic complaints, most specifically low back pain, stomach pain, and headaches. Children who report everything is going well in their lives but also report frequent, unexplained headaches are likely experiencing trauma, but it is manifesting in a way most people are not accustomed to asking about. If your client describes any of these symptoms, ask her when they happen. Can she remember what she was doing just before her most recent headache? Some children will tell you they know these symptoms occur when they think about something specific. Compared to adults, children tend to be more attuned to their bodies, so they often know what is happening. And if they do not, your inquiries can help you and the child understand how the case is affecting her.

Outside of your specific conversations with your clients, trauma manifests in many behavioral ways, including aggression, regression in development, tantrums, and loss of sleep. The NCTSN provides information on behaviors children may express indicating they are acting from a trauma response. Many of these behaviors are similar to the behaviors used to diagnose ADHD and other mental health diagnoses many of your clients in these systems receive and for which they receive a plethora of psychotropic medication. For example, the NCTSN explains these children are easily triggered and are more likely to participate in high-risk behaviors, including drugs, alcohol, and other activities that could result in their entry into the juvenile justice system.[46]

Unfortunately, it is still new for society to see these actions as trauma responses and not children being out of control. Instead, they are seen solely as problematic

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<FN>[46] The National Child Traumatic Stress Network, Effects of Complex Trauma, www.nctsn.org/trauma-types/complex-trauma/effects-of-complex-trauma (last visited Oct. 31, 2017).

behaviors leading to removal from placement, removal from school, delinquent behaviors, and diagnoses that remain with children their entire lives. Further, dissociated children who do poorly in school are seen as needing tutors, not trauma therapy. As we will discuss specifically with types of trauma later in the book, these behaviors often result from traumatic events and chronic trauma in children, and it is important to recognize the *why* of these behaviors more than *what* the behaviors are.

It is very common for children to attach meaning to their experiences as well, especially believing their case is their fault. That is the meaning they have ascribed to the case or the separation of their parents. Rebecca once had a client say she was cutting herself because she felt guilty. She had ascribed meaning to her situation such that she believed the situation was her fault, and it caused her to use a cutting behavior. Children can also assign a meaning that no one loves them. This question of meaning is similar to asking your clients why they feel the way they do. It gets deeper than just the initial statements, and it can help explain what their experience is like for them. We all prescribe meaning to every event. When that meaning is tied up to trauma, however, it can be damaging to the child and how he interacts with the world around him.

Many of your clients believe no one, including you, is to be trusted or that they are completely alone in life or that all professionals in the system are against them. Often children see you as just another person paid to be there, so what is the point of engaging with you? Understanding these deeper meanings children have about life in general can help you put their specific experiences into the context of the case and your work with the child. When children have these core meanings tied around the system, it can be very difficult for you to work with them because they do not believe you are to be

trusted. It takes time to repair these relationships, and you may not be able to work with that child client the first time you meet. It may take several meetings where you let the child be angry with you and you keep showing up anyway. You keep working for her anyway.

Our hope is that this section has helped you see children manifest trauma in numerous ways. The problem for your clients, however, is that most therapy systems in this country, particularly when they involve insurance (and Medicaid is insurance), ask the therapist to focus on behaviors and not the underlying cause of those behaviors. These systems are behavioral health systems, not mental health systems. This means that if your client is not expressing "negative" behaviors, she will not qualify for mental health services. Moreover, if your client is expressing negative behaviors but does not meet the *DSM-5* criteria for PTSD, she may be diagnosed with something she does not have, such as oppositional defiant disorder. This diagnosis can cause other problems later in her life. Children who do not express overt, external signs of distress may not qualify for therapeutic services despite the fact that they have somatic complaints, and you know they think the case is their fault, but no one else has asked, so they have not told anyone else.

For your client's sake, and her therapeutic process, it is important for you to know the signs of trauma. But knowing those signs also is important for your direct representation because of how trauma affects your client's ability to interact with you and the system.

