Children Australia
Volume 42 | Number 2 | pp. 93–103 | © The Author(s) 2017 | doi:10.1017/cha.2017.13

Treating Chronically Traumatised Children with the Sleeping Dogs Method: Don't Let Sleeping Dogs Lie!

Arianne Struik
Institute for Chronically Traumatized Children, Perth, Australia, PO box 394, Scarborough, 6019, WA, Australia

Many traumatised children in Australia do not receive the type of trauma-focused treatment endorsed by international guidelines and, as such, they suffer from the consequences of intergenerational trauma. Even when trauma-focused treatment is available, there is a group of children who are difficult to engage in treatment and do not want to talk about their traumatic memories. Clinicians are often reluctant to address the trauma, for fear of 'waking up sleeping dogs'. All children deserve a chance to heal from trauma and I believe we, as a society, have a responsibility to provide children with appropriate services and treatment methods to help them achieve this. This article describes the *Sleeping Dogs* method, a three-phased trauma-focused treatment method, based on a collaborative use of interventions by therapists, child-protection workers, residential staff, school and the child's network. A Six Test Form is used to analyse the possible reasons why the child is unable to talk about his or her traumatic memories, for which interventions are planned. Case examples with children who can be difficult to engage in trauma-focused treatment are used to illustrate interventions. Clinical experiences show the *Sleeping Dogs* method has been successfully used internationally, as well as remote communities in Australia.

■ **Keywords:** Chronic trauma, stabilisation, resistant, children

Introduction

Across Australia, and indeed internationally, there is growing attention placed on the significance of traumatisation in children and an acknowledgement of the importance of offering these children trauma-focused treatments. According to the American Academy of Child and Adolescent Psychiatry (AACAP), Practice Parameters for children with posttraumatic stress disorder (PTSD) (Cohen et al., 2010), trauma-focused psychotherapies should be considered first-line treatments for children and adolescents with PTSD, and this treatment should be focused on processing their traumatic memories:

> Among psychotherapies there is convincing evidence that trauma-focused therapies, that is, those that specifically address the child's traumatic experiences, are superior to nonspecific or nondirective therapies in resolving PTSD symptoms (Cohen et al., 2010, p. 421).

Moreover, the World Health Organization (WHO) recommends the use of trauma-focused cognitive behavioural therapy (TF-CBT) and eye-movement desensitisation and reprocessing (EMDR) as a way of helping these children heal from psychological trauma (WHO, 2013).

Single Event and Chronic Traumatisation

The literature distinguishes between two types of traumatic experiences: Type I Trauma – a single traumatic experience and Type II Trauma – multiple and/or recurrent traumatic experiences, that can be chronic and interpersonal, like child maltreatment. These experiences can lead

ADDRESS FOR CORRESPONDENCE: Arianne Struik, Director Institute for Chronically Traumatized Children, Perth, Australia, PO box 394, Scarborough, 6019, WA, Australia.
E-mail: ICTC@ariannestruik.com

to the development of trauma-related symptoms or a PTSD. The likelihood of children exhibiting PTSD symptoms after trauma seems to decrease when traumatisation becomes more complex, with the reporting of significantly more severe non-specific trauma symptoms after child maltreatment (Jonkman, Verlinden, Bolle, Boer & Lindauer, 2013). Chronically traumatised children can develop a broad range of trauma-related symptoms affecting most areas of development (Cloitre et al., 2009; D'Andrea, Ford, Stolbach, Spinazzola, & Van der Kolk, 2012; Schore, 2001). Processing of traumatic memories is understood to help diminish symptoms and stimulate the normal processing system for many children (Solomon & Shapiro, 2008).

Untreated Trauma

If trauma remains untreated then children, their families and communities can continue to suffer from trauma-related symptoms unnecessarily. Results from studies that have profiled children in out-of-home care (OOHC) in South Australia have highlighted a strong association between early trauma and abuse and subsequent placement instability for children and young people with high support needs in Australian OOHC (Barber & Delfabbro, 2003; Barber, Delfabbro, & Cooper, 2001; Delfabbro, Barber, & Cooper, 2002; Delfabbro, King, & Barber, 2010). Almost a quarter of all children had experienced ten or more placements during their time in care and providing care for children with behavioural problems proved costly to the South Australian OOHC system.

The adverse childhood experiences study (Felitti et al., 1998) has shown that adverse childhood experiences have a strong, graded relationship to numerous health, social and behavioural problems throughout a person's lifespan, including promiscuity, substance abuse and severe obesity. A report commissioned by Adults Surviving Child Abuse (ASCA) found that the economic impact of unresolved childhood trauma in Australian adults was $9.1 billion annually (Kezelman, Hossack, Stavropoulos, & Burley, 2015). The report recommends that costs could be reduced by improved training for healthcare providers to help them identify underlying childhood trauma or abuse and make appropriate referrals. It also proposes raising awareness of the possibility of unresolved childhood trauma in patients and better investment in specialist services. In an interview in the Sydney Morning Herald on February the 4th of 2015, ASCA president Dr Cathy Kezelman said: 'By intervening in that way there will be substantial savings in health care, social security support and lost tax revenue. It's an absolute travesty that in this country we are not providing services that enable people to recover and live their lives to full potential' (Browne, 2015).

