



THE SLEEPING DOGS

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Chronically traumatised children can develop diverse trauma-related symptoms affecting most areas of development (Cloitre et al., 2009; D'Andrea, Ford, Stolbach, Spinazzola, & VanderKolk, 2012). Some of these children grow up in foster or adoptive families or in a residential facility. According to the AACAP guidelines for PTSD in children (AACAP, 2010), trauma treatment and processing of their memories would relieve the trauma-related symptoms of these children. But for some of these children, the available trauma treatment methods are not sufficient. They have amnesia, are resistant,

or become very upset when someone tries to talk to them about their trauma. Some of them function relatively well and we are afraid to destabilise them, we don't want to 'wake up sleeping dogs'. How can these children heal from their trauma without making their problems even worse?

The Sleeping Dogs method (Struik, 2014) is a phase-oriented treatment developed to stabilise these children and their environment, so they can process and integrate their traumatic memories and heal from trauma. In this article the Sleeping Dogs method is shortly explained, illustrated by case descriptions and some examples of interventions. The identity of the clients is disguised by omission

and alteration of non-crucial information. Currently over 2,100 clinicians have been trained in the Sleeping Dogs method, and several residential and foster-care organisations and Child Protection Services have implemented Sleeping Dogs (partly) in their organisation in The Netherlands, Belgium, Denmark and Western Australia.

The Sleeping Dogs Method

The Sleeping Dogs method is developed for the most difficult to treat chronically traumatised children for whom regular trauma treatment is not possible. With these difficult cases it can be complicated for therapists to set up a treatment plan that prepares the child well enough, but is not too extensive. The Sleeping Dogs method has a similar but more structured system than the Fairy Tale Model (Greenwald, 2005, 2009) to analyse cases and determine what needs to be worked on. The therapist fills in the Six Tests Form (see appendix): a checklist of six items that addresses all possible elements of the stabilisation phase by clinical judgment to assess what might help the child to overcome his or her resistance and understand why the child does not want to or cannot talk about the traumatic memories. These six tests are not real tests but items that need to be considered. The focus is to start trauma processing as soon as possible; items that are passed can be skipped; items that are not 'passed' need to be worked on by interventions. The Sleeping Dogs method describes a great variety of interventions for all phases, but most extensively for the stabilisation phase. The tests and associated interventions have a fixed order based on the principles of the neurosequential model of therapeutics (Perry, 2006, 2009; Perry & Dobson, 2013) related to human brain organisation, function, and development. But interventions from different tests that are interconnected can be worked on in parallel.

The Sleeping Dogs method focuses not only on therapeutic treatment. The lives of these children can be complicated by, for example, decisions made by child protection workers about living arrangements, foster placements, court cases,

contact arrangements with biological family and reunification. These decisions can have a major impact on their lives and can either support or undermine treatment. The Sleeping Dogs method offers a framework to determine all essential elements and interventions that are needed and can also give direction to decision-making by child protection workers or other practitioners working with the child, like foster care workers and residential staff. Everyone around the child collaborates, which makes the treatment more effective. The length of treatment can vary. Throughout treatment the therapists work on motivating the child and carers mainly by psycho-education about trauma reactions, the functioning of the brain, stress regulation, dissociation, and attachment. This can help children to understand the connection between their current difficulties, such as extreme anger, dissociation or difficulty concentrating, and their traumatic memories. Then they can understand why it would be beneficial for them to process these memories.

Test 1 Safety

The first priority when treating traumatised children (Boris & Zeanah, 2005) is to ensure their safety. Some of these children might refuse to talk because they still are in danger. The abuse might still be ongoing and instead of referring them back to child protection because treatment is not possible, providing safety, as a first step, is part of the Sleeping Dogs method. Any form of safety planning can be used to help families build safety for the children and keep them home, make weekend visits possible, or reunify child and parent.

Another aspect of safety is having a caregiver with sufficient control over the child's behaviour. The caregivers must have enough authority over the child to make him or her get out of bed and attend therapy sessions or come home at night instead of wandering the streets. If necessary, some form of parenting skills training can help parents to regain that control. Furthermore, lack of emotional support from an attachment figure can be a reason for children to refuse to talk about their memories.

