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## **Inner City Children of Trauma: Urban Violence Traumatic Stress Response Syndrome (U-VTS) and Therapists' Responses**

ERWIN RANDOLPH PARSON

What happens to kids who learn as babies to dodge bullets and step over dead corpses on the way to school? -Lois TIMNICK (1989)

### **VIOLENCE AND TRAUMA IN THE INNER CITY**

From an early age, children living in the inner cities are exposed frequently to the use of drugs, guns, arson, and random violence. They witness injury, suffering, and death, and they respond to these events with fear and grief, often experiencing dramatic ruptures in their development. The list of psychological reactions is long and grim: hatred for self, profound loss of trust in the community and the world, tattered internalized moral values and ethics of caring, and a breaking down of the inner and outer sense of security and of reality. They are particularly vulnerable to traumatic stress illnesses and to related behavioral and academic abnormalities (Gardner, 1971; Parson, 1994; van der Kolk, 1987).

Two decades ago, Meets (1970, 1973; Meers & Gordon, 1975) spoke prophetically about the inner city child: "Since traumatization is endemic in the ghetto ... this might produce in the child some equivalent of 'combat fatigue,' i.e., a further overloading of the ego because of the constancy of real dangers' (Meers & Gordon, 1975, p. 586). These socioenvironmentally induced stress reactions in urban children are what I refer to as urban violence traumatic stress response syndrome (U-VTS). Children's stress responses range from normal reactions (in response to an abnormal situation), to mild, moderate, and severe levels of distress and dysfunctions. When these children enter treatment, they present unusual challenges to therapists and often elicit powerful countertransference reactions (CTRs). As of yet, no comprehensive studies exist on the traumatic sequelae of violence associated with "urban firefights" in ethnic minority children who live in the harsh brick and stone jungles of the inner city. Accounts of the experience of urban children have appeared in the media. Timnick (1989), in her Los Angeles Times Magazine article, "Children of Violence," highlighted the images of horror and traumatic effects of inner city-generated violence experienced by children of South Central Los Angeles. She presents the poignant verbal accounts by these children (pp. 6, 8, 10):

- \* "They shoot somebody everyday," "I go in and get under the bed and come out after the shooting stops."
- \* "My daddy got knifed when he got out of jail," and "My uncle got shot in a fight-there was a bucket of his blood. And I had two aunties killed and of them was pushed off the free-way and there were maggots on her."
- \* "It's like the violence is coming down a little closer." "We don't come outside a lot now."
- \* "Just three people [in my family] died." "I been seein' two of them' (as haunting ghosts at night).
- \* "How about the cemetery?" (in response to teacher's request for ideas for a field trip).
- \* "Her eyeball was in her shoe" (boy witnessed woman's mutilated body).

The following are statements made by traumatized children served through my clinical practice in New York City:

"At 5, in front of my own eyes I saw my dad and baby brother burn to death. They didn't get out. My dad had gone into the house to bring him out." (This adolescent was referred to me by a judge after he had shot a child he said had "hassled" him.)

"I saw my mother stab my father with a knife and killed him. She was put in jail; he was dead. I had no one. I see a knife in my dreams every night." "They killed my dad as I watched, and I stayed with the body for a very long time, and all the time the killers threatened to kill me too."

Children who witnessed single extreme events or who suffer chronic exposure to aversive stimuli require interventions to repair cognitive, emotional, and physiological damages to the self to mobilize post-violence arrested development caused by violent acts. Interventions aim to create a climate in therapy that allows the child to learn how to cope and continue healthy growth (Winnicott, 1975). This is in part made possible by the presence and relationship of a benevolent authority—a therapist who understands children's unique reactions to traumatic experiences, and who is determined to empathically care for young victims by ensuring psychological continuity and integration of the trauma.

Working with children subjected to various forms of violence calls for sensitivity, maturity, and a stable sense of self in the therapist. The therapist needs to be the symbolic representation of the safe, nonviolent world. This work requires that therapist have the capacity and willingness to assist these children to decipher the riddle of their traumatic responses—a conundrum of mental confusion, of distorted moral values, of search for meaning, and of cognitive and emotional disruptions. In this regard, the issue of therapist countertransference takes on a special role and significance for psychotherapy outcome. Later in this chapter, the special role of countertransference in treatment will be discussed.

