

Treating Childhood Trauma with Mindfulness

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Treating Childhood Trauma with Mindfulness

Childhood is sometimes characterized in books and movies as being an idyllic and carefree time. However, research suggests that more than two-thirds of all children are exposed to at least one potentially traumatic event prior to adulthood (Copeland, Keeler, Angold, & Costello, 2007). Many are neglected or abused by those they are dependent on the most – parents, caregivers, or other adults in positions of trust (e.g., Finkelhor et al., 2009). Others are bullied and/or physically or sexually assaulted by their peers or older children (e.g., Singer, Anglin, Song, & Lunghofer, 1995), or are exposed to fires, accidents, natural disasters, or life-threatening medical conditions (e.g., Saltzman, Babayon, Lester, Beardslee, & Pynoos, 2008; Vogel & Vernberg, 1993).

In many cases, childhood trauma is compounded by adverse social factors, such as parental unemployment, divorce, and neighborhood crime (Twenge, 2000). In the United States, 15.5 million children live in families with incomes below the federal poverty level (Addy & Wight, 2012). Many of these children live in decaying crime- and drug-infested neighborhoods and are regularly exposed to violence or gang activities (Schwab-Stone, Ayers, Kaspro, Voyce, Barone, Shriver, & Weissberg, 1995).

Consequences of Childhood Trauma

Trauma exposure can lead to a wide range of psychiatric, medical, social, academic, occupational, and criminal problems throughout adolescence and adulthood (see Copeland, Miller-Johnson, Keeler, Angold, & Costello, 2007; Dube et al., 2006; Kubak & Salekin, 2009; Ramiro, Madrid, & Brown, 2010). Abused children often develop negative representations of

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themselves and others, which then influence how they interpret events and interact with others. These children may have trouble with relational problem-solving or be seen by family and friends as being socially immature, unable to trust others, physically aggressive, emotionally over-reactive, and generally more difficult than non-abused children (Hildyard & Wolfe, 2002).

One of the most common impacts of trauma in childhood involve symptoms of posttraumatic stress disorder (PTSD; American Psychiatric Association, 2013). Children experiencing posttraumatic stress often present with an array of cognitive, emotional, physiological, and behavioral symptoms. These include trauma-specific fears; fears of recurrence; intrusive trauma-related thoughts or images; nightmares and other sleep disturbances; anxiety, depression, irritability, or anger, and pessimistic attitudes about the self, others, and the future (Jon A. Shaw, 2000). Behaviorally, children may display age-regressive behaviors such as crying, temper tantrums, separation anxieties, and school refusal. Posttraumatic play reenactments, somatic symptoms, avoidance of traumatic reminders, and social or academic problems are also common (Vogel & Vernberg, 1993). Depersonalization, or disconnecting from emotions and physical sensations, is also not uncommon in traumatized children (Michal et al., 2007). Behavioral avoidance also can become a major problem. This has been shown to be true in youth of all ages, although younger children may display more somatic symptoms to avoid daily activities while adolescents are more likely to self-isolate or develop alcohol or other substance-related problems (Dube et al., 2006).

Clearly, one of the most important challenges that parents, educators, and mental health professionals face is to help children and adolescents avoid or overcome psychological and behavioral problems in the aftermath of chronic daily stressors, victimization, and other potentially traumatic experiences. As also indicated for adults in other chapters of this volume,

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there are a number of interventions that may be helpful in the treatment of such children. We will suggest that “mindfulness” training may be especially helpful, as described below.

Mindfulness in the Moment and Afterwards

One often quoted definition of mindfulness is “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (Kabat-Zinn, 1994; p. 4). The effectiveness of structured mindfulness-based interventions in treating a variety of adult mood and anxiety problems is now well established (see recent meta-analyses by Hofmann, Sawyer, Witt, & Oh, 2010; Piet & Hougaard, 2011). Unfortunately, research on the effectiveness of this approach with children is limited, and none has specifically addressed PTS symptoms. In our clinical experience, however, and based on existing theoretical perspectives, it is likely that mindful awareness practices parallel many of the components that are known to be effective in treating traumatized children. These include identification of maladaptive trauma-related cognitions, affect regulation skills, decentering from thoughts, and therapeutic exposure to traumatic memories (Briere & Lanktree, 2012).

Anxiety is an emotion that is experienced in response to expectations of anticipated threat or danger. Traumatic events or situations, by definition, are sufficiently powerful to overwhelm the child’s existing coping abilities. Physically, cognitively, and emotionally, the child’s “cope runneth over.” During and after a traumatic event, cognitive catastrophizing can further escalate the impacts of what was already a very upsetting experience. High anxiety interferes with problem-solving and decision-making abilities (Bondolfi, 2005). Mindful awareness appears to enhance the individual’s ability to stay focused on the most immediate, important, or relevant aspects of a challenging situation. Being able to modulate one’s cognitive and emotional experiences and better manage behavioral reactivity allows greater access to situational,

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cognitive, and emotional information that might then be applied toward creative problem-solving post-trauma (Mennin, Heimberg, Turk, & Fresco, 2005). Mindful awareness brings clarity to see what is happening in the moment – including recognizing that catastrophic thinking or intense emotional reactivity interferes with skillful decision-making and makes it more difficult to respond appropriately or choose the best behavioral responses. In this way, being able to decenter from catastrophic cognitions may improve affective self-regulation and increase the child’s ability to see whatever choices might present themselves.

Posttraumatic anxieties are often sustained far beyond the precipitating traumatic event. Just as psychological debriefing following trauma may actually impede the natural recovery process (Mayou, Ehlers, & Hobbs, 2000), after the traumatic situation has resolved, repetitive cognitive ruminations about the experience that are maladaptive or distorted by strong emotions, may increase the likelihood of developing posttraumatic stress symptoms (Speckens, Ehlers, Hackmann, Ruths, & Clark, 2007). Following the event, therefore, an ability to maintain the same present-focused clarity of thought and affective equanimity that develops with mindfulness practice can offer some protective resiliency and reduce the likelihood of the individual developing PTS symptoms. As we will see, even when posttraumatic stress does develop, mindfulness may serve several functions for the traumatized child, ranging from cognitive restructuring to a form of intrapsychic exposure therapy.

Adapting Mindfulness for Children

Mindful awareness practices are being taught more frequently to children and adolescents in clinic, school, community, and retreat settings. Evaluation of these techniques for developmental appropriateness or effectiveness is in the very early stages, however, and few manualized treatments are currently available. Well-controlled effectiveness studies, although

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promising, are still limited. In this chapter, we will explore how one mindfulness-based therapy for children might be helpful for children suffering from PTS symptoms.

Mindfulness-based Cognitive Therapy for Children (MBCT-C; Semple & Lee, 2011) is a child-friendly psychotherapy for anxious children ages eight to twelve years old. It was adapted from two well-known adult programs – Mindfulness-based Stress Reduction (MBSR; Kabat-Zinn, 1990) and Mindfulness-based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002, 2013). Translating an adult therapy for use with children always requires significant practical adaptations, but the theoretical model and broad aims of MBCT-C are consistent with the adult MBSR and MBCT programs.

MBCT-C is a structured 12-week group program of mindfulness training. Each weekly session lasts 90 minutes. Groups generally consist of six to eight children with one or two therapists. Before the children's program begins, parents attend an orientation session, during which they are introduced to some of the children's mindfulness activities and encouraged to practice at home with their child. To facilitate parental participation, all the children receive written summaries at each session with that week's home practice activities described.

Mindfulness is cultivated mainly by practicing mindful awareness activities, which in MBCT-C, includes a greater variety of activities than do the adult programs. Metacognitive awareness and insights emerge from a process of Socratic inquiry and dialogue that is facilitated by the therapist after each mindfulness activity (Briere & Lanktree, 2012). This is similar to the inquiries conducted in the adult MBSR and MBCT programs, but generally includes less abstract explanations and more explicit practice guidance.

Following the introductory session, each session begins with a brief meditation and review of the previous week's home practice activities. In the initial sessions, one therapeutic

aim is to help the children discover their own motivations for wanting to practice mindfulness. These are often related to some difficulty the child may be encountering in his or her daily life. Common examples include wanting to deal with debilitating test or social anxieties or to develop better anger-management skills.