This attachment figure must be able to assure the child that he or she will keep in contact even when, for example, a foster placement disrupts because of their difficult behaviour.

Damian had been physically abused by his father, until he was placed in a foster family when he was seven. Damian refused to talk about the abuse and got very upset when this was addressed. Damian had weekly aggressive outbursts and over the last months there were three incidents in which he took a knife and threatened his foster mother. With Damian's foster parents the future scenario of possible worsening of his aggressive behaviour and a disruption in his placement was discussed. The foster parents were clear they would wish to keep seeing him, since they felt he was part of their family. They explained this to Damian and took a photo of the family with him in the middle to illustrate that. That gave Damian enough emotional safety to talk about the abuse he had experienced.

Following the Sleeping Dogs method, the therapist engages in extensive work with the network of the child's attachment relationships, like his biological family, (ex-)foster family(ies), adoptive family and others since the relational environment of the child is the major mediator for therapeutic change (Barfield, Dobson, Gaskill, & Perry, 2012; Perry, 2006, 2009; Perry & Dobson, 2013).

Then a child must know he can talk about his or her memories without risking being punished by the abuser for talking. This is called therapeutic safety and Eve's situation is an example of the importance of that.

Six-year-old Eve regularly witnessed her mother being hit by her father before their divorce. The father has unsupervised weekend arrangements with Eve. Eve suffers from posttraumatic stress disorder but refuses to talk about what she has experienced and she panics when her mother tries to force her to do so. She disclosed being worried about her father's reaction if he found out she talked about his violence.

After preparing the father for this session, he was

able to tell Eve, that he would be proud of her if she would talk to the therapist about what happened. He said he would not be angry with her and was sorry for what happened. That took away the barrier for Eve and she was enabled to start the trauma processing.

By this test, the therapist can determine whether there is enough safety or that safety needs to be worked on. Besides these elements it is also important that the child feels safer internally. But this is a more gradual process built on by strengthening attachment and learning skills.

Test 2 Daily Life

Processing traumatic memories can improve daily life functioning. But it requires a lot of energy and can lead to temporary worsening of symptoms. There must be enough stability in daily life before the child can start processing traumatic memories. If a child fears being expelled from school or a disruption of placement, it might prevent him from talking about his memories. And for therapists it is not possible to start trauma processing if all treatment sessions are spent on managing crises. With this test the problems in daily life that need to be addressed in order to start trauma processing, such as school, sleeping problems, lack of daily routine, can be identified and worked on, by a variety of interventions like making a box to put away memories or relaxation exercises. The case of seven-year-old Eline illustrates the need to do that.

Eline was six years old when she was placed in a foster family with a baby. Eline has nightmares and wakes up screaming. She wakes up the baby who in turn starts to cry. Often the foster parents end up taking both children in bed with them. They are exhausted by the lack of sleep. At work the foster father's supervisor warned him that his performance need to improve or he will be laid off. Eline's foster parents are desperate but Eline refuses to talk about her traumatic memories.

The risk that trauma processing worsens Eline's

nightmares temporarily resulting in a placement disruption, is significant. That might be the reason for Eline's refusal. First her foster parents need more help in managing daily life problems and a plan was made.

They moved the baby to another room and during the weekdays the foster father sometimes slept at his brother's house and used earplugs. Eline made a box, which she put beside her bed. Every time she had a nightmare, she drew it and put the drawing in the box. At her bedside they put a recent photograph of Eline and her foster parents that could help her reorienting. The foster mother made a recording of her voice while reading. Every night Eline listened to a recording of her foster mother reading as well as using relaxation exercises which made her feel connected and safer. This created enough space to start trauma processing.

The older children are, the more work usually needs to be done on this test. This is the second test because this stable daily life is necessary for working on the subsequent tests. But interventions from this test can continue to be worked on while working on tests 3, 4 and 5.

Test 3 Attachment Part I and II

With this test the attachment relationship is assessed. For trauma processing a child needs an attachment figure who can help the child to regulate stress and is not overwhelmed by his emotions (part I). When this part of the test is not passed, the therapist can work with the parents on coping with their own emotions and developing parental sensitivity. Then the child must also have an activated attachment system (part II) in order to use the attachment figure for regulation. If the child does not use the attachment figure for regulation, work needs to be done on improving attachment and further activating the attachment system of the child.