Most of the literature on inner city children of trauma identifies the problem young victims experience, but few highlight the nature of intervention with these children, and the role the therapist's personality and competence play in treatment outcome. Obviously, in the absence of outcome studies it is difficult to assess which interventions are most effective at this time.

This chapter highlights the reality of violent traumatic stress in the daily lives of urban children and explores the complexities of treating these children from the perspective of using therapists' human dynamic responses to promote healing in the child. Moreover, the chapter discusses the need for therapists to monitor and control negative responses toward the child's own response to the trauma—altered sense of self and his or her racial/ethnic heritage. Typical child reactions to the therapist include transference feelings directed toward the therapist who is perceived as an authority or parental figure, friend or foe, benevolent person or villain, rescuer or perpetrator, and similar transference projections. These transference projections have strong implications for countertransference processes in treatment that will also be discussed in this chapter.

### **Epidemic of Random Violence and Tragedy in the Presence of Children**

Bell and Jenkins (1991) reviewed the literature on black children and youths living in violent communities, particularly those in South Central Los Angeles. They indicated that homicide will increase significantly in urban America. Compared to other Western nations, violent crime in the United States has climbed dramatically during the past two decades. Bell and Jenkins also noted that recent surveys found that the United States surpassed other industrialized nations in violent crimes, including homicides. Homicides have increased in black populations, and they are the leading cause of death among black men and women ages 15-34, a 39% increase since 1984. The eyewitnessing of violence among children is also on the increase. Bell, Prothrow-Stith, Smallwood, and Murchison (1986) reported that 44% of murder victims were found in black populations, and that 84% of elementary school children had seen someone physically assaulted. Bell and Jenkins (1991) also reported that in 1982 in Los Angeles County, 10-20% of the 2,000 homicides were witnessed by dependent children, and that in 1986 one-half of the homicides cases were witnessed by 136 children 18 years and under. Dubrow and Garbarino (1989), in a small, uncontrolled sample, noted that "virtually all" of the inner city, ethnic minority children in South Central Los Angeles witnessed a homicide or a shooting of a person by age 5.

### **Case Example One: Toby**

At age 11, a girl named Toby and her father were kidnapped from their inner city home in New York City. A child of African-American and Hispanic heritages, Toby watched as her kidnappers killed her father. They then continually threatened her with death for many hours. The child was referred to an inner city, community mental

health care facility for therapy. Toby was very close to her father, and the tragedy of that day had never left her mind. The vicious death of her father, and the accompanying loss and grief, made her feel very empty, bitter, and alone. Though Toby's mother tried to care for her daughter the best she could, Toby was often abrasive and showed a lack of gratitude. The family felt sorry for her because of her ordeal, and they would overlook the girl's hostility, her moodiness, and her indiscretions such as visiting friends after school without first calling home to let family members know of her whereabouts.

Toby has a younger brother and two older sisters living in a squalid public housing building, where young children are recruited to "run" drugs, and where shootings and stabbings are daily expectations. Toby's mother describes her daughter as having been outgoing and a good student before the traumatic event. After the incident, the girl lost interest in school, and withdrew from friends and family, preferring solitude and isolation. She also showed a preoccupation with fantasy and with older boys.

At the time of the therapy, Toby presented with the symptoms of post-traumatic stress disorder (PTSD), depression, anxiety, phobic reactions, and hyperaggressive fantasies to destroy everyone around her. She suffered traumatic dreams and nightmares "almost every night," diminished interest, guilt, foreshortened future, irritability, hypervigilance, sleep disturbance, and general autonomic hyperreactivity. She was filled with rage toward the assailants, her mother, her brother and sisters, school teachers, and the world.

Toby was very cynical and distrustful of most people, and reportedly engaged in violent behavior in school against certain girls who she believed were attempting to humiliate her and steal her boyfriend, "Supreme." She would write him long letters cursing him for not loving her more, for going out with other girls, and for making her so lonely. The flavor of these letters manifested a psychotic or delusional quality. Toby often spoke of a sense of defilement, degradation, guilt, grief, sorrow, and death anxiety. She felt that life had dealt her a horrific blow, and she was determined to make everyone pay a high price for her misfortune. Toby usually gave the impression that people and reality were not worth relating to.