Anyone who has tried to make a small child sit still for 45 minutes will immediately understand why significant adaptations from adult mindfulness training activities were necessary. The adaptations in MBCT-C are intended to meet a variety of developmental needs – cognitive, affective, physical, attentional, and relational – appropriate to elementary school-age children. Similar to MBSR and MBCT, the children cultivate mindfulness with seated breath meditations, simple yoga postures and a technique known as the body scan (Kabat-Zinn, 1990), which is a guided activity of exploring interoceptive body sensations using directed attention. In MBCT-C, however, each of these activities lasts only three to five minutes. These basic techniques are practiced multiple times throughout the program by balancing creative repetition with variety. Repetition enhances learning, while the shorter activities make it easier to engage and maintain the children’s interest. In addition to these customary adult mindfulness activities, children participate in a wide variety of activities that focus on developing mindful awareness in individual sensory modes (e.g., taste, touch, sight, sound, smell, and body kinesthetics). Each activity is structured to allow the child to practice bringing attention to the moment-by-moment thoughts, feelings, and body sensations that arise with each activity. Mindful eating may involve giving attention to the eating of a single raisin, while mindfulness of touch is cultivated by exploring small objects that are held behind the back, which are selected for their interesting or unusual tactile qualities. Mindful hearing can be receptive (listening to music) or expressive (making music) while noting the internal cognitive commentaries that, as the children soon

discover, often consist of rapidly formed judgments about the experience rather than being observations or descriptions of the experience. Children also practice mindful movement activities by mirroring each other's random (often silly) body gestures, mindfully walking very slowly, or pretending to be a flower – mindfully stretching, growing, and opening to the sun. Relevant poems and stories are included in each session that helps sustain the children's engagement and deepen their understandings.

In this chapter, we offer only a brief description of MBCT-C because the book, *Mindfulness-Based Cognitive Therapy for Anxious Children* (Semple & Lee, 2011), provides a thorough background to the theoretical model, a description of modifications needed when teaching mindfulness to children, a detailed, session-by-session guide to conducting each intervention, and all handouts used in the program. Instead, we will discuss its core concepts and explore some of the issues that clinicians should consider when using mindfulness-based interventions with traumatized children. Although mindfulness is a broad-based resiliency approach, MBCT-C was developed to help children manage stress and anxiety. Traumatized or abused children have distinct needs that must be considered, regardless of the mode of therapy.

Foundations of Mindfulness

Anyone who has had the privilege of working with children knows that effective child psychotherapy generally requires a flexible, creative approach and a healthy dose of patience. Compassionate acceptance and a gentle sense of humor are often useful as well. The MBCT-C model encourages therapists to teach mindfulness from their own experiences of mindfulness. Doing this requires the therapist to cultivate mindfulness in his or her personal life, developing understandings that are grounded in experience. Working in this model can sometimes demand as much of the therapist as the therapist might ask of the child. Perhaps even more so when

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working with traumatized or abused children. At times, the children’s emotional suffering and your own empathic attunement may feel quite intense.

Pain and Suffering

Traumatic experiences produce both pain and suffering. Pain had been defined as, “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Merskey & Bogduk, 1994). Suffering is an emotional response to pain. We suggest that suffering is intensified when thoughts and feelings about the traumatic experience are not differentiated from direct perceptions of the experience. For some traumatized children, the thoughts and feelings about the experience dramatically increase their reactions to the traumatic event. However, when we first began teaching mindful awareness practices to children, we learned that some children had found a different way to relate to their own thoughts and feelings. They discovered that what they inferred was not necessarily true, what they feared was not necessarily real, and that thoughts were “just” thoughts. These are liberating and empowering insights. This “decentering” from thoughts bolster the child’s self-compassion and affective equanimity. Suffering might be reduced by strengthening the child’s ability to tolerate the intensity and vividness of the traumatic memories – with self-compassion.

Judging and Accepting

In Buddhist psychology, judging our experiences serves to increase suffering (Bhikkhu Bodhi, 1993), particularly when the judgments are grounded in strong emotional memories that are not accurate to the child’s present reality. It may be particularly difficult to teach acceptance (non-judging) when a child has experienced a horrific abuse that we all fervently wish had never happened. In the MBCT-C model, acceptance is not an attitude of passive resignation. Nor is it

necessarily related to forgiveness of the other, although acceptance of the experience may arouse greater self-compassion. Rather, acceptance refers to the wholehearted recognition that, difficult though it was, the traumatic experience did actually happen. It was not a dream or a fantasy. It did happen. Really. That's acceptance. Nonetheless, it happened in the past, not in this moment. It is not being judgmental to acknowledge and accept the existence of the traumatic experience, and then say, "Okay, so what can we do now?"