Test 4 Emotion Regulation

During trauma processing it is necessary to prevent the child from being overwhelmed by intense emotions such as rage, fear, and shame, and as a result not wanting to continue, closing off and losing contact during trauma work. If needed, interventions can be used like psycho-education about emotions, exercises to learn to feel and recognise bodily sensations and the basic emotions as well as emotion regulation techniques. The attachment test is a prerequisite for the emotion regulation test because children need a safe attachment relationship to be able to learn how to regulate emotions.

Test 5 Cognitive Shift

This test is mainly important if the child was abused or otherwise traumatised by a parent, family member or someone the child had a close relationship with and the child does not want to talk about his memories out of loyalty or fear. An important part of trauma processing is correcting negative cognitions and assisting the child to make a shift in cognition (cognitive shift) like: 'it is my fault' to 'it is not my fault' (Cohen, Mannarino, & Deblinger, 2006; Ehlers & Clark, 2003; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005; Ehlers, Mayou, & Bryant, 2003; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Shapiro, 2007). But if it wasn't the child's fault, who was responsible? In order to be able to make that shift in thinking, the child must be able to put the responsibility with his abuser (often a parent) without risking rejection or punishment. Extensive effort is made to contact the abuser in a live session, by phone, email, or Skype, and discuss his or her views on what happened and who was responsible. A Trauma Healing Story can be made with the parents for the child. This story, based on the Words and Pictures story (Turnell & Essex, 2006), explains in simple language and drawings which possible traumatic event happened and describes the parents', child protection agencies' and other important people like foster parents' views on these events and on the child's

responsibility. Experience is that meeting a parent, hearing his or her story, explaining the impact of trauma on the child's cognitions, almost always leads to some sort of acknowledgement of responsibility for the child. Saying: 'It was not Tom's fault that mom and dad were fighting' can be easier to acknowledge than: 'It was our fault, mom and dad were wrong'. And for the child any kind of acknowledgement can already be very helpful. The Trauma Healing Story forces parents to be clear on their views and that enables the child to determine his own stance. If the parents cannot acknowledge his or her responsibility for the trauma, the child cannot make the cognitive shift safely. Then the child cannot process the traumatic memories unless he can rely on another adult, like a foster parent or a grandma, to take care of him. With the assurance of another adult taking care of him, the child can risk being rejected by his parents and can process trauma and make the cognitive shift. This however can be a very difficult step for a child and these children might need more work on the attachment test to build their trust in the attachment figure. By this test, the consequences for the child of making that cognitive shift are considered. Being socially connected and experiencing stability in relationships is an important protective factor for children (Perry, 2009) and this is worked on by helping families to build safety for the children in the first test and working on acknowledgement and healing in the fifth test.

Test 6 Nutshell

To check whether the child is ready for trauma processing he needs to be able to make an overview of his traumatic memories without becoming too overwhelmed or blocked. All memories are described briefly which is called: 'tell in a nutshell'.

The child does not have to be able to remember all memories as long as the child can talk about the memories she is aware of without being overwhelmed. If the child does not pass this test more work needs to be done on the previous tests. If the child passes all tests, after little or extensive work on the interventions, she is stable enough for trauma processing.


Trauma processing Phase

Trauma processing can start if there is enough stability and there is no need to use anymore interventions with the different tests. Any form of treatment focused on processing the traumatic memories can be used but preferably evidence-based treatments such as cognitive behavioral therapy or EMDR. The Sleeping Dogs method describes extra interventions to support the child in this phase.

Integration Phase

Interventions from the Sleeping Dogs method on emotion regulation and attachment can contribute to integration. The child can for example make a journey and visit all the houses he lived in, interviewing people from his past and recording it on video. A child may also feel the need to renew broken contacts, for example with the abuser as long as the child's safety and protection can be guaranteed on long term. The therapist can support the child in this contact.