### **Case Example Two: Danny**

At age 7, Danny, a 12-year-old boy of African-American background, witnessed his father and younger brother burn to death in a house fire in New York. His father had rescued him and his mother and three sisters. However, his father soon realized that the youngest child was still in the burning house. He ran into the house and upstairs to find the young child. As he and the baby descended the stairs, they were engulfed in flames and were burned alive as Danny watched in helpless horror and shocked disbelief.

At age 16, Danny was referred to me for psychotherapy by the juvenile court after shooting a 13-year-old boy who "had made me mad because he was calling me names." Part of the child wanted the world to pay dearly for what had happened to him: he had lost his best friend, his father, and still desperately missed him. Cocaine helped him kill the pain within and manage overwhelming affective turmoil and anxiety. Danny showed signs of PTSD, and, like Toby, suffered reenactments of the traumatic event in dreams, play, fantasies, and relationships with children and adults.

Prior to the traumatic event, Danny was described as a happy boy whose early developmental history was uneventful. There was no violence, and no alcohol and drug abuse in the family. Danny was his father's favorite child, and he knew this. Over the years Danny suffered traumatic dreams that reenacted the fire he had witnessed with horror 5 years before. His mother and older sisters mentioned how Danny's personality had changed after his father's death: he withdrew into a -shell of silence, and he became introverted, sad, angry, irritable, and defiant.

The child also suffered intense fears, annihilation anxiety, sleep disturbance, and what his mother described as "his depressed state." Danny's mother remarried and his stepfather tried to be a positive influence in the boy's life to help him forget his traumatic past. However, Danny was very rebellious and defiant. He felt he had only one father, and that he was dead. No one could replace his father. Danny's alcohol and cocaine abuse can be understood as attempts to manage inner tensions, depression, and post-traumatic memories through self-medication.

### **URBAN VIOLENCE TRAUMATIC STRESS RESPONSE SYNDROME (U-VTS)**

Urban violence syndromes may involve psychic conflicts, central nervous system alterations, distorted images of social life, physical damage, and chronic stress. My experience in treating inner city children suggests that, though the PTSD criteria in the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-111-R; American Psychiatric Association, 1987) aid in the assessment process with violence-traumatized children,

the DSM-111-R fails to address the clinical and socioenvironmental issues that children traumatized by violence bring to the clinical setting. It also fails to deal with most aspects of violence and the resulting self-altering biopsychic manifestations in behavior. The concept of U-VTS is introduced to complement the DSM-III-R PTSD criteria and to offer a more comprehensive and realistic understanding of the responses of low socioeconomic status, ethnic minority and white youths living in the inner cities. Research is needed to better understand the common and unique properties of PTSD and the actual impact of violence upon the mind, body, and spirit of urban children of trauma.

The response to violence-driven stressors can occur after a single violent episode, after multiple episodes, or after ongoing prolonged exposure to overwhelming events of violence. Observation and experience suggest that these stressors can occur when the individual is either alone or in a group, and they affect very young children as well as older children and adolescents (Parson, 1994; Pynoos & Eth, 1985; Terr, 1979).

U-VTS features a number of component symptoms and reactions observed in child eyewitnesses to overwhelming events. In assessment and diagnostic work the relative weight given each of the following factors depends upon the developmental stage of the child; the specific kind, intensity, and duration of traumatic stimuli (Parson, 1994); the family structure; and the child's general experience in his or her community. The components of U-VTS are (1) damaged self syndrome; (2) trauma-specific transference paradigms; (3) adaptation to danger; (4) cognitive and emotional stress response; (5) impact on moral behavior; (6) post-traumatic play; (7) PTSD; and (8) post-traumatic health outcomes. Each of these has implications for CTRs that can either hinder or enhance the child's progress toward recovery.

### **Damaged Self Syndrome**

Most, if not all, stressors leading to post-traumatic stress responses and U- VTS may be described as a violent intrusion into the self, its organization, integrity, and adaptive functioning. The concept of damaged self syndrome is an explanatory one, deriving from clinical observation of children's responses to extreme or chronic violence as seen in their behavior and interactions with others, and in analysis of dreams, nightmares, and spontaneous recall of events. Children with damaged selves appear to be in constant psychological distress.