“Should-ing” on Oneself and the World

Much of life is unsatisfactory – particularly so when traumatic events occur which are beyond our control. To wish that a traumatic event “shouldn't” have happened is a normal human response. To focus on what one “should” have done during or after the experience is also a common response to feeling helpless in a situation that is typically beyond personal control. Getting stuck in the “shoulds” (or “shouldn'ts”) to the exclusion of all else is to reject the reality of what is happening now as well as what actually happened during the traumatic experience. Emotionally pushing away the reality that did happen may be part of what interferes with emotional healing and learning to move beyond the experience. How do we avoid this natural reaction to push away an unpleasant reality? And what may be done about it now?

Practicing mindful awareness allows us to see what is in the present moment more clearly. In the present moment, the traumatic event isn't happening. In the present moment, choices are possible. In order to see those choices, attention must be redirected from the traumatic memories to the present moment. Redirecting attention takes practice. For example, bringing attention to each breath is also practice in letting go of each breath, moment-by-moment. Over and over again. In order to stay present with this breath, the child must first acknowledge, and then let go of the previous one. Breath-by-breath. Acknowledge and let go of

the difficult memory, return to the present. Moment-by-moment.

Thoughts Are Not Facts

Some mindfulness practices focus on simply observing thoughts as they come and go. Learning from repeated observations that thoughts are not facts. Thoughts are events in the mind, or as Kabat-Zinn (1994) has suggested, thoughts are “just thoughts.” Learning to relate to one’s own thoughts in a different and perhaps more helpful way is known as decentering. Following a traumatic event, a child may feel as if their thoughts are compelled to return to the traumatic event, which will likely increase the child’s distress. With repetition, these anxious or depressive ruminations become habituated, “automatic thoughts.” In learning new ways to relate to their thoughts, children may be less inclined to incorporate the thoughts into their self-identity. Defining themselves in terms of repetitive negative or self-judgmental thoughts can further damage these already vulnerable children by limiting their ability to see what choices may be available in the current situation (Frewen, Evans, Maraj, Dozois, & Partridge, 2008). Children can become trapped in self-destructive mind states, which are likely to block the healing process. This is not to suggest that practicing mindfulness meditation will eliminate unwanted thoughts. However, finding a different way to relate to these thoughts may make it easier to let go of them when they do emerge. Mindful awareness can offer children a sense of separation from their own thoughts. Children can learn that they don’t need to believe everything they think. By not confusing thoughts with reality, decentering increases the child’s opportunities to make clear and conscious choices.

Feelings are Not Facts Either

Children often develop strong “emotional memories” following traumatic events,

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particularly when the trauma is related to chronic neglect or abuse from caregivers (Gilbert & Tirsch, 2009). Children may internalize these experiences – growing up feeling unworthy, unlovable, and defective. Traumatic memories are strong and tend to be resistant to extinction. This may have evolved as a survival characteristic, but it also makes trauma processing work more difficult. Traumatic emotional memories may feel overwhelming and frequently trigger what may be protective dissociative episodes. The habit of dissociating becomes an obstacle to maintaining awareness of what is happening in the present moment. Constant negative self-talk develops into negative self-schemata. The memories influence how the child interprets all of his or her experiences. Negative emotional memories become like a dark filter, distorting the child's interpretations of current experiences. Negative emotional distortions serve to both maintain the negative self-schemata and decrease the likelihood of the child making appropriate or wholesome decisions in the present. Traumatic emotional memories become more real than the current reality. Mindfulness practices may help the child hold these intense emotions without dissociating, develop the resiliency to breathe through the strong emotions, and perhaps learn that feelings are not facts either.

Choice Points

Children and adolescents make a multitude of choices every day. Some are as minor as choosing what color socks to wear or which way to walk to school. Some may feel weightier, such as choosing to align with one group of peers or another. Others might feel life changing, such as deciding what college to attend. But, every choice made – no matter how large or small – contributes something to the course of their life. Although planning is an essential step in reaching one's goals, the opportunity to make a choice occurs only in the present moment. Have you ever spent a great deal of time weighing a choice, perhaps investigating carefully to decide

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which car to purchase, and then, when the moment arrived, impulsively making a completely different choice than the one you had spent so much time considering? The actual choice is always made in the moment.

Since choices only occur in the present moment, it seems reasonable to assume that by looking more closely at what is present, we might see more choices. In particular, by looking more closely, children discover that they have internal experiences (thoughts, feelings, and body sensations) that often seem to be independent of external events. With practice, they may notice that sometimes the thoughts and feelings are accurate to the present-moment external event. Much of the time, however, they are not.

Children often can't choose what happens to them. Many of their daily activities are directed by parents, teachers, or older children. They can, however, choose how to respond to what happens. To see more clearly what those response choices might be, they must attend to the only moment in which a choice can be made. Mindfulness might be defined as practice of keeping the mind and the body in the same place at the same time. Ruminating about an unchangeable past or worrying about an unknowable future shifts attention from what is happening in the present moment – away from the place where choices can be made. Attention is a limited resource. Becoming “lost in thought,” the child has less attention to give to the present. With attention focused on an unchangeable past or straying to an unknowable future, the child may easily miss attending to what choice points may be available in this moment (Semple, Lee, Rosa, & Miller, 2010).

Traumatic events, and particularly those that involve neglect or abuse, also precipitate enduring “emotional memories.” Memories associated with feelings of being unloved or unwanted may make it harder for abused children to develop self-compassion and act as a barrier

to maintaining awareness of the present. When children are caught up in the negative emotional memories, they may have difficulty making conscious, unbiased choices. Decisions are likely to arise from the re-experienced emotional memories (or body sensations) rather than from events occurring in that moment. Practicing mindful awareness of seeing the emotional memories as memories that are not associated with the current situation, may interrupt a maladaptive repetition of emotional memories that can precipitate inappropriate behavioral choices.

Self-Compassion

Self-compassion may buffer the emotional dysregulation that often results from childhood maltreatment (Vettese, Dyer, Li, & Wekerle, 2011). Children with low self-compassion seem to be at increased risk to develop maladaptive coping strategies, such as anxious or depressive rumination and dissociation. Greater self-compassion also appears to be directly related to psychological resilience (Neff & McGehee, 2010). Mindfulness is generally considered one component of self-compassion, along with other emotionally protective factors, such as self-kindness and feelings of common humanity (Vettese et al., 2011). With adults, the practice of mindfulness seems to increase both self-compassion and compassionate empathy for others (Orzech, Shapiro, Brown, & McKay, 2009; Robins, Keng, Ekblad, & Brantley, 2012). Simply redirecting attention by focusing on the breath or body sensations may reduce the frequency, intensity, or duration of self-blaming ruminations. With no cognitive restructuring necessary, decentering may reduce the negative self-talk, increase children's self-esteem, and create a sense of self-empowerment (Semple & Lee, 2011). Paradoxically, increasing awareness of the habituated negative self-talk and understanding how this affects depressed or anxious moods, may increase self-compassion.

Mindfulness Interventions with Traumatized Children

Psychoeducation

Mindfulness-based psychotherapies generally include some psychoeducation about psychiatric symptoms. Similar to trauma-focused therapies for adults, it can be helpful for children to learn about common symptoms and reactions to trauma. In educating children about traumatic stress responses, therapists convey understanding and acceptance of possible cognitive, affective, physiological, and behavioral reactions to the event. This can help normalize the PTS reactions and reduce the likelihood that the child will internalize the experience as evidence or guilt or worthlessness (Phoenix, 2007). Essentially, psychoeducation may help prevent children from blaming themselves for their own victimization. Psychoeducation also supports the development of resiliency factors, such as identification of emotions, cultivation of empathy, greater self-efficacy, and improved problem-solving abilities (Briere & Lanktree, 2012).

Dissociation versus Decentering

Dissociation and mindful awareness may be conceptualized as being at opposite ends of a continuum and opposite states of mind (Corrigan, 2002). Dissociation is, in some sense, a looking away from difficult thoughts and feelings. This may occur during the traumatic event or afterwards, when strong memories of the experience arise. Dissociative episodes can range from brief moments of temporarily losing touch with whatever is happening in the moment to prolonged periods of time for which the child has no memories. Although dissociation has been found to be a risk factor for developing PTS, it is also a common, and sometimes even helpful, sequelae of trauma. Traumatized children may dissociate from the present moment as a coping strategy to contain what may otherwise feel like overwhelming thoughts and emotions. This can

happen during the trauma or afterwards. When dissociating, the child disconnects from his or her self, the environment, and those around them.