Conclusion

In this article the Sleeping Dogs method was presented as a treatment intervention for the most difficult-to-treat chronically traumatised children. The Sleeping Dogs method offers a framework to determine all essential elements and interventions that are needed to prepare a child for trauma processing and gives direction to decision-making by child protection services/agencies/workers. With a three-phased customised treatment plan, everyone around the child, like the therapist, family and network, child protection worker, foster care worker and residential staff, collaborates on what may possibly make treatment more effective. 

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Appendix: The Six Tests (from http://documents.routledge-interactive.s3.amazonaws.com/9780415717229/9780415717229_web%20material.pdf)

Test 1 Safety

- » There is sufficient physical safety
 - Any abuse has ended
 - Neutral person who checks this: ...
 - Physical care is adequate
- » There is sufficient behavioural control
- » There is sufficient emotional safety
 - Attachment figure = ... (quantity)
 - Continuity is / is not guaranteed
 - There is sufficient emotional support
- » There is sufficient therapeutic safety
 - Parent / abuser does / does not give permission
 - I will / will not involve abuser

Cross out what does not apply and complete where necessary. Mark the items that have been considered. Unmarked items need more attention or work. The child passes the test if there is sufficient safety in all four safety areas.

Test 2 Daily life

- » Daily routine
- » Sleep
- » Nightmares, flashbacks and triggers
- » Eating
- » School
- » Drug or alcohol abuse
- » Behavioural problems

Mark the boxes when the child is doing well with regard to this item. Mark the aspects that need to be addressed before starting trauma processing (see Worksheet Daily Life 1 – What Is Going Well?). The child passes the test when there is not a continuous occurrence of new problems in his daily life, which need attention.

Test 3 Attachment

Part I Necessary requirements for attachment bond

- » Continuity of contact with the attachment figure guaranteed / not guaranteed
- » Psychological abuse and neglect have stopped / have not stopped.
- » Attachment figure does / does not have a calm brain: ... (quality)
- » Parent needs: therapy / parental coaching / minimal contact with parents.
- » Long-term prospects regarding living arrangements are / are not clear to the child.
- » Contact with (biological) parents is / is not clear to the child and consists of: living together / weekend visits / visits / supervised visits / no contact with:
- » Long-term prospects regarding contact with biological parents are / are not clear to the child and consist of:

Cross out what does not apply and complete where necessary. Mark the boxes if conditions are met or if the item is clear. Circle items that need work in order to make trauma processing possible.

Part I of the test is passed if the attachment figure can maintain a sufficiently calm brain when the child panics and can put his own feelings and needs aside in order to regulate the child. Then the parent will be able to make the necessary adjustments in his or her way of parenting in order to activate the attachment system of the child in part II.

Part II Activating attachment system

- » The child seeks support and comfort from the attachment figure
- » The child stays in contact with the attachment figure in stressful situations and uses this person to regulate himself
- » Attachment system is activated

Mark the box if the condition is met. Circle items that need work in order to make trauma processing possible. The child passes part II of the test when the child makes sufficient use of the attachment figure for stress regulation.

Test 4 Emotion regulation

- » Child knows physical sensations
- » Child knows the basic emotions
 - Child is able to calm himself when he is angry
 - Child can comfort or soothe himself when he is sad
 - Child can reassure himself when he is afraid

Mark the box when the condition is met. Circle items that need work in order to make trauma processing possible. The child passes the test if he is sufficiently able to regulate his emotions during trauma processing (on his own or with help) to stay in contact with the therapist and continue until all traumas are processed, without losing control and harming himself or anyone else when the session is over.

Test 5 Cognitive Shift

- » The cognitive shift(s) the child has to make is/are:
 -
 -
 -
- » Parent/abuser does/does not accept responsibility
- » Parent/co-abuser does/does not accept responsibility
- » The child does/does not have another attachment figure
- » The consequences of this shift are not dangerous to the child

Cross out what does not apply and complete where necessary. Mark if an item is clear enough. Circle items that need work in order to make trauma processing possible. The child passes this test if the parent/abuser has told the child that he accepts responsibility for his behaviour, or if the child has another attachment figure/parent and can risk rejection by the parent.

Test 6 The Nutshell

- » The child has made a survey of traumatic memories, and stayed within his window of tolerance while doing so.

Mark the box if the child is able to do this. The child passes this test if he can give an overview of his traumatic memories, in a nutshell, while remaining within his window of tolerance.