Shock

Shock is a form of ANS freeze response and a manifestation of trauma, but

because it is so common in your practice as a children's lawyer, we believe it needs its own explanation as one of the major trauma manifestations. Shock makes your job as a children's lawyer more difficult. Physiologically, shock is when the nervous system shuts down. Whatever is happening externally is too intense for the nervous system to process, so it becomes overwhelmed and goes into a near-complete freeze state. People in a state of emotional shock have lost the function of the neocortex, so their executive functioning is turned off. Very often the emotional center of the brain shuts down too. People in a state of shock are in a non-feeling state. When there is a physical injury, shock allows the person not to feel the pain of that injury. It quite literally shuts off the pain receptors so the pain is not so overwhelming to the person. Emotional shock works similarly, wherein all emotions shut down, and this includes "good" emotions, e.g. joy, happiness, and excitement.

This is a vital protection for humans in many ways, as it allows us to continue living despite what would otherwise be overwhelming emotional or physical pain. But when your child clients experience it and you meet with them at that time in their lives, it is very difficult to have any real conversation with them about the past, the future, or even the present. Besides numbing the emotions, shock also shuts down the higher brain functioning, making it difficult for children to remember who you are and what you tell them and often means they have forgotten you the next time you meet.

Imagine for a moment what the experience of removal is like for a child. It involves, at the very least, a social worker showing up and telling the child to take the most essential parts of his life and put them in a bag and go to someone else's home, sometimes that of a stranger. It often includes an act of violence, an interview reviewing

traumatic history, or police involvement. These are situations that would shock anyone, let alone a child who has little control over his environment generally and no control in these situations. This experience by itself leads to a state of shock for many children. And it is in this space that you arrive for the first time, usually within a week of this occurring.

The other problem with the shock state, and any freeze state for that matter, is that it can appear at first glance as if everything is going well for the child, particularly for very young children. One of the red flags with infant clients is when someone says a child is a "good baby" who never cries. With a child whose needs are always being met, slight whining can be sufficient to get her needs met, so it may not be unusual that a child like that rarely cries. In your clients, however, they likely have a history of not having had their needs met, or even if their needs were being met, the fact the court system is involved means the child has had a recent trauma. Therefore, a child in that state who is not crying is a red flag. It may not mean anything bad for the child, but it generally means you need to look more closely. Thus, it is very important to ask not only about negative behaviors but also about these numb-like behaviors.

Familial Trauma Is Unique

Now that we have discussed what trauma is and how it manifests, it is important to understand what makes familial trauma unique. As we will discuss below, trauma resolves best when there is a strong, stable adult in the child's life. Thus, in war or when someone dies in a car accident, families come together to support one another. Although the external event is terrible, healing happens with this support.[47] As we will

<FN>[47] This is not to say there is no residual trauma from war-torn countries, only that the nature of how trauma heals is different in external vs. familial trauma.

discuss in Chapter 5, children learn to self-regulate through the emotional regulation their primary caregivers express and teach. As noted elsewhere in this chapter, Dr. Levine teaches that trauma is held in the nervous system and can be released safely in situations where we can cry, shake, and move the trauma through our system. Thus, children must have (1) the implicit self-regulation knowledge and (2) a safe environment in which to move the trauma through the system in order to heal.

Familial trauma can destroy that ability to heal. When the trauma exists within the family structure, the very people who are supposed to be supporting the child through the trauma are the ones causing it. Therefore, even if the adult is capable of self-regulation, which is often not the case, the adult is not a safe person in whom to confide and release the trauma the child experiences. It is important to recognize that caregivers may be sources of ongoing trauma for children despite laws giving them rights to contact the children and even rights for visitation and placement. This can be true in both dependency and family court.

Resilience

This chapter can be a little overwhelming, but we do not want you to think that simply because someone has experienced traumatic events and that trauma has become stuck or unresolved there is no hope for him. This section will look at the beginning of the resilience research and some of the forms of therapy that work best with trauma.

The Center on the Developing Child at Harvard University created a working paper that stated:[48]

<FN>[48] Center on the Developing Child at Harvard University (2015). *Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper No. 13* (emphasis added).

> Science shows that children who do well despite serious hardship have had *at least one stable and committed relationship with a supportive adult*. These relationships buffer children from developmental disruption and help them develop "resilience," or the set of skills needed to respond to adversity and thrive. This working paper from the National Scientific Council on the Developing Child explains how protective factors in a child's social environment and body interact to produce resilience, and discusses strategies that promote healthy development in the face of trauma.