Challenges in Providing Trauma-focused Treatment to Children

There are many factors involved in the poor provision of specialised trauma-focused therapies to all traumatised children, but especially chronically traumatised, maltreated children. For example, traumatisation is not always recognised as an underlying reason for problematic behaviour, specialised services might not be available in remote areas, and there is often said to be a generalised lack of funding for treatment. Moreover, some children function relatively well, which makes their family, carers and professionals question the need for trauma-focused therapy, and this can cause them to be reluctant to start talking about the trauma out of fear of 'waking up sleeping dogs' and destabilising the child. Finally, there are some chronically traumatised children who do not want to participate in any trauma-focused treatment or for whom these treatments are not effective. They may have amnesia related to the trauma that they have experienced, may be resistant to trauma therapy, or become very upset when someone tries to talk with them about their trauma. Some clinicians would question whether the child was 'ready' for trauma-focused treatment and would rather focus on behaviour and symptom management instead of dealing with the underlying trauma. The practice parameters are clear about this dilemma:

> Timing and pacing of trauma-focused therapies are guided in part by children's responses that therapists and parents monitor during the course of treatment. Clinical worsening may suggest the need to strengthen mastery of previous treatment components through a variety of interventions, rather than abandoning a trauma-focused approach (Cohen et al., 2010, pp. 421–422).

Enabling difficult to engage traumatised children to participate in trauma-focused treatment, The Sleeping Dogs method (Struik, 2014) has been developed to provide trauma-focused treatment for those chronically traumatised children who seem difficult to engage in regular trauma-focused treatment, like Sean in the following case example:

> Case example: Twelve-year-old Sean lives in a remote community and he has not attended school for three years. He was taken into care two years ago after he asked a police officer to provide him with a place to stay so he did not have to return home to his mother and stepfather. He was physically abused and had witnessed domestic violence and drug and alcohol abuse ever since he could remember. Sean has been arrested several times for burglary and vandalism over the last six months and his file had fifteen reported incidents of Sean displaying sexually inappropriate behaviour in the last three years. He had lived in residential facilities, but after running away numerous times, he had been living with his uncle for three months. Sean does not see his mother and stepfather because the child protection services denied his parents access. His uncle seems to have a good influence on Sean and has expressed some concerns about Sean having nightmares, being anxious and having a negative self-image. Sean has expressed feeling like he does not belong anywhere. The child protection case manager was worried that Sean had been sexually abused and she would have liked Sean to participate in trauma-focused treatment and provided help

to resume school. Sean refused both, stating, "I am not doing therapy, I am not a psycho".

Sean clearly displays trauma-related symptoms and could have benefited from trauma-focused treatment, but he refused to meet with a therapist. Existing methods like TF-CBT and EMDR fail because they require a child to attend sessions. The Sleeping Dogs method has been developed for maltreated, chronically traumatised children like Sean. The purpose of this method is to challenge professionals to find creative ways to help these children overcome their inability to engage. The purpose of this article is to provide an explanation of the Sleeping Dogs method through case descriptions and examples of interventions. The identity of clients is protected through the omission and alteration of non-crucial information and by changing their names.

The Sleeping Dogs Method

The Sleeping Dogs method is a three-phase method involving stabilisation, trauma-processing and integration. The aim is to stabilise chronically traumatised children and their environment so that they can then process and integrate their traumatic memories and heal from traumatic experiences.

Collaboration as the Key to Overcome a Child's Inability to Engage

The Sleeping Dogs method is not only a therapy model used in the therapy room, but provides a framework in which everyone involved in a child's care collaborates. Given that the relational environment of a child is a major mediator for therapeutic change (Barfield, Dobson, Gaskill, & Perry, 2012; Perry & Dobson, 2013), the network of a child's attachment relationships, like the biological family, (previous) foster families, adoptive family and others (i.e., teachers, aunts, grandparents and neighbours) are involved. Carers, foster-care workers, child-protection workers, social workers, paediatricians, nurses, teachers and therapists can all carry out Sleeping Dogs interventions with the child and their network. The lives of chronically traumatised children can be complicated by the decisions made by child-protection workers about their living arrangements, foster placements, court cases, contact arrangements with biological family and reunification plans. These decisions can have a major impact on a child's life and can either support or undermine treatment. The Sleeping Dogs method can provide therapeutic direction to decision-making by child-protection workers or other practitioners to support or facilitate treatment.

Being socially connected and experiencing stability in relationships is an important protective factor for children (Perry, 2009). Once the child's safety has been established, the Sleeping Dogs method encourages the abuser parent to build on a child's actual safety and sense of safety, by acknowledging responsibility for the abuse and improving the interaction and attachment relationship between the child and them self. The intensive collaboration with, and involvement of, the child-protection worker provides more opportunities to adequately prepare the involvement of this parent and guarantee a child's safety by, for example, deciding on supervised contact with the parent or explaining to the child that the judge has decided that they will not be reunified with their parent. The involvement of the abuser parent will be addressed in several of the six tests.

Assessment with the Six Test Form

The Sleeping Dogs method starts with an assessment of the possible reasons why a child cannot or will not talk about the traumatic memories underlying their presenting symptoms with the Six Tests Form (see Appendix 1). The Six Test Form is a checklist of items that help identify reasons for a child not being able to talk about traumatic memories. Items that are not 'passed' are identified as potential reasons for a child being unable to talk about these memories. Interventions need to address the issues identified by these tests as a way of overcoming these problems. Items that are passed are not identified as being a reason for a child being unable to talk about traumatic memories and, therefore, do not require intervention. Therapists can use the six tests, but also professionals who do not provide trauma-focused treatment, like child-protection workers, caseworkers or residential staff, can use it to analyse a child's situation.

Once the problem issues have been identified, interventions that aim to help the child overcome these issues and engage in trauma-focused therapy are planned. The tests, and associated interventions, have a fixed order that are based on the principles of the neurosequential model of therapeutics related to human brain organisation, function and development (Perry, 2009; Perry & Dobson, 2013).

Case example: Sean's case manager completed the Six Tests for Sean and decided there were several reasons why Sean may not want to participate in trauma-focused treatment. Sean might not see the benefit of talking about his trauma; he might be afraid that his behaviour may become more difficult for his uncle and that the placement may break down; he might feel too lonely without anyone to support him while going through these difficult feelings and memories; he might be afraid that his mum would be angry with him if he was to talk about what happened and, if Sean had experienced sexual abuse, then he may not want to disclose this secret because of feelings of shame, self-blame or fear of punishment. The case manager discussed Sean's case with a psychologist who could provide trauma treatment and, together, they planned interventions that would address each of the presenting issues, and help Sean engage in therapy by overcoming the reasons why he is unwilling to talk about his traumatic memories.

In the following paragraphs the six tests are explained with case examples and examples of interventions that can be used if the test is not passed.

Psycho-Education

Throughout treatment, clinicians work on motivating the child and carers by providing psycho-education about trauma reactions, the functioning of the brain, stress regulation, dissociation and attachment. For example, a simplified version of the *Window of Tolerance* is used to explain to children and their parents/carers the different reactions to stress and how chronic stress reduces the amount of stress a child can tolerate in daily life; which makes their 'window smaller'. This also provides traumatised parents with a narrative and explanation for their own behaviour and trauma reactions. The *Volcano*, a metaphor of a volcano exploding, is used to explain how old feelings like anger or anxiety can build up inside. When a child feels a little bit angry or afraid then old feelings can be triggered and they may suddenly feel overwhelmed and explode like a volcano.

Psycho-education can help chronically traumatised children to understand the connection between their current symptoms and behaviours, such as extreme anger, dissociation or difficulty concentrating, and the traumatic memories of their experiences. The aim is to increase insight and allow children to understand why it may be beneficial for them to process traumatic memories. When a child does not want to participate in therapy psycho-education can be provided by other professionals who are in contact with the child such as child-protection workers, social workers, teachers or residential staff as a way of increasing the child's insight and becoming more willing to engage in therapy.

Test 1 Safety

The first priority when treating traumatised children is to ensure their safety (Boris & Zeanah, 2005; Zeanah, Chesher, & Boris, 2016). Several aspects relating to safety are assessed in this test: physical safety, safety by experiencing sufficient boundaries, emotional safety and safety to be in therapy and talk about traumatic memories. Some chronically traumatised children might refuse to talk of their trauma experiences because the abuse is ongoing and they are still in danger. The safety test can help determine whether a child is reluctant to talk about traumatic experiences because of actual or perceived level of inadequate safety, and develop interventions to improve safety. Various forms of safety planning can be used to help families build safety for children and keep them home, make weekend visits possible, or reunify child and parent (Parker, 2011; Turnell & Edwards, 1999; Turnell & Essex, 2006).

Another aspect of safety that can contribute to a child's inability to talk about traumatic memories is the lack of a caregiver who is able to maintain sufficient control over the child's behaviour by being able to effectively set and maintain clear boundaries and limits. For example, they need to be able to ensure that the child attends therapy sessions or comes home at night instead of wandering the streets. If necessary, some form of parenting skills training can assist parents/caregivers to develop an ability and confidence in setting boundaries.

Furthermore, emotional unsafety, a lack of emotional support and fear of abandonment by an attachment figure, can be a reason for children to refuse to talk about their traumatic memories. Children must feel encouraged by attachment figures to be able do this difficult work. If no one is going to notice, why would they do it? 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 breaks down because of their difficult behaviour:

> Case example: Ten-year-old Damian had been physically abused by his father nearly every weekend since he was born until he was placed in a foster family when he was seven. Damian had aggressive outbursts once or twice a week and over the last three months there were three incidents in which he took a knife and threatened his foster-mother. Damian had problems concentrating in school and it was thought that he may be suffering from Attention Deficit Hyperactivity Disorder. He had trouble socialising with other children because of his aggression and controlling behaviour. Damian refused to talk about the abuse and got very upset when this was addressed in therapy. The therapist completed the Six Tests to analyse potential reasons for Damian's reluctance to speak with the therapist. By examining the various reasons outlined in the Six Tests, it became apparent that Damian might be worried that if he talked about his experiences then his parents might reject him for betraying them. This, he may have believed, would leave him with no one to take care of him.
>
> As a way of overcoming this, the possible rejection of Damian's parents was discussed with Damian's foster parents. His foster parents were clear they would wish to care for him like parents, and they felt he was part of their family. In between sessions, the foster parents explained this to Damian and took a photo of the family with him in the middle to illustrate that. This gave Damian a greater sense of emotional safety and that enabled him talk about the abuse he had experienced.

The fourth element of safety is that a child must know that they can talk about their memories without the risk of being punished by the abuser. This is called therapeutic safety and Eve's situation is an example of the importance of this:

> Six-year-old Eve regularly witnessed her mother being hit and shouted at by her father in the eighteen months before their divorce, a year ago. Eve's father has unsupervised weekend visitation with Eve. Eve suffers from Posttraumatic Stress Disorder but refuses to talk about what she had experienced and she panics when her mother tries to force her to do so. Eve disclosed being worried about her father's reaction if he found out that she talked about his violence. After preparing Eve's father for a session, he was able to tell her that he would be proud of her if she would talk to the therapist about what happened. Eve's father said he would not be angry with her and was sorry for what happened. This conversation helped remove the barrier and Eve was able to start the trauma-processing.

If a child does not want to talk about traumatic memories because they are not sure of their parents' permission, this

needs to be discussed with the parents in a meeting, a phone call or even an e-mail or letter. Therapists, but also other professionals, like child-protection workers, social workers or residential staff can have this conversation. Parents can be contacted via other family members, visited in prison or a mental health facility and they can express their permission in a face-to-face or recorded meeting, a phone or video conferencing meeting, a postcard, a painting or a brief video clip made on their phone, to help the child to overcome his fear. As discussed before, this can only be done when the child-protection worker guarantees the child's safety, and it is appropriate to approach parents.

Test 2 Daily Life

Processing traumatic memories can improve daily life functioning (Solomon & Shapiro, 2008), such as sleeping better, being able to concentrate in school and feeling less anxious. However, traumatic memory processing that utilises desensitisation techniques requires a lot of energy and can lead to temporary worsening of symptoms (Cohen et al., 2010). If a child fears being expelled from school or a disruption of placement, the child will not want to risk aggravation of their symptoms by talking about these difficult memories in therapy. This can be one of the reasons why children are unable to engage in the process. By utilising the daily life test, problems, disruptions and crises in daily life are examined with a view to determining which areas require intervention before trauma-processing can commence. The aim of these interventions is to remove some of the instability in daily life so that it becomes manageable enough to get through the trauma-processing phase. The case of seven-year-old Eline illustrates this:

> One year ago, when Eline was six years old, she was placed in a foster family who had a baby. Eline experienced nightmares and often woke up screaming, which woke up the baby who in turn would cry. As a solution the foster parents often took both children to bed with them, but this meant they were exhausted from a lack of sleep. The foster father's supervisor at work had warned him that his performance needed to improve or he would be laid off. Eline's foster parents were desperate for a solution and did not want to terminate the placement, but Eline refused to talk about her traumatic memories.

The risk that trauma-processing may worsen Eline's nightmares and temporarily result in a placement disruption was significant. That may have been the reason for Eline's refusal:

> Eline's foster parents needed help with managing daily life problems and a plan was made for this. They moved the baby to another room and during the weekdays the foster father sometimes slept at his brother's house and used earplugs when at home. Eline made a box which she put beside her bed so that every time she had a nightmare she could draw it and put the drawing in the box. At her bedside they put a recent photograph of Eline and her foster parents as a way of helping her feel grounded and understand that she was safe now in the new family. Her foster mother made a recording of her voice while reading and every night Eline listened to the recording as well as using relaxation exercises which made her feel connected and safer. Her foster parents told Eline that they were prepared for a possible temporary worsening of her symptoms and they would really like her to process her traumatic memories so she could get rid of her nightmares. Eline consented to do so.

Interventions with this test can focus, for example, on reducing the risk of being expelled from school by providing psycho-education to the school and making a plan to manage trauma-related behaviour. Moreover, plans can be made with foster parents to prevent placement breakdown by providing them with psycho-education or involving family members or friends to support them during the trauma-processing phase. The *Safe Deposit Box* exercise, in which a child imagines or makes a place to store away his or her disturbing traumatic memories, can be taught and practiced daily and used as a way of increasing a child's sense of control when they have nightmares or intrusions. Relaxation exercises practiced daily can help children to calm themselves and parents or carers can support children by doing these exercises together. As a general rule, the older the chronically traumatised children are, the more work usually needs to be done on this daily life test.

Test 3 Attachment Part I and II

The attachment figure has a calm brain (part I). This component of the test assesses attachment relationships. To aid in trauma-processing, a chronically traumatised child needs an attachment figure that can help them regulate stress and is not overwhelmed emotionally. Children can refuse to work on their memories because they are afraid it will upset their parent(s) and they do not want to make them feel angry, sad or afraid. This is especially true for children whose parents have been traumatised by the same events, such as domestic violence. Moreover, it can be difficult for traumatised parents to manage children's processing, particularly when children ask questions or discuss their memories, which may trigger their own trauma.

> Case example: Ten-year-old Suzy was sexually abused by her uncle and a few months later by some boys from school. Suzy told her mother after the second incident and she became very angry and upset. Suzy's mother said that she should have told her straight away and became very angry with her husband, because he persuaded her to let their daughter have an overnight stay with family. Her parents were worried about Suzy's anxiety and depression and wanted her to undertake trauma therapy, but Suzy refused to talk about what had happened. Having discussed the possible reasons for Suzy's refusal with her parents, they came to the conclusion that Suzy was most likely afraid it would upset her mother again and create problems between her parents, which was likely to happen.

When this part of the test is not passed the therapist can work with the parents on coping with, understanding,

and managing their own emotions and developing parental sensitivity. Psycho-education about the impact of trauma, trauma reactions and attachment can improve the parents' understanding of their child and often even themselves if they are traumatised too. Parents can use the same interventions as their children, like relaxation techniques or the Safe Deposit Box exercise to store their memories. Parents can be assisted in making a plan on how to manage difficult questions from the child, for example, by writing them down and discussing them together with the therapist. Or they can ask the child not to discuss the trauma with them, and identify a family member or friend with whom the child can talk. When the parent is confident that they can deal with the child processing their memories, they can encourage the child to do so. By finding ways to compensate for the things parents cannot do, processing becomes possible. Some parents choose to do their own trauma-treatment, to enable them to help their children in a better way:

> Suzy's father stated that he thought his wife might benefit from treatment because she too had experienced abuse, and Suzy's mother agreed with this. In a session for herself she processed her own memories of abuse by several family members after her mother had passed away and memories of trying to protect her younger sisters from being abused too. She discovered that her anger was caused by the fact that she failed to protect her daughter, just like she failed to protect her sisters. By processing her memories from her childhood, she could remain calmer and support her daughter through therapy. She apologised for her anger and encouraged Suzy to process her own trauma as well, which she did.

The attachment system is activated (part II). Besides having an attachment figure who can remain calm, the child must also have an activated attachment system in order to use the attachment figure for regulation. If the child does not seek the attachment figure for regulation but instead dissociates or avoids, work needs to be done to further activate the child's attachment system just enough to get through the trauma-processing phase. Elements from attachment-focused therapies, such as Child–Parent Psychotherapy (Lieberman & Van Horn, 2008), Dyadic Development Psychotherapy (Hughes & Baylin, 2012), Theraplay (Booth & Jernberg, 2010) or Circle of Security (Cooper, Hoffman, Powell, & Marvin, 2007) can be used to improve the attachment-relationships.

Test 4 Emotion Regulation

During processing of traumatic memories, the child should not become overwhelmed by intense emotions and shut down, become non-responsive or dissociate. When needing to develop emotional regulation, interventions such as psycho-education about emotions or interventions to improve awareness of bodily sensations can be employed. Exercises like asking a child to identify different materials while being blindfolded, or taste and identify different types of cookies while blindfolded might stimulate the child's senses. In addition, relaxation exercises and calming techniques like diaphragmatic breathing can help children to regulate their bodily feelings and feel more in control. Children can also learn to identity their feelings through a daily exercise in which they select a daily life situation and discuss the feelings they had in relation to this situation with their carer. They then colour in a smiley face (sad, happy, angry or afraid) showing the feeling they had in that situation. Children can make a plan on how to deal with different emotions in daily life and how to regulate these on their own. Carers can be involved in this plan, as can therapists, residential staff and foster carers.

The attachment test is a prerequisite for the emotion regulation test because, as mentioned in the previous test, chronically traumatised children need a secure attachment relationship to be able to learn how to understand and regulate emotions.

Test 5 Cognitive Shift

The Cognitive Shift test encourages the practitioner to consider the consequences to the child when making adaptive cognitive shifts. This test is particularly important when a child has been 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 their memories because of loyalty or fear.

An important part of trauma-processing is correcting negative cognitions and assisting children to shift some of their cognitions (cognitive shift) (Cohen-2003). For example, changing thoughts from 'it is my fault' to 'it is not my fault' (Cohen, Mannarino, & Deblinger, 2006; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005; Ehlers et al., 2003; Ehlers, Mayou, & Bryant, 2003). However, in order for a child to be able to make a shift in thinking about responsibility, the child must be able to put the responsibility with their abuser, who is often a parent. If the parent cannot acknowledge his or her responsibility for the traumatic events and either blames the child or denies the traumatising events, the child might not want to risk being rejected or punished by this parent by placing the responsibility onto them. With the assurance of another supportive adult such as a foster parent or grandparent to take care of them until they reach adulthood (which is assessed in test 1 with emotional safety), the child can risk some level of rejection by parents and make adaptive cognitive shifts about self and others. This can, however, be a difficult step for a child, particularly a chronically traumatised child, who may need more interventions to build their trust in a supportive alternative attachment figure.

If this issue is identified as a possible reason for a child refusing to talk about traumatic memories, extensive effort is made to contact the abuser in a live session, by phone, e-mail or Skype, with the aim of discussing with the abuser his or her views on what happened and who was responsible. This message can then be delivered to the child in a face-to-face contact with the child and the abuser, via a recorded message, a letter or phone call. In complex cases,

where parents need support with verbalising this message, a *Trauma Healing Story*, an intervention described in the Sleeping Dogs method, can be made with the parents for the child. This story, based on the *Words and Pictures* story by Turnell and Essex (2006), explains in simple language and drawings the traumatic events the child has experienced and describes the views of parents, child protection agencies and other important people like foster parents in relation to these events as well as the child's responsibility. In the Trauma Healing Story parents need to be clear about their views on who is responsible for the abuse. This information enables the child to determine their own stance and prepares them to make the cognitive shift more safely.

In my experience, most parents are willing to provide the child with some form of acknowledgement of responsibility, especially when the practitioner has met with them, listened to their story, and explained the impact of trauma on their child's cognitions. Most parents can say, for example: "It was not Tom's fault that mum and dad were fighting, he could not have stopped us". They can continue blaming each other for fighting or being violent, but that does not have to be included in the message for the child. Hearing from their parents that it was not their fault can be enough for some traumatised children to begin talking about their memories.

Test 6 Nutshell

To ensure that a chronically traumatised child is sufficiently stable and ready for trauma-processing, they need to be able to provide an overview of the traumatic memories they want to process without becoming overwhelmed and being able to remain within their window of tolerance. The child is asked to briefly describe the significant memories that underlie the trauma symptoms, which is called 'tell in a nutshell'. The child does not have to be able to remember all of their memories. The main focus here is that the child can look at the overview of the memories that they are aware of at that moment without being overwhelmed. One memory is then selected to work on, while the other memories are stored away in the Safe Deposit Box. If the child does not pass this test, interventions from the previous tests need to be utilised. A chronically traumatised child passing all six tests is a good indication that he or she is stable enough for trauma-processing work and they can begin the next phase – trauma processing.

Trauma-processing phase. TF-CBT (Cohen, Mannarino, & Staron, 2006) and EMDR therapy (Shapiro & Forrest, 2001) are the two evidence-based recommended treatments for processing traumatic memories in children and adolescents (WHO, 2013). These therapies can be used once the child is ready to talk about traumatic memories. Several of the elements described in the TF-CBT and EMDR, such as psycho-education, Safe place exercise, relaxation, emotion regulation and the parent modules, can also be used in the stabilisation phase if the child is still unable to talk about traumatic memories.

The Sleeping Dogs method describes extra interventions in this phase to prepare chronically traumatised children to engage confidently and safely in the trauma-processing phase of therapy and support them when things become difficult. For children in care, for example, biological parents can support their children by sending a postcard or text message before every session to wish them good luck. The therapist can ring the biological parents with the child at the end of each session to inform them about the brave work their child has done. The therapist can instruct the carers to use the Safe Deposit Box exercise to help the child to deal with nightmares and flashbacks.

This phase ends when the child believes he or she has sufficiently processed the traumatic memories and both the child and carers report symptom reduction or positive changes have taken place.

Integration Phase

During the integration phase, children need to integrate their experiences into daily life and build strengths and resilience to prevent future traumatisation. For example, children might struggle in social interactions with other children or with protecting their boundaries and so treatment can focus on learning new behaviours to manage these situations. Children can have difficult relationships with their parents or family members and in this phase children, therapists, child-protection workers, social workers or residential staff can help a child to experiment with ways to deal with these relationships while protecting their own boundaries and emotional wellbeing. A child may also feel the need to renew broken contacts, such as with the abuser. So long as the child's short- and long-term safety and protection can be guaranteed, a component of this phase is supporting the child with this contact and relationship. Interventions from the Sleeping Dogs method on emotion regulation and attachment or TF-CBT modules can be used in this phase. A way to integrate past experiences is for carers to create a life story with the child by visiting all the houses the child lived in and schools they attended, interviewing people from their past and recording it on video or with photos or painting.

Treatment is ended when there is enough symptom reduction and the child feels strong enough to deal with future situations related to past experiences. Some children might be referred for assessment and treatment of co-morbid problems like Attention Deficit Hyperactivity Disorder, Foetal Alcohol Spectrum Disorders (FASD) or learning difficulties.

> Case example: Sean's case manager first discussed with the team manager whether it was possible to involve Sean's parents. The team leader agreed contact could be resumed and the case manager visited Sean's mother to notify her. Sean's mother and stepfather were very happy and more than

willing to engage with the case manager. The case manager reported her concerns about Sean, and said she was worried about the impact that their problems had had on him. Sean's stepfather said he had cared for Sean since he was in nappies and had taught him swimming and he felt like his own son. When asked, Sean's mother expressed her concerns about Sean's sexualized behaviour and was worried he might have been sexually abused. Sean's mother and stepfather said they would hope Sean would disclose if this had happened (test 1) and they would not be angry with him or blame him, but want to support and comfort him (test 3, part I) and keep him safe (test 1). They said they were sorry for not being there for him when they were caught up in their own problems (test 5). With this information the case manager and psychologist made a Trauma Healing Story for Sean and adjusted it until his parents felt it reflected their views. One of the drawings represented stepfather and Sean going to the swimming pool when he was little (test 3, part II).

Sean's father was in prison and the case manager asked Sean's mother if he could visit him. Sean had not seen his father for five years, since he went to prison. The case manager visited his father and discussed with him the issues Sean was struggling with. Sean's father expressed his concerns and wanted to help his son in whatever way he could (test 1). The case manager assisted him in writing a simple letter to Sean, in which he expressed his love for his son. He apologised to Sean for not being available to help him, but told him he would think about him every day and send him good vibes (test 3 and 5). This was included in one page of the Trauma Healing Story.

With the permission of Sean's parents, the case manager showed the Trauma Healing Story to Sean's uncle, who added to it by writing a page about his reasons for caring for Sean. Sean's uncle wrote that he would be very proud of Sean if he would start talking about his memories and he would understand and be able to deal with a temporary worsening of his symptoms (test 2). He reminded Sean about the other family members who could help and take him fishing and hunting.

The case manager visited Sean at his uncle's house and showed him the Trauma Healing Story with his mother and stepfather present. They all expressed their love for him and encouraged him to think about going to therapy. The case manager explained that his mother, father, stepfather and uncle thought there was a relationship between his old feelings and traumatic memories and his current difficulties, using the Volcano metaphor (psycho-education) as an example, and asked him to think about what he wanted to do.

The following week Sean decided to start trauma-therapy and met the psychologist with the case manager. The psychologist asked Sean if he could meet with his family to explain to them the possible therapy options and to ask them for their opinion, to which Sean agreed. During the next session the psychologist told Sean his parents were so proud of him and supported the therapy (test 1). Sean was willing to talk about his memories and told the psychologist about the different pictures that were in his head (test 6). Sean had memories of his mother and stepfather drinking and doing drugs and forgetting about him. He had memories of them fighting, of being bullied in school and he disclosed being sexually abused over a period of four months by a few older boys at school three years earlier. This was the reason he did not want to go back to school. After discussing it with Sean, he asked the psychologist and case manager to inform his family. The psychologist and case manager informed his parents who were sad but also very proud and relieved Sean had spoken about it, and asked them to speak to Sean about how proud they were.

In three subsequent sessions Sean processed his traumatic memories with EMDR (trauma processing phase) until he said he felt much better and was not having disturbing memories anymore. The team leader took steps to further investigate the abuse and other possible victims in the school.

The case manager made a safety plan with Sean's mother and stepfather for intensified contact visits, and Sean and his uncle started to visit Sean's father in prison (integration phase). The psychologist joined them at one visit and discussed the Trauma Healing Story with Sean and his father. A plan was made with Sean and his family to start going to another school.

In Sean's case, the case manager conducted most of the Sleeping Dogs interventions with Sean's network. The initial assessment with the psychologist enabled the case manager to focus the interventions on the possible problem areas and to provide a smooth transition to the psychologist once Sean was ready. With the Six Test form the case manager could explain to the team leader the importance of the decisions to resume contact with Sean's parents.

Conclusion

Benefits of the Use of the Sleeping Dogs Method

The costs of untreated childhood trauma in Australia are immense (Kezelman et al., 2015), yet there is a lack of trauma-focused treatment for chronically traumatised children, especially for those children who cannot or will not talk about their traumatic memories. The Sleeping Dogs method could be a promising treatment for these children because it provides ways to analyse the child's situation and plan customised interventions to address the problems that make the child unable to talk about their traumatic memories. By having everyone around a child collaborate and conduct interventions, children who refuse to attend therapy sessions can be accessed. For children in remote areas, specialised treatment becomes possible because the local partners can collaborate with a specialised therapist who is involved on a Fly In Fly Out (FIFO) basis. Through collaboration, the local partners can gain an increased awareness of trauma symptoms. Experiences in working with the Sleeping Dogs method in Australia have shown trauma-focused treatment has become possible for children who initially refused to engage in trauma-focused therapy. These children appear to have no more trauma-related nightmares, are less anxious and angry, return to school and have stopped self-blaming and self-harming. These children

often re-established contact with their parents and are able to have improved relationships, with some even reunifying with their parents after years of being in care. I have even noticed some cases in which parents have found ways to heal themselves and stop drinking, using drugs or being violent.

Limitations to the Use of the Sleeping Dogs Method

The lack of evidence for the Sleeping Dogs method is a major limitation. A pilot study ($N = 14$) in the Netherlands has been conducted and it is anticipated that the results will be published in 2017. It has proven to be very difficult to gather these data for a number of reasons. The most difficult to treat and chronically traumatised children are not very motivated to participate in research. The children do not want to fill in symptom questionnaires because they do not want to be perceived as 'psychos' and often family members cannot read English or their chaotic daily lives present a challenge in returning questionnaires. Moreover, multiple professionals are collaborating over long distances, which can make it difficult when trying to standardise treatments. For each child a different set of interventions is chosen, based on the outcome of the six tests, which makes it hard to evaluate treatment. The motivation for a follow-up assessment is low and the local professionals get caught up in other priorities. And, finally, the different areas where treatment is provided have different cultural restrictions and procedures in doing research.

Insights in the Use of the Sleeping Dogs Method

Since 2011, 2450 clinicians have been trained to use the Sleeping Dogs method in a number of international settings. Foster care, residential care and child protection organisations have implemented the method into their practice. Working with the Sleeping Dogs method is time consuming and clinicians need to be creative, flexible and willing to collaborate. Treatment is not limited to the therapy room and all professionals collaborate and provide therapeutic services. Waking up sleeping dogs is not easy and it requires energy and faith to go against challenging resistance. However, seeing these children and families grow, heal and recover is very rewarding.

Acknowledgements

I would like to express my thanks to all the children and families willing to collaborate with me and share their thoughts and feelings in their journey towards healing.

Conflict of Interest

This article might lead to an increase in book sales and conducting training in the Sleeping Dogs method, from which the author would benefit.

References

Barber, J. G., & Delfabbro, P. H. (2003). Placement stability and the psychosocial well-being of children in foster care. *Research on Social Work Practice, 13*(4), 415–431.

Barber, J. G., Delfabbro, P. H., & Cooper, L. L. (2001). The predictors of unsuccessful transition to foster care. *Journal of Child Psychology and Psychiatry, 42*(6), 785–790.

Barfield, S., Dobson, C., Gaskill, R., & Perry, B. D. (2012). Neurosequential model of therapeutics in a therapeutic preschool: Implications for work with children with complex neuropsychiatric problems. *International Journal of Play Therapy, 21*(1), 30–44. doi:10.1037/a0025955.

Booth, P. B., & Jernberg, A. M. (2010). *Theraplay: Helping parents and children build better relationships through attachment-based play*. San Francisco: Wiley.

Boris, N. W., & Zeanah, C. H. (2005). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(11), 1206–1219. doi:10.1097/01.chi.0000177056.41655.ce.

Browne, R. (2015). Report finds government could save $9 billion in healthcare costs by addressing childhood trauma. *The Sydney Morning Herald*. Retrieved from http://www.smh.com.au/nsw/report-finds-government-could-save-9-billion-in-healthcare-costs-by-addressing-childhood-trauma-20150203-134ozc.html.

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22*(5), 399–408. doi:10.1002/jts.2044419795402.

Cohen, J. A., Bukstein, O., Walter, H., Benson, S. R., Chrisman, A., Farchione, T. R., ... Medicus, J. (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(4), 414–430.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.

Cohen, J. A., Mannarino, A. P., & Staron, V. R. (2006). A pilot study of modified cognitive-behavioral therapy for childhood traumatic grief (CBT-CTG). *Journal of American Academy of Child Adolescent Psychiatry, 45*(12), 1465–1473. doi:10.1097/01.chi.0000237705.43260.2c.

Cooper, G., Hoffman, K., Powell, B., & Marvin, R. (2007). The circle of security intervention: Differential diagnosis and differential treatment. In L. J. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy. Duke series in Child Development and Public Policy* (pp. 127–151). New York: The Guilford press.

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & Van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal of*

Orthopsychiatry, 82(2), 187–200. doi:10.1111/j.1939-0025.2012.01154.x 22506521.

Delfabbro, P. H., Barber, J. G., & Cooper, L. (2002). Children entering out-of-home care in South Australia: Baseline analyses for a 3-year longitudinal study. *Children and Youth Services Review, 24*(12), 917–932.

Delfabbro, P. H., King, D., & Barber, J. (2010). Children in foster care-five years on. *Children Australia, 35*(1), 22–30.

Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy, 43*(4), 496–503. doi:10.1016/j.brat.2004.03.006 15701354.

Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., Fennell, M., Herbert, C., & Mayou, R. A. (2003). A randomized controlled trial of cognitive therapy, a self-help booklet, and repeated assessments as early interventions for posttraumatic stress disorder. *Archives of General Psychiatry, 60*(10), 1024–1032. doi:10.1001/archpsyc.60.10.1024 14557148.

Ehlers, A., Mayou, R. A., & Bryant, B. (2003). Cognitive predictors of posttraumatic stress disorder in children: Results of a prospective longitudinal study. *Behaviour Research and Therapy, 41*(1), 1–10. doi:10.1016/S0005-7967%2801%2900126-7 12488116.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–258.

Hughes, D. A., & Baylin, J. (2012). *Brain-based parenting: The neuroscience of caregiving for healthy attachment*. New York: WW Norton & Company.

Jonkman, C. S., Verlinden, E. F., Bolle, E. F., Boer, F., & Lindauer, R. J. (2013). Traumatic stress symptomatology after child maltreatment and single traumatic events: Different profiles. *Journal of Traumatic Stress, 26*(2), 225–232.

Kezelman, C., Hossack, N., Stavropoulos, P., & Burley, P. (2015). *The cost of unresolved childhood trauma and abuse in adults in Australia*. Retrieved from http://www.blueknot.org.au/Portals/2/EconomicReport/The cost of unresolved trauma_budget report fnl.pdf.

Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York, NY: Guilford Press.

Parker, S. (2011). *Partnering for safety case consultation process: A process for consulting on child protection cases using the partnering for safety risk assessment and planning framework*. Perth: SP Consultancy. Retrieved from http://www.spconsultancy.com.au.

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

Perry, B. D., & Dobson, C. L. (2013). The neurosequential model of therapeutics. In J. D. Ford & C. Courtois, (Eds.), *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models*. (pp. 249–260). New York, NY: Guilford Press.

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1–2), 201–269.

Shapiro, F., & Forrest, M. S. (2001). *EMDR: Eye movement desensitization and reprocessing*. New York: The Guilford Press, US.

Solomon, R. M., & Shapiro, F. (2008). EMDR and the adaptive information processing model: Potential mechanisms of change. *Journal of EMDR Practice and Research, 2*(4), 315–325.

Struik, A. (2014). *Treating chronically traumatized children: Don't let sleeping dogs lie!* New York, NY: Routledge/Taylor & Francis Group.

Turnell, A., & Edwards, S. (1999). *Signs of safety: A solution and safety oriented approach to child protection casework*. New York, NY: W W Norton & Co.

Turnell, A., & Essex, S. (2006). *Working with 'denied' child abuse. The resolutions approach*. Berkshire: Open University Press.

World Health Organization. (2013). *Guidelines for the management of conditions specifically related to stress*. Geneva: WHO.

Zeanah, C. H., Chesher, T., & Boris, N. W. (2016). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder and disinhibited social engagement disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 55*(11), 990–1003. doi:10.1016/j.jaac.2016.08.004.

Appendix

The Six Tests (Struik, 2014. 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.

■