One aim of mindfulness is to bring clear awareness to the internal and external events that arise in each moment. Moment-by-moment. The central therapeutic change that may emerge from sustained mindfulness practices may be this ability to experience thoughts, feelings, and memories as events in the mind (Segal, Teasdale, & Williams, 2004). Decentering is a metacognitive process of seeing these phenomena clearly – as being “just thoughts” or “just memories.” Decentering can shift narrowly focused or ruminative thinking by encouraging changes in how the child relates to his or her internal experiences. Thoughts or feelings begin to be experienced as transient events in the mind, rather than being unquestioned evidence of reality. Decentering appears to strengthen the ability to look toward difficult thoughts and feelings with less emotional reactivity (Taylor et al., 2011). The simple awareness that we have choices in how we respond to our own thoughts may be what underlies the self-empowered feelings associated with decentering.

Intrapsychic Exposure to Life, the Universe, and Everything

Avoidant behaviors can maintain or exacerbate traumatic anxiety (Mowrer, 1960). In adults, mindfulness and acceptance are associated with greater psychological adjustment following exposure to trauma (Smith et al., 2011), while persistent dissociation, experiential avoidance, and emotional disengagement as coping strategies are associated with greater PTS severity (Thompson, Arnkoff, & Glass, 2011). Mindful awareness practices aim to enhance a child’s ability to distinguish external events occurring in the present moment from intrapsychic events, which includes difficult thoughts or emotion-laden memories of a past traumatic event. To do this, the child must look directly at the difficult thoughts and emotions rather than using

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avoidant strategies such as dissociation. Essentially, mindful awareness practices can be considered a type of unconditional intrapsychic exposure with response prevention, much as has been described by Briere (2012) and others for adults. The practice of looking toward these difficult intrapsychic events shifts the mental representations that define the child's relationship to his or her own thoughts, feelings, and body sensations (Teasdale, 1999).

Hyperarousal, Desensitization, and Body Awareness

Although physical relaxation is not the aim of mindfulness practices, feeling more relaxed after practicing is a common “side effect.” Physiological hyperarousal, agitation, muscular tension, and being overly attentive to body sensations are common responses to trauma. Body sensations are often linked to intense trauma-related emotions. Obvious examples include physical or sexual abuse, but experiences such as medical emergencies or natural disasters can also produce hypersensitive trauma-related body sensations. Children may try to manage some of the intensity of emotions linked to these traumatic events by blocking out both emotions and body awareness – essentially choosing to live in their heads, rather than in their bodies. Although this might initially seem protective, the choice to withdraw attention from the body means that the emotional processing of the difficult experiences will be incomplete. Consequently, ongoing efforts are required to suppress these emotion-related body sensations from entering awareness. For some children, intentionally cultivating awareness of body sensations may be very difficult and bring up intense, seemingly overwhelming emotions. It is important for therapists to be attentive to indications of this during body-focused mindfulness activities. The therapist can help each child find a wholesome balance between shutting out awareness of body sensations entirely versus feeling overwhelmed at the intensity of the emotional-sensory experience. Breath meditations can provide a calming foundation that allows

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the child gently to bring awareness to body sensations present in the moment. Some children may find movement activities such as mindful walking or yoga practices easier than an activity such as the body scan, in which the body is still and attention is focused on internal bodily sensations. Mindfulness may provide a way for children to feel emotionally more stable while reconnecting with their own body sensations.

Distinguishing Past, Present, and Future

To practice mindfulness is to practice seeing clearly what is present in this moment. Some PTS symptoms are past-focused. That is, the child's attention is focused on remembering the previous traumatic experience, which likely contributes to repetitive, intrusive thoughts. Other symptoms tend to be future-focused. For example, anticipatory anxiety and behavioral avoidance of places or people associated with the trauma may develop or be exacerbated when the child believes that being in a certain place or near a particular person might somehow invite a recurrence of the trauma. Attention, however, is a limited resource. None of us is able to give full attention to every thought, emotion, perception, sensation, or event that arises in each moment. Given this constraint, cultivating a present-focused awareness necessarily reduces the attention that we have to give to thoughts and feelings about past or future events. Living more fully in the present may help a traumatized child to let go of the past experience and reduce his or her fears of the future.

Home Practice and Home Life

During the 12-week MBCT-C program, children are encouraged to engage in daily, home-based mindfulness practices. The aim is to integrate these practices into the child's everyday life. In ordinary circumstances, the home practice activities themselves raise

awareness of obstacles that might interfere with developing a daily practice of mindfulness. For the most part, children are encouraged to simply note these experiences and discuss them at the next group discussion. Attending to the challenges that arise in one's home practice becomes a practice that supports the further cultivation of mindfulness.

Unfortunately, a common source of childhood trauma is familial neglect or abuse (Jennifer A. Shaw, 2010). Living in a chronically unsupportive or abusive environment negatively affects a child's emotional health and increases the likelihood that clinical services will be necessary (Dube, Felitti, Dong, Giles, & Anda, 2003). After learning mindful awareness practices in a clinic (or school-based) program, the child may be returning to the source of the trauma – the neglectful or abusive home. For some children, it will be difficult or impossible to gain support in developing a mindfulness practice from parents or caregivers. When the child is in a high-stress situation, the decision to begin a mindfulness-based treatment program warrants careful consideration. Increasing access to highly charged negative thoughts and feelings while still immersed in an unwholesome environment may emotionally overwhelm some traumatized children (Briere & Lanktree, 2012). In addition, children commonly use dissociative coping strategies to manage what may otherwise be an intolerable environment. This seems likely to interfere with both learning and applying mindful awareness practices. The biggest challenge may be in learning how we can support a child's home practice, when the home environment is a big part of the problem. We need to be clear about these and other possible contraindications to beginning mindfulness training with traumatized youth.

Conclusion

Mindfulness-based interventions show considerable promise in the treatment of cognitive, emotional, physiological, and behavioral PTS symptoms in children. By practicing

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mindfulness, children may become more adept at distinguishing traumatic memories and other intrapsychic events from their current realities. Simply because of our limited attentional capacity, practicing mindful awareness of the present may reduce past-oriented traumatic memories and future-oriented anticipatory fears. Mindfulness-based therapies for adults have increasingly focused on specific clinical problems. This approach appears to be effective in enhancing attention and emotion self-regulation while decreasing anxiety and depressive symptoms. A great deal of interest, therefore, is focused on the role of mindfulness in the treatment of PTSD symptoms with adults and children. Child-friendly mindfulness programs for stress management are being used in schools and community locations as well as being developed for clinical settings. Given the recent explosion of research supporting the efficacy of mindfulness-based interventions in treating adult mood and anxiety disorders, further development of mindfulness-based interventions focused on the specific clinical issues of traumatized children seem likely to yield promising results.

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Healing From Attachment, Complex Trauma & Developmental Trauma: A New Approach. Dr. Laurence Heller - <https://neuroaffectivetouch.com/about/healing-developmental-trauma/>. What Do ACEs Have To Do With Childhood Trauma? Everything! Childhood Trauma is a Risk Factor for Chronic Illness: How Healing Trauma Can Help Heal Chronic Illness And Why It's Not in Your Head. Veronique Mead - https://chronicillnesstraumastudies.com/avaiya_ace-fact-sheet/. What Most People Don't Realize About Childhood Trauma. Laura Reagan - <https://www.bahealing.com/podcast>. 9 Steps to Healing Childhood Trauma as an Adult. Treating Trauma with Internal Family Systems. Richard Schwartz - <https://selfleadership.org/>. Juggling Parenting & Healing. Here's how mindfulness can help to deal with childhood trauma in adults. Most adults living with childhood trauma use the same coping strategy that they used as a child which is to avoid anything that might trigger their unwelcome emotions and trauma. However, doing so, the suppressed and unprocessed emotions since childhood stay stuck in the body and never get a chance to be released. Mindfulness works differently. It allows you to feel everything as it is and not judge your experience and emotions as good or bad. When there is discomfort, you don't run away from it. Childhood trauma is often described as serious adverse childhood experiences (ACEs). Children may go through a range of experiences that classify as psychological trauma, these might include neglect, abandonment, sexual abuse, and physical abuse, parent or sibling is treated violently or there is a parent with a mental illness. These events have profound psychological, physiological, and sociological impacts and can have negative, lasting effects on health and well-being. Kaiser Permanente and the Child abuse can cause psychological ramifications for many years. Keeping your childhood trauma a secret, delays the process of healing. Childhood trauma is devastating, no matter what form it takes. It affects your self-esteem, trust, future relationships, and sense of safety in the world. And, no matter what you do to forget, the secrets haunt you every day. You know some of the reasons you've kept secrets, but is there more? Plus, you wonder, are some of the things you're struggling with caused by your secrets? Yes, keeping secrets can cause psychological symptoms and problems. So, let's talk about 6 reasons why you might be keeping your childhood trauma a secret, how secrets lead to psychological problems, and what you can