This makes sense. Remember that Dr. Levine defined trauma as a loss of connection. Thus, coming back to a sense of connection is vital to healing trauma.

With regard to the nervous system, the polyvagal theory, as described by Stephen Porges, describes "a complex social engagement system mediated by facial gestures and vocalizations,"[49] meaning that humans' nervous systems regulate through engagement with others and we learn to regulate through viewing others' facial expressions. Thus, when someone feels safe, his defensive emotions become less intrusive.[50] In other words, social interactions that feel safe are what help the nervous system stabilize and come back into the normal ebb and flow the system can handle rather than the stuck sympathetic and parasympathetic responses you see with trauma. This is why it is so important for your clients to have someone in their life with whom

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<FN>[49] STEPHEN W. PORGES, THE POLYVAGAL THEORY: NEUROPHYSIOLOGICAL FOUNDATIONS OF EMOTIONS, ATTACHMENT, COMMUNICATION, AND SELF-REGULATION xiii (W. W. Norton & Company, Inc.).
[50] *Id.* at xiv.

they feel safe.

This is good news and difficult news for those who work with children in the family and dependency law systems. The good news is that children have the potential for resilience and having a stable adult in their life can help them make it through these difficult times. The problem, as stated, is that a resilient adult is often the child's caregiver, but in family and dependency law cases, the caregivers often cause the trauma. It can be difficult because of laws, child welfare constraints; and in family law cases, the adversity between families to help children connect with these stable, resilient adults. But supportive adults can be a coach, a pastor, a band teacher, a therapist, or even a neighbor. The most important resilience question you can ask your clients is, "Who matters to you?" Helping ensure that your clients have continued contact with these people is vital. Your own ability to create a safe place for children is important to a child's healing in this difficult process.

Peer relationships can also help in the healing process and sometimes are necessary for healing. As Dr. Perry learned with a child who spent his first three years of life in a Russian orphanage, even very young peers can provide healing for extensive trauma patterns. In one of the most incredible stories in his book, Dr. Perry went to a first-grade classroom and explained how the brain develops and how it learns from having experiences and how young Peter's brain could learn from his classmates:[51]

> [O]ver time, their (the other students') natural goodness emerged . . . They were tolerant of his developmental problems, patient in correcting his mistakes and nurturing in

<FN>[51] Perry, *supra* note 149, at 229.

their interactions. These children provided many more positive therapeutic experiences than we (the clinic where Dr. Perry worked) ever could have given Peter.

And, of course, there are different forms of therapy that help children. For young children who have attachment/relationship trauma, they need a form of dyadic therapy,[52] meaning the therapy is with an adult who can be a parent or another caregiver. If the child is not living with a biological parent and is having issues, the therapy can begin with the caregiver, and if the child is eventually returned to a biological parent, the parent can begin to do the therapy with the child.

Generally, talk therapy is not very helpful for children, particularly when there are deep trauma patterns because "the best verbal therapies can offer is to help people inhibit the automatic physical actions that their emotions provoke."[53] Thus, the trauma is still present in the nervous system, but the talk therapy helps the child to stop acting on his impulses. Over time, that will be insufficient to resolve the trauma itself. One form of therapy becoming more common, however, is trauma-focused cognitive behavioral therapy. When done in its best form, this also is a form of quasi-dyadic therapy. It involves a caregiver as someone who helps use the skills learned in therapy in the home setting. One of the benefits of talk or play therapy with traumatized children is the fact that the therapist is a stable, calm, consistent, and supportive adult in the child's life. But ultimately, we believe other forms of therapy are better suited to resolve nervous system trauma.

<FN>[52] Dyadic simply means two; thus, there are two people in the therapy, generally the child and any caregiver or parent.

[53] Ogden, *supra* note 125, at 22.