The sense of powerlessness over the traumatizing environment creates within the child a sense of insecurity and an experienced sense of impotence. Chronic feelings of impotence harm the child's sense of self, which turns to a compensatory feeling of omnipotence to cope. With this sense of omnipotence, the child feels and behaves as if nothing can affect @ or her, that the self is impregnable against further hurt and feelings 'Of vulnerability. Vendetta rage is primitive, narcissistic rage against parental figures, other so-called protectors, and authorities and society. The damaged self, moreover, often maintains its organization and integrity by managing anxiety via the creation of defenses to protect inner vulnerability. This may be a partial explanation of why victims become victimizers.

Thus, traumatically damaged children appear disposed to impulsive actions that harm themselves (as in self-mutilations), and that defensively inflict damage to others, perhaps thus unconsciously "spreading the damage around." Violence, for many youngsters, is an issue of self-esteem regulation. This reflecting of self through violence against others is unconsciously geared to repair the experienced damage to self-esteem and to master the inner fragmentation, annihilation anxieties, and agonies in the child.

Referring to inner city children struggling with hyperaggressive impulses in a school-based therapy group, Dyson (1990) makes a similar observation: "Violence, for them, seemed the only way to repair their injured self-esteem' (p. 19). For some children, moral development becomes permanently fixated at the primitive vendetta or "pay-back" stage (Field, 1977,1985; Garbarino, Kostelny, & Dubrow, 1991; Tapp, 1971).

This is often one of the most problematic issues for therapists, namely, the apparent transformation of the child from passive recipient to perpetrator of violence. This is because basic traumaphobia (fear of trauma repeating itself in some children becomes traumatophilia (attraction to trauma) as a way to manage the internal effects of violence.

Like the survivors of psychological damage Krystal and Niederland (1968) saw in their clinical work with survivors of the Holocaust, many traumatized inner city children feel fragmented internally. Dissociative reactions in traumatized children represent a breakdown of internal systems of coordination of sensory, perceptual, affective, and conceptual functions. It implies that the child's synthetic and integrative ego functions are defective, and that there may be a blurring of self-environment boundaries. Dissociation accompanies psychological traumatization in inner city children, and it ranges in severity. Therapists can react to this with pity, an unhelpful Type 11 CTR (see Chapter

2, this volume). However, if they monitor their countertransference, they can instead offer an adaptive containing function" (for the split-off, anxiety-driven defenses) for the child's ultimate benefit.

Meaning, purpose, and feelings of safety are the casualties of trauma, and they are replaced by cynicism, apathy, shattered values, and distrust. For many children these positive attributes have been stripped away from their lives as sequelae to traumatic witnessing. Toby (Case Example One) used this existential defensive strategy to cope with the murder of her father in her presence.

Tainted by death, loss, and a surfeit of sorrow and grief, children often suffer intense anxieties related to a sense of "death immersion" (Parson, 1988) or to what Lifton (1982) has identified in adult survivor groups as the "death imprint." Death-related anxiety comes from identification with the dead and the sense of being trapped in death with the deceased relative, friend, or other persons who died. Rage over physical and psychological injuries endured often prevents the working through of sadness, grief, and sorrow.

Both children discussed above in my case examples had grief and mourning reactions after their stressful experiences, particularly Toby. As the child's death imagery floods the treatment, the therapist's challenge is to begin to see how death invades the therapy and to monitor his or her defenses against it. Sustained empathic responses by the therapist may serve as a holding posture through which the child learns how to manage internal death stimuli and thus integrate the trauma.

There are many other expressions of narcissistic injury in children. Many of these themes have been discussed elsewhere (Parson, in press; Wilson & Raphael, 1993) but are important to identify here, despite the fact that space limitations preclude a full discussion of them. Among the indicators of damaged inner-self structure following urban violence are (1) cumulative grief and mourning, (2) feelings of hopelessness and powerlessness, (3) a sense of betrayal and defilement, (4) fears of recurring trauma and violence, (5) the expectation of danger and violence, (6) a loss of future orientation, (7) feelings of incompetence and an external locus of control over life events, (8) a disposition for self-abuse, (9) detachment and a loss of bonding capacity, and (10) dysfunctional socialization—a reversal of the normal, healthy patterns of interaction with abnormal and disruptive socialization.

### **Trauma-Specific Transference Paradigms and the Imprint of Violence**

Stress associated with violence is often so toxic that a complex mental imprinting process occurs, which can alter the child's personality. This alteration sets up a number of response tendencies in the child that the therapist identifies and uses to enhance the efficacy of the treatment experience. For example, after trauma the child may experience self as both victim and perpetrator, as innocent and culpable, as passive and active, and as rescuer, benevolent authority, or malevolent authority.

Transference reactions occur in therapy when the unconscious dynamics of the child are activated in relation to the violence experience. The therapist is often seen in a distorted manner (e.g., as a perpetrator, a nonbenevolent authority that caused the trauma, etc.), and, depending upon the stability of the child's reality-testing and controls, he or she may a' Out Psychological or physical violence in the course of therapy.

Children who were exposed to violence are often confused when they come for treatment, and so struggle between passivity and aggressivity. Although the latter may initially be avoided because it is too closely associated with the behavior of the aggressor, the former may be embraced as a way to distance self from internalized violent impulses. The child may later find the aggressive mode to offer an increased sense of inner stability and self-esteem management.

In violent trauma, the child internalizes self-images in relation to the traumatizing event, and self in relation to other people at the scene of the event. Thus, "trauma-engineered" identifications serve as the basis for transference responses in therapy. These are (1) victim-self (identification with the victims), (2) victimizer-self (identification with the aggressor), (3) rescuer-self (identification with constructive, competent behavior at the scene), and (4) authority-self (identification with culpable or responsible persons or government institutions).

Early in post-traumatic child therapy, Danny (Case Example Two), in the rescuer-self transference, saw the therapist as helpful but vulnerable, impotent, and self-destructive (his father had tried to help him but was killed in the fire). Seeing his father as self-destructive was an interesting distortion of the actual facts, but such distortions offer great opportunity for working through the child's traumatic responses and problems. The child's own self-destructive

behavior was an identification with his dead father whom he perceived as "killing himself" in the fire. Later in the therapy, Danny realized that his father had not intentionally lost his life to hurt him.

A significant stressor (e.g., shooting) is therefore associated with co-occurring, multisensory immersion such as sirens from emergency vehicles (fire trucks and police cars), other loud noises, screams, confusion, shouting, smell, temperature, and other sensations. Transference reliving of trauma elements may be triggered or accompanied by any of these sensations. Socioenvironmental stimuli may trigger traumatic responses through one or more sensory channels, which may then be reenacted during treatment.

The therapist may be unconsciously seen as a benevolent and caring authority, as a victim or covictim, as a rescuer, or as a violent perpetrator from the traumatic scenario. These transferences should be addressed in most psychotherapy approaches with children. They are, after all, the other side of countertransference and constitute one whole unit.

CTRs may vary from time to time depending upon the specific identifications projected onto the therapist by the child. For example, if the child in the transference views the therapist as a violent perpetrator, he or she may invoke punitivity, violence attribution, or some other Type I CTR in the therapist.

Adaptation to danger may involve becoming "danger" itself: this may serve defensive ends, in that it spares the child the pain of experiencing the self as passive and vulnerable, or as different and separate from others in the socioecology. As such, these defenses can result in transference projections. The child's defenses against inner vulnerability may arouse latent fears and anxieties in the therapist that set CTRs into motion. However, by becoming the selfobject (Kohut, 1977), the therapist creates the climate in which violence-mitigating internalizations and a sense of internal safety can occur.

### **Cognitive and Emotional Stress Response**

Cognitive development incrementally shapes and defines the child's view of the world. Piagetian theory of cognitive development is germane to understanding how in eyewitness trauma children's thinking and feeling are altered by the event(s). Traumatized children suffer a number of cognitive symptoms that include having trouble concentrating and attending to what is going on in the home, school, and community.

The cognitive stress response is a dematuring of the traumatized child's cognitive functioning. It is marked by regression from formal and post-formal operations thinking to more concrete operations as seen in (1) the deficits in cognitive controls and related loss of conservation and misalignment of emotion, time, and reality, (2) loss of once acquired language effectiveness in categorizing information, (3) disturbance in object constancy, and (4) a reactivation of sensorimotor functioning-focusing on less well-organized perceptual memories. Attention deficit disorder (American Psychiatric Association, 1987) is frequently found in cases of chronic exposure to violence stress. The existence of regressed states or attention deficit disorder causes a number of academic deficiencies in traumatized children. It may also be associated with the development of irrational omens.

The chief psychological reaction of children after trauma is an intolerance for strong affective tensions. Disturbing emotions include fears (e.g., fear of being alone), sadness, grief, guilt, depression, shame, anxiety, anger, belligerence, revulsion, despair, poor impulse control, and persistent, anticipatory fear of being overwhelmed by strong affects and losing control. The specific emotional symptoms and adaptive responses that children show after trauma are naturally dependent upon their developmental phase.

Emotional stress reactions reflect the disturbances in the reciprocal coordination of assimilation and accommodation that often accompany psychic trauma in children. Problems in this area produce serious impairments in self-regulation and in human relationships. Trauma-origin regression (from mature to immature developmental levels) is noted in the child's (1) reversion to intense psychophysiological symptomatology, irritability, and hyper-vigilance; (2) sleep problems; (3) annihilation anxiety; (4) separation anxiety; (5) panic attacks; (6) phobias (relates to specific places, persons, and structures in the physical environment); (7) enuresis or encopresis; and (8) the undoing of basic trust.

### **Stress Response Impact on Moral Behavior**

Extreme or prolonged exposure to threat, danger, and violence may force a regression from advanced forms of moral reasoning to primitive levels of moral conviction and behavior. Changes in moral behavior may be sequelae to violence exposures shattering of pre-traumatic values, moral and ethical mental structures. In addition, the child may regress from a rational, beneficial, utilitarian stage (Tapp, 1971) to a morality of absolutist obedience, punitivity, and "a vendetta mentality" (Garbarino et al., 1991, p. 379; see also Flavell, 1983; Kohlberg, 1964).

It is important to keep in mind that strengths may also result from violence stress among urban children and youths, for social conflict and dangerous conditions may stimulate growth and moral development in many disadvantaged children (Coles, 1967; Garbarino et al., 1991), especially if there were opportunities for early "introjection of parental demands" (Mahler, Pine, & Bergman, 1975, p. 192) or the opportunity to transform traumatic experiences in more resilient ways. Violence-based trauma often truncates human connectedness and breaks the "great chain of humanity" that connects us all. As a consequence of both psychic trauma and the failure of the post-violence milieu to restore confidence, trust, and function in children, many of them become hardened to other people's needs and points of view, adopting an interpersonal anesthetic in the form of a cold, tough, aloof, and intimidating street-wise demeanor. In the aftermath of trauma, the child finds that painful, suppressed, repressed, and split-off feelings are difficult to express in words. Due to the relative reduction in the ability to use symbols, many children release tensions more through action than through thinking and reflecting. Many are unable to sit still for even a few minutes; they are unable to attend to details at home or at school. Post-traumatic behavioral abnormalities have a negative effect on these children's immediate social environments and result in rejection and hostility from others. Conduct disorders are significantly represented among traumatized children.

### **PTSD**

Urban violence may result in PTSD, a psychiatric malady that manifests in the aftermath of overwhelming events (American Psychiatric Association, 1987). Frederick's (1985) research study on 150 children (50 survived disasters, 50 were victims of physical abuse, and 50 were sexually molested) found that 77% had PTSD. Arroyo and Eth (1986) found that 33% of children traumatized by Central American warfare had PTSD. Though the adequacy of the PTSD diagnosis for children has been documented (Parson, 1994), the DSM-III-R (American Psychiatric Association, 1987) included developmental issues that strengthened the diagnostic criteria for children. Thus, the following child-sensitive criteria have been added. These are (1) reliving via repetitive play, (2) loss of acquired developmental skills (e.g., bowel and bladder control, motility), (3) sense of foreshortened future, (4) omen cognition, (5) personality changes, and (6) regression in attachment security, resulting in separation anxiety and fear.

### **VULNERABILITY TO U-VTS**

A child's vulnerability to toxic socioenvironmental stress involves several factors: the nature of the stressor, its severity and duration; the child's achieved developmental level, nature of family/community social support network, history of exposure to violence stress, previous psychic trauma (physical abuse, sexual abuse, etc.), and the child's personality organization before the episode (a critical factor, because urban children may have been exposed to many stressors). One or more of the following vulnerability factors may apply to a specific child.

1. Complete lack of parental care and absence of "good-enough parenting."
2. Paucity of credible and respected models, driving children toward identification with and emulation of the violent aggressor, the pimp, or the drug dealer.
3. Narcissistically traumatizing parental figures (those who wound the child's sense of self and safety by fostering chronic frustrations and disappointments).
4. Abuse by caretaking figures-the use of psychological means to abuse and devastate the child's sense of self and security.
5. Traumatizing parental behavior-inflicting physical and sexual trauma, such as brutalization, incest, rape, and the failure to provide 'de a protective shield for the outside the home setting.
6. Lack of functional secondary family system (i.e., extended families, teachers, ecclesiastical figures, etc.).
7. Family aggression (e.g., wife-beating, husband abuse by wife).
8. Ineffectual ecclesiastical influences, eroding values, and lack of ethical and moral base.
9. Prevalence of drugs and pervasiveness of dependency/abuse.
10. Ineffectual educational institutions that kill hope in children.
11. Chronic cynicism and distrust of parents, teachers, elders, and other authority figures in the urban community (overtly disrespected, and covertly seen as "damaged models," too weak, too passively acquiescing to the racist status quo to inspire hope, confidence, and trust in youthful populations in trouble).
12. Breakdown of mutual trust and respect between law enforcement and youth and adults of inner city communities.

13. Instrumental violence (for power over adverse environmental contingencies, internal fears, learned helplessness, and low self-esteem).

14. Racism and its evil derivatives of systematic exclusion, leading to poverty, high infant mortality, high rates of incarceration, especially among black males.

Realistic knowledge about vulnerability factors, U-VTS, PTSD offers the therapist an opportunity to cope with potentially harmful CTRs when intervening with the urban child in trouble.

## PATTERNS OF THERAPISTS' RESPONSES AND COUNTERTRANSFERENCE MANAGEMENT

Therapists working with children and adolescents living in violent urban worlds face particular forms of CTRs—some beneficial and some potentially harmful to the child. My view is that countertransference is as important as transference, and that the ultimate success of the therapy depends upon the therapist's use of the "empathic tools" found in positive CTRs. Thus, in any intervention, "clinicians must come to believe that there is not only no place to hide, but also no reason to do so" (Maroda, 1991, p. 5).

### Countertransference Considerations in U-VTS Treatment

#### **Minimizing Response**

Therapists who have this kind of Type I CTR may, for example, see the violence in urban areas as unusual but not clinically traumatic. They believe that no significant psychological scars and symptomatology should occur in these violence-exposed children, or they assume that the child will "grow out of it," and that such exposure is "normal for urban kids." These therapists often have great difficulty dealing with their own aggressive histories, impulsivity, passivity, sense of vulnerability, and they may feel overwhelmed by the child's stories of trauma. In Toby's case, for example, a therapist might have found it difficult to believe that the child had gone through such a horrific loss and traumatic ordeal.

#### **Avoidance/Fear Response**

When a therapist experiences avoidance it is usually a fear of reliving the child's traumatic past. This manifests in therapists who are confronted by intense reexperiencing symptoms by the child. In this instance, the therapist is unable to model the necessary courage and confidence the child needs to verbalize painful and "dangerous" emotions. A Type I CTR, avoidance is often too rigid to contain the child's fears and anxieties; to assist in achieving a sense of safety, freedom, and inner tranquility; and to efficiently process the trauma. Maneuvers to manage death imagery in the child's clinical dynamics may also be related to avoidance phenomena.

#### **Racial Bias Response**

This response derives from unresolved conflicts around racial prejudice, particularly unconscious racism (Butts, 1971). Views of urban children as "violent" and as "difficult patients" may find their source in racial or ethnic bias in the therapist.

#### **Pitied Child Reaction**

These therapists view the child as pitiful because of the tragic exposure to traumatizing violence. In this response, the therapist identifies with the helpless aspects of the child's experience and may fail to recognize and identify with the child's strengths and potential resiliency. If the therapist lacks self-confidence in alleviating the child's distress, he or she may vacillate between avoidance (or reluctance) to intervene and overidentifying with the child. In both case examples (Toby and Danny), therapists with these fears might see the children as hopelessly damaged and possibly too far beyond their professional capabilities and emotional stamina.

#### **Passionate Parenting**

This Type 11 CTR is found in therapists who are motivated to "right all wrongs" suffered by the child. They unconsciously desire to fulfill the child's total narcissistic and dependency needs as expeditiously as possible. However, though the therapist might be intent upon "spoiling the child," he or she actively avoids getting to know the child's own reality and "true self" (Winnicott, 1975) aspects of personality.

### **Raciocultural Countertransference**

Some therapists are uncomfortable with racial issues in psychotherapy. Race refers to the historical legacy of a group of people whose phenotypic characteristics distinguish them from other groups; for example, the black race is ostensibly distinguished from the white race by skin color and other physical characteristics. Cultural means of or pertaining to culture, culture being the "shared creativities" (Hilliard, 1984) of a group of people, which include values, art, language, and othersymbols of collective life. "Racio" is a combining form that refers to race. The term raciocultural thus refers to issues pertaining to racial differences and associated subjectivity in a context of a shared reality and customs. CTRs motivated by raciocultural issues are important to highlight in any discussion of therapists' responses to inner city children in therapy.

Some therapists, who may have been raised with strict discipline, negate the urban child's morality. They view the child's behavior as "loose" or "undisciplined," requiring reprimands and strict control in the therapeutic space. Often influenced by media reports, some therapists view urban children and families as basically immoral.

Additionally, many therapists, in different parts of the world, may view impoverished inner city children as inherently violent. This perception and bias may undermine the therapists' ability to interact therapeutically with the child. Holding such a view may create ambivalent feelings as to whether the child is a passive witnessing bystander or an active victimizer.

On the other hand, some therapists may be fearful of being the therapeutic target of intense transference reactions by children who have been exposed to violence. Children relive transference relationships associated with the violent event. When the child's transference feelings distort the therapist into being the perpetrator or victimizer, denial, avoidance, and other defensive mechanisms may be used in order to keep the child's feelings in check so they do not overrun the therapist's capacity for control.

The therapist may be concerned about the possibility of repeating the parental abuse, neglect, and abandonment suffered by the inner city child. As a result, the therapist may remain counterphobically aloof and avoid taking responsibility for the treatment enterprise. A Type I CTR abrogation of leadership is not uncommon in the treatment of trauma survivors (Parson, 1988), but does need to be managed for optimal beneficial effects.

### **Organizational Countertransference**

Organizations have long been seen as living systems that may be understood by using dynamic principles borrowed from individual psychology. Organizations, like society as a whole, view certain racial or ethnocultural groups as inferior, deserving the harsh realities of crime, poverty, disease, and traumatic violence-of the life to which they are subjected. Similarly, emergency rooms, clinics, hospitals, and other health care facilities may allow the collective negative view (often stereotypes) of blacks, other ethnic minorities, and indigent white individuals to cloud their professional judgment in terms of offering equal or comparable quality of health care.

Countertransference management refers to the therapist's active coping with negative, treatment-destroying feelings and transforming these into empathic orientations that work on behalf of the child. Management efficacy may call for supervision, peer supervision, and training for therapists. It is important for therapists to explore and monitor their ethnocentrism and their feelings about race and about people who differ from themselves in economics, politics, race, religion, and gender.

### **POST-TRAUMATIC CHILD PSYCHOTHERAPY AND COUNTERTRANSFERENCE**

Like dreams and traumatic dreams, play in child psychotherapy is perhaps the most direct way to access and influence the child's inner world of traumatic responses and illnesses. This is accomplished in part through the countertransference-controlled "archaeological work" of using cues from the child's trauma behavior that take "into account the nature of the ... [traumatic] destruction in order to ... make inferences about what has been destroyed ... and its possible function" (Ekstein, 1966, pp. 134-135).

### **Empathic Resonance: Instrumental Countertransference**

Integral to the practice of post-traumatic child therapy (PTCT) is the monitoring of negative CTRs and the applications of positive CTRs or "instrumental countertransference" to promote healing in the child. This response is one that places the child at the center of the therapy through empathic resonance. The term "resonance," as I use it here, comes from the fields of electronics and mechanical engineering. It is defined as "the enhancement ... intensification and prolongation of a tone by sympathetic vibration" (Concise American Heritage Dictionary, 1980, p. 601). The child's "tone" is the traumatic anguish of sadism, brutality, and cruelty seen or endured. Empathic resonance enhances the strength of the therapeutic alliance.

The therapist's own positