# Treatment of a 12-Year-Old with Trauma

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When Colin was 10 years old he was told that he had diabetes. In retrospect, his symptoms leading up to his diagnosis made complete sense, but since he had such a full, busy schedule, his parents and pediatrician believed that he was merely over-tired and needed some rest. But when Colin began to lose weight and muscle mass, his parents became alarmed and brought him to his doctor.

"You have diabetes," the doctor blurted out. "Your blood sugar is so high I can't believe you're even standing." Colin stood in stunned silence, unable to process what he was being told.

The doctor ushered Colin's parents into the room. "His blood sugar is dangerously high. He needs to go to emergency."

That is how Colin and his parents learned that he had a chronic life-threatening illness. To him and his parents it was all so unreal.

Two years after his initial diagnosis of diabetes, Colin's parents came to see me for a consultation to discuss their son's increasing feelings of anxiety and depression—feelings that Colin and his parents attributed to the stress associated with the management of his diabetes. Although Colin's distress was related to his illness, I did a detailed social, developmental, and medical history even before discussing the presenting problem, all the while giving his parents the opportunity to get a sense of what I was like so that they could decide whether or not they wanted me to work with their son.

It turned out that Colin was an exceptional 12-year-old, achieving at high levels in all areas of his life. He was an A student, a competitive swimmer, an artist, and he had a busy social life. Other than the diabetes, his medical history was uneventful. He usually had a good appetite, slept soundly through the night, and responded well to physical affection. He made appropriate eye contact when spoken to. He was polite and courteous, and respectful toward his elders. Colin got along with everyone who came into his orbit.

But during the unstructured periods of his day, Colin was feeling increasingly anxious and depressed, and some of the more pleasurable methods of relieving his symptoms (such as video-game playing, skate boarding, or shooting hoops in the backyard) had lost their effectiveness. Colin's new pediatrician offered a trial of antidepressant medication to treat his symptoms, but he and his parents decided to try therapy instead.

Colin presented as a tall, thin and lanky boy with a somewhat pale and drawn complexion. His parents introduced him to me and we shook hands. A few minutes later he told them that they could wait outside the room until the session was over. I reached behind my side table and raised a soft squishy round ball above my head. "Catch?" I smiled.

"Sure!" Colin laughed as if he was caught off guard.

"Tell me about your day. From the moment you wake up until you go to sleep."

As we tossed the ball back and forth, Colin filled me in. “On school days I get up about 7:30, check my levels, and have something to eat. I get dressed, pack my lunch, make sure my insulin pump and pack are right, and catch the bus at 8:30.”

Colin went on to tell me that most school days went smoothly—he liked his teachers and enjoyed his special subjects, especially art and woodwork.

“Three nights a week I swim with the team and one night I have an art lesson.”

“How often do you compete?”

“We have meets every couple of weeks.” Colin’s parents had told me that the swim meets often involved early morning travel on weekends and they asked him if he wanted to take a break from it, but Colin declined because he loved being on the team.

“Most weekend nights I do homework and assignments, watch some TV, take a shower, and head off to bed,” Colin concluded.

“Thanks for filling me in,” I smiled.

During our next two sessions, I sought the answer to two important questions regarding having a chronic (although manageable) disease. Did Colin accept his diabetes, and did he feel confident in his self-care?

“I do accept it, but I’m hopeful that there will be a cure one day. I think I manage it pretty well, although checking my levels and adjusting what I eat is annoying. I get frustrated at times.

“Have you had a scare in the past year and a half, regarding your sugar levels or your health?’

“No,” Colin replied.

“Sounds like you’ve got things under control,” I replied. “And I too hope that there is a cure one day.”

At the next session I checked in with Colin on how well our sessions were going for him. He said he felt comfortable and positive. I then proceeded to review with him what he had told me the previous two sessions about his full and busy life and his acceptance and management of his diabetes. He reaffirmed that it was manageable. Consequently, I felt confident about my next intervention.

“But I was wondering,” I offered, “Why then do you think you’re feeling anxious and depressed?”

Colin looked away. “I don’t know.” Tears welled up in his eyes.

He removed his glasses and wiped his face.

Minutes later, Colin looked up at me, his weary brown eyes seeking an answer.

I leaned forward and gently asked, “Do you think you might be able to describe what happened in the doctor’s surgery when he told you that you had diabetes? Whatever you can remember.”

Colin nodded. “I can remember it like it was yesterday.”

I waited.

“He said my blood sugar was so high he couldn’t believe I was standing. And he blurted out that I had diabetes! Just like that. When he told my parents, they turned white.”

I shook my head.

Since I was working on the hypothesis that Colin’s experience in the doctor’s surgery was likely a traumatic one, I did not encourage him to tell me more than he had already offered for fear of re-traumatizing him by over-exposing him to too much traumatic energy so early in the therapy. But I did feel confident enough to do some cognitive work.

“How do you think the doctor should have handled it?”

“Not like that,” Colin asserted. “He should have been calmer, more reassuring.”

“You’re exactly right, “I replied. “I’ve had several colleagues in a similar situation, and they handled it a lot differently. They would have told you that they were concerned about your blood sugar reading and brought your parents in. They would have calmly but firmly instructed your parents that you needed to get to the nearest emergency department.”

“That would have been better.” The color had returned to Colin’s face.

We sat in silence for a while. Then I proceeded to do more cognitive work.

“You know, Colin, that doctor appeared to panic, and he handled the situation poorly. For all we know *his* blood sugar was up, and *he* was having a stressful day.” We both chuckled. “But nonetheless, from a purely medical point of view, his doctoring was right on the mark. He got you out of his surgery quickly and straight to emergency so you could get proper care.”

“I can see that,” Colin shook his head in agreement.

Doing cognitive work in trauma therapy is important. It not only serves to elucidate partial misinterpretations or “take-aways” from the traumatic event but can simultaneously loosen up or safely defuse traumatic energies lodged in the autonomic nervous system. In Colin’s case, presenting a more balanced, *more realistic*, picture of what happened in the doctor’s office is a good example of this. In some cases, the client’s misinterpretations of a traumatic event can be dissociative, requiring more time to carefully examine and reconstruct.

At the following session, I reviewed with Colin the material we had previously covered and asked if it had been helpful. “Yes,” he replied. “I feel less shaky.”

“Good.”

I grabbed the ball from behind my side table and threw it to him. He smiled broadly, red cheeks and all.

“Today I would like to talk about triggers,” I continued. “What causes you to become overly anxious?”

Colin gave it some thought. “It’s when my levels spike despite my best effort.” “OK,” I nodded affirmatively. “I’ll teach you some relaxation techniques to reduce your anxiety. Anybody can use them; all you need is a brain!” Colin laughed out loud.

I proceeded to demonstrate a few easy breathing exercises: the limp noodle (where the client bends over and goes limp and holds the position for one or two minutes), mindful focused breathing, and a form of breathing that initiates self-hypnosis. I also told him that sucking on peppermints, pressing a small cold bottle of water against his forehead, or counting backwards from a hundred by threes were also ways to signal to your brain to relax. I did not want to complicate matters by explaining to Colin that all these anxiety-reducing offerings were evidenced-based methods of transitioning from the sympathetic (all feeling and dysregulation) to the parasympathetic (calm and equilibrium) nervous-system branches within the autonomic nervous system.

Before the session came to an end, I gave Colin some therapeutic homework. I asked him to consider describing in verbal, narrative, or pictorial form what happened in the doctor’s surgery after he was told that he had diabetes. “This would be for a future session,” I explained. The focus on triggers and the introduction of relaxation techniques to address them was a way to help Colin take control of his anxiety in the here and now and prepare him to deal with and process much more emotionally intense material in the future.

The next week Colin came in and said that he had practiced some of the relaxation techniques and they were helpful. He especially liked the limp noodle because it approximated the way in which he rotated his shoulders and bent his upper body over the lip of the pool at swim meets. Colin added that counting by threes backward from a hundred was also effective.

“The counting promotes deliberate thinking,” I told him.

Deliberate thinking exercises wed the parasympathetic nervous system to the neocortex, the part of the brain where reason resides.

Colin offered to verbally describe what happened after the doctor told him he had diabetes. “I was put on the examining table and was hydrated with an intravenous line. An ambulance came and took me to the hospital. I continued on fluids for a while longer and eventually was given insulin.”

“How did that go?”

“I was really scared at first, but as I began to feel better, more like my old self, I began to settle down.”

“How were you treated in the hospital?

“Good. Everyone was great. For three days my parents never left my side.”

Once again I reinforced the positive elements of his experience at the doctor’s surgery and at the hospital. I encouraged him to talk them over with his parents as well. Through the reinterpretation of these experiences I was hopeful that Colin would emotionally internalize a more balanced and realistic perspective and supplant the traumatic belief system that fueled the traumatic energy that had been lodged in his body for two years.

During the next few sessions Colin and I practiced the relaxation techniques I had introduced earlier in the therapy and continued to review the new ways in which he was conceiving his experiences at the doctor's and at the hospital that had occurred two years earlier. We agreed to meet again after he returned from a two-week family vacation and the start of a new school year in September.

After Labor Day, I texted Colin's father about setting up our next appointment. I waited for his reply with great anticipation. I was looking forward to resuming my work with this exceptional young man.

Colin's father called me that night. "Colin says that he's feeling real good. He's using the techniques you taught him and doesn't think he needs to come in anymore. He told me to tell you thanks for all your help."

"Terrific," I said, even though I was deflated over his decision to discontinue the therapy. "Tell him to have a great school year!"

***Case considerations.*** Colin had a "lower-case" traumatic experience; it was much easier to treat than a capital "T" trauma. Colin was also experiencing puberty, and his increased anxiety was a result of hormonal turbulence. He simply needed to give shape and order to his experience at the doctor's and the hospital to move on emotionally.

When I contacted Colin's parents to get their permission to write this case study, they told me that Colin was doing great. "He's never been better."

SIDEBAR A:

***Starting conversations with children***

There are numerous ways that conversations can be started with children, ranging from simple narratives about themselves and their activities to asking them to use their skills of observation and deduction. These are examples of simple, but effective prompts:

1. A straightforward request: "Tell me about your day from start to finish."
2. Imagine if: "What would you do if you were given two thousand dollars a week for the rest of your life to live on? What would you do with it?"
3. Detective work: my office window overlooks a parking lot for a shopping strip across the street: "The person or persons who just got out of their car—what store do you think they're going to?"

The third example is especially helpful for children on the autistic spectrum to teach them forms of symbolism—older people might be going to their local coffee shop, people who are more "dressed-up" to the high-end restaurant, and tradesmen to the deli. We observe their ages, clothes, the manner in which they are walking; where they're parked; and, of course, what kind of car they're driving.

There are other avenues from different cultures that can open the channels for conversation. Many cultures use some form of a "talking stick" that empowers the holder both to have the right to speak and to have some feeling of control in the conversation. They may choose to speak or to just hand the stick on—either action involves the child directly in the conversational experience. Children who pass the stick on may be more comfortable speaking the next time they are handed the stick (Mehl-Madrona & Mainguy, 2014).

Counselors and therapists who work with children will benefit from exploring the many ways in which conversations with children can be encouraged, including online (e.g., "Helping Children Talk," 2017).

It is equally important to know how to be sensitive when children are not ready to talk.

SIDEBAR B:

***Re-traumatization***

Therapists too often allow their clients to go too far, too soon in the re-telling of traumatic experiences. The person has to be ready. Triggering bound-up traumatic energy can overwhelm the autonomic nervous system, causing parasympathetic freeze and re-traumatization (Szasz, 2003). Therapists need to be aware of the inadvertent potential to retraumatize children due to "therapeutic initiatives to assist them speak of their experiences trauma and its consequences" (White, 2005, p. 10). This is an important concern for all therapists who work with traumatized children—and adults. Recall of the trauma can reconsolidate the memory in such a way that it becomes a worse memory or

establishes associations with the current timeline, in effect re-traumatizing the client (Ecker, 2015). The prevention of re-traumatization is sensitively described by Heidi Hanson in her "Art of Healing Trauma" blog (http://www.new-synapse.com/aps/wordpress/?p=1842) in which she explains how slowing down and allowing for trauma to be dealt with in a measured way can help to reduce and even avoid re-experiencing the overwhelming feelings that can occur when taken back to the context in which the trauma was initially experienced.

SIDEBAR C:

***Cognitive work***

Traumatic experiences often result in cognitive misinterpretations that become the implicit message (or subconscious "take-away") of the event. This is related to retention of emotional memory in the limbic area, particularly the amygdala, of highly charged events that trigger the sympathetic nervous system (Clark, 1995). For example, if parents have to leave a child in hospital overnight, and the child is traumatized by the medical procedures, this may cause a negative phobic adaptation toward doctors and nurses that can manifest in certain behaviors later in life. The implicit retention of this misinterpretation or dysfunctional take-away—that doctors and nurses are in some way bad—is related to the body's memory of the catastrophic events and the distress of abandonment. This needs to be addressed and a positive reinterpretation introduced. In severe cases, there may need to be a process of de-association of the event from the many connections that may have been created over time before deeper trauma work can be begin. J. Eric Gentry addresses this issue in his book, *Forward-Facing Trauma Therapy* (Compassion Unlimited, 2016).

SIDEBAR D:

***Thinking deliberately***

Deliberate thinking has been shown to reduce anxiety by calming the amygdala in response to increased activity in the prefrontal cortex and the cingulate gyrus. Deliberate thinking reduces the amount of fantasy and imaginative wandering. Research on mind wandering has provided a surprising amount of information on the process of deliberate thinking on the basis of an "either/or" neural contingency (Fox & Christoff, 2018).

Increasing focus on deliberate thought is another way of calming the emotional centers of the brain and increasing the sense of safety and feeling of comfort in the therapeutic, conversational process. Edward de Bono describes effective thinking as beneficial for self-empowerment and building self-esteem (de Bono, 2014). Asking someone to think deliberately about something, as suggested in the examples above, can disrupt the negative process of ruminating on problems and difficulties.

SIDEBAR E:

***Capital "T" trauma and lower-case "t" trauma***

Capital "T" traumas are usually caused by severe events, such as life-threatening confrontations, and have a single event catastrophic impact on the autonomic nervous system, causing a high degree of emotional dysregulation in the form of post-traumatic stress symptoms.

Lower-case "t" traumas can occur over time and are usually of less intense impact. Growing up in an unstable home due to financial stressors, alcoholism of a parent, or the mental illness of a sibling can cause lower-case traumas. "Post-traumatic-like" behaviors of parents or grandparents, inadvertently passed on to their offspring, or constant exposure to media coverage of terrorism, can also be sources of lower-case "t" traumas.

Both types of trauma result in emotional dysregulation and an inability to sustain periods of calm or relaxation without assistance or unhealthy symptom reduction such as alcohol consumption and/or drug use. Peter Levine describes a series of gentle, self-nurturing exercises to treat trauma pockets in the body in his book *Healing Trauma: A Pioneering Program for Restoring the Wisdom of Your Body* (Sounds True, 2008).

For more information, see Barbash (2017).

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