New trauma therapies continue to emerge. Somatic experiencing, a form of therapy created by Dr. Levine, is showing promise with PTSD[54] and has worked very well with children, even preverbal children.[55] Unfortunately, because somatic experiencing is still in the early stages of becoming "evidence-based," it is rarely available with insurance. Eye movement desensitization and reprocessing (EMDR) is another newer form of non-talk trauma therapy with good results for trauma. As EMDR has become more accepted, it is slowly making its way into the offices of therapists who take insurance. Therefore, it may be available to your clients depending on your jurisdiction. There are still other forms of emerging somatic-based therapies, and we will continue to update the online materials with them.

Interestingly, sometimes therapy is not the most therapeutic avenue, especially for children. In *The Body Keeps the Score*, Dr. van der Kolk provides a list of a variety of non-therapy therapeutic interventions specifically for trauma, including yoga and theater. Both of these are body-based and bring some structure to actions. Yoga allows the body to learn to move in new ways and release energy in safe patterns. Meditation can also help calm an overactive nervous system.[56] Theater allows someone to enter the cathartic aspect of playing someone else and working through issues somewhat at distance rather than through a direct experience that may be too overwhelming.

<FN>[54] Danny Brom et al., *Somatic Experiencing for Posttraumatic Stress Disorder: A Randomized Controlled Outcome Study*, 30 J. TRAUMATIC STRESS 304 (2017), *available at* https://traumahealing.org/wp-content/uploads/2017/06/Somatic-Experiencing-for-Posttraumatic-Stress-Disorder-2017.pdf.

[55] PETER A. LEVINE, IN AN UNSPOKEN VOICE: HOW THE BODY RELEASES TRAUMA AND RESTORES GOODNESS (North Atlantic Books 2010).

[56] Rebecca is a yoga teacher and still believes it is necessary to point out that there are times when yoga and meditation can be too overwhelming for someone who is in the throes of a trauma response. That stillness can set off an activation response that can overwhelm a system. That said, if that does not happen, yoga and meditation can greatly reduce the trauma responses that people hold in their bodies.

Rebecca had a client who had been sexually abused and raised by a variety of relatives; the client found her voice and her healing in her drama class in high school. Similarly, Phil had a teenage therapy client from a very high-conflict divorce who had previously been socially avoidant; he found his voice and learned to trust his peers when he started acting in college. Both of these children explained the acting itself as being therapeutic along with the community they met in the theater class[57].

Sports are also a great way for children to begin to heal from trauma. Sports get bodies moving, and they often have a team component. For children who refuse therapy, see if they are interested in joining a sports team if you believe your client is experiencing trauma reactions. It may not be the right time to work through the trauma itself. It could be years before the child is ready for that. But getting the body and the nervous system moving in a healthy way is a big step toward allowing the healing to begin.

Finally, humans need human contact to heal. Yes, touch. This is difficult for us to write because in the work you do in family and dependency law, when you talk about touch, it is almost always unsafe touch. But supportive, loving touch is not only helpful but also crucial to a child's development. Dr. Perry describes a foster mother who would rock and hold children of all ages, and as Dr. Perry stated, "Mama P. discovered, long before we did, that many young victims of abuse and neglect need physical stimulation, like being rocked and gently held, comfort seemingly appropriate to far younger children."[58] If children were never provided that safe, loving touch, it can be necessary

<FN>[57] There are numerous examples of popular actors (male and female) who have described abusive childhoods and that acting has helped them learn to deal with those residual issues.
<FN>[58] Perry, *supra* note 149, at 95.

for them much later in life. Food and shelter matter, yes, but the care and love that comes with holding and rocking and interacting with children is just as important. Many of your clients will have missed this part of their infancy. Instead, caregivers either were too absent to provide it or did not know how to provide it. Therapists who work with adults who have experienced significant trauma in their childhood often need to teach their clients about safe touch and how much rocking can help. Even using a phrase such as "always rocking with you," with or without the actual rocking, can help these clients learn to feel safe.

You can help foster parents and caregivers understand the importance of this in children's lives. This is one of the reasons it is important for children to be placed with people they know, if possible, because children and caregivers alike are less fearful to provide this physical closeness. But you can also encourage it in foster caregivers. This educational piece can be one of the most effective interventions in helping children heal from the trauma they have experienced because it allows the trauma to heal in a more natural course than through means that could make it worse and increase the PTSD-like symptoms.[59] We cannot overemphasize the importance of loving and comforting caregivers in a child's life to help that child heal from trauma.

Implications for Your Practice

This chapter has been focused on the science and the psychology behind trauma. This section pulls these issues together and discusses how and why these issues affect your practice and what you can do to help your clients understand themselves better and to help you understand your clients better.

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[59] ***Id.*** **at 71.**

Myths about Trauma

First, it is important to dispel some common myths we have experienced in the legal profession. After reading this chapter, we hope you will understand why these myths are myths. We continue to hear people say the effects of domestic violence are not as bad because the child was not in the room and did not see the violence. We continue to hear that a dirty home is only a dirty home and not a form of severe neglect. We continue to hear that if a child cannot remember the trauma, it cannot affect the child's development later in life. Why are these all false? Because trauma is in the nervous system. It is in a lack of connection. It is in the feelings of fear and not being safe. These are key components of severe neglect or abuse, as described by the NCTSN, and trauma that happens around but not to the child. Remember that children are exposed to the traumas even if they are too young or are somewhat removed from the traumatizing events.

Another common myth is that if a monitor can be present during visits, a child is safe with a dangerous parent. After reading this chapter, what would you think if an infant were placed in a visit with a perpetrator of domestic violence and that perpetrator fed the child and cared for her but the child remained silent the entire time? What if after the visit the child cried for two hours? There are many ways to interpret these actions, but from a trauma-informed place, we see a child who is in a state of freeze while in the presence of the perpetrator because that is the only safe way to be around that person who has committed such acts of violence. Then after the visit is over, the child's system is so overwhelmed with having been in "freeze mode" for the visit, the child begins to cry to release all of that pent-up activation. We continue to hear people say that these visits

are safe for children because “nothing bad happens during the visit, and the perpetrator appears to parent well during the visit.”[60]

Remember that one of the requirements of a PTSD diagnosis is either avoidance of trauma-related thoughts or feelings or avoidance of trauma-related reminders. So someone experiencing PTSD wants to avoid reminders of the initial trauma, but if the court system places children in a room with the trauma reminder, is that not just retraumatizing the child who has no say in the matter? Obviously, this is not true of all children, but understanding how trauma affects the nervous system gives you another avenue for understanding how the decisions you make in court affect your child clients.

These examples are not to say this interpretation is the only one, but rarely have either of us heard it offered as a possibility at all. Instead, we encourage you to use the information in this chapter to make a more holistic evaluation of the circumstances. Always ask about behaviors and think about the effects of what the child experienced previously before assuming that just because you know nothing bad will happen in a situation, the child’s nervous system knows that as well.

Speaking with Your Client

One aspect we discuss less often as lawyers for children is that part of your job is to have distressing conversations with your client and then often leave them in that distressed state. Unlike therapists who have an opportunity to mitigate the increased distressing responses in their clients, your job is to get information, discuss issues relevant to the case, and move on. This causes two main problems. First, when children

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<FN>[60] We also often hear stories that children seemingly act fine while at the home of an allegedly abusive parent, but the other parent expresses concerns that the child has meltdowns not long after the exchange. Such discrepancies can be a function of that trauma experience.

are distressed, they are less able to have a meaningful conversation, *particularly* if they are young children; remember that the neorcortex shuts down when in a trauma response. Second, you likely do this work because you care about children, and seeing children in that distressed state and sending them on their way can be draining on you as their lawyer. We will discuss that issue more in Chapter 11, but here we will discuss how to notice what is happening in your client and some simple tools to help you manage it.

To be clear, this is not a section on how to be a therapist. But there are simple techniques you can use to help your client (and potentially yourself, but that will be discussed in Chapter 11) regulate some of the extreme emotions and nervous system states that exist during conversations with you. This is important for another reason; if your client is so activated or frozen by your discussion, the conversation you have will not benefit the case in any way. Your client's memory will be shot, and her ability to tell you what she wants will be nearly gone. We call this trauma sensitive interviewing.

Perhaps the most important aspect of trauma-sensitive interviewing is ensuring you are as regulated as possible. Your own state of dysregulation can cause dysregulation in a child. Thus, it is important to self-regulate before entering a conversation with the child client. We will discuss ways to do this in Chapter 11, but your self-regulation helps in two main ways. First, it models self-regulation for children, and second it creates the safe container for a child who desperately needs a safe place to begin to feel what it is like to be around a safe person. You become less safe when you are dysregulated. Every person has days when they are more and less regulated, but being conscious of your own dysregulation and regulation when entering

conversations will begin to help create that safer space for children. Once you do that, you can begin to notice how trauma manifests in your child clients and what to do about it.

First, it is vital to notice what trauma a child has experienced, including the trauma that is specific to the case as well as the trauma that is not. Second, one of the best ways to help a child regulate the trauma in the moment is to take a break when you notice something is becoming overwhelming. The easiest way to do this is to intersperse asking the child a question about something he likes to do for fun or a movie he recently watched. That simple question can bring a child out of a trauma response and into a more functional and coherent place.

We cannot state this enough; let children cry. We have both seen countless well-meaning caregivers and professionals who tell children not to cry because everything will turn out all right in the end. Rebecca also sees this frequently with judges in the courtroom. But these cases deal with very difficult situations that would overwhelm most well-adjusted adults, not to mention children with underdeveloped coping skills. Crying is going to happen. And it is perfectly natural and very healthy for children to release some of that grief through tears. Phil was in the middle of a relocation evaluation with a school-aged girl who loved both of her parents and needed to cry as a way of managing her distress that her parents were likely to live a plane-ride apart. This is normal. Crying is one of the releases Dr. Levine mentions for resolving an overactive ANS response. It can be very difficult to learn just to sit with someone who is crying, but it can also be the greatest gift you give your clients. Let them know it is okay to be sad, to be upset, and to cry. You can still let them know you will do everything in your power to help them

through this difficult process as their legal representative.

That said, try not to let them stay there too long. The nervous system is designed to move, not get stuck, and you can help by bringing the conversation to a topic unrelated to the trauma. After a short time, ask about movies, fun, school, animals, anything that is not connected to the trauma. Help these children's nervous systems, and eventually their higher cognitive functioning, understand that nothing lasts forever, knowing that while it is appropriate to be sad in the moment and going forward, there is a place in them that still feels joy and can laugh and can play with puppies. After letting the crying continue for a while, one of Phil's favorite expressions is to tell the child, "I know this is how you feel now, but let's also talk about other feelings you have and will continue to have as things improve." This process of simultaneously supporting and acknowledging the current emotion and then providing a temporal structure to it can be very comforting.

Because of the memory issues and cognitive issues involved with trauma, it is often important to provide the same information to children multiple times. Make sure you reintroduce yourself and explain your role each time you speak with children. Do not just ask if they remember you. No one feels comfortable saying they do not remember someone, and children are no different. Let them know it is okay not to remember you and, even if they do, you just want to give them a reminder in case they forgot anything else.

Children who are experiencing trauma responses can be easily overwhelmed. Thus, it is important to slow down—a lot. This can be a very difficult task for lawyers. The law moves quickly. You have hundreds of tasks to finish. You are never done. You

just want to get information and move on. The judge is telling you to hurry up if you are interviewing your clients at court. But that rushing can overwhelm the child, and you are unlikely to get any beneficial information from the conversation. If you catch yourself rushing and talking faster than you can think, stop, slow down, and tell the child you want to start over, but slower. Phil routinely slows down when the children with whom he is talking speed up in their talking. Sometimes he takes a deep breath and encourages his clients to do the same.

Finally, have a little fun. Sometimes children enjoy being goofy. Sometimes they like to play. Sometimes they like to draw. Sometimes they want to ask you a million questions. Let them be themselves and guide the conversation. You have a job to do, but part of that job is helping these children navigate the legal system, and part of that is letting them have a little fun in the process. This will not work for every client, but it can be very beneficial when it does.

Conclusions

Most of this book connects strongly to the concepts identified in this chapter. There is so much to learn about trauma, and some court systems are doing an incredible job of becoming trauma-informed and trauma-responsive. We hope this chapter has helped reshape how you think about your clients, from birth through adolescence. We hope you can engage with your clients a little differently and be the imaginary friend they need to navigate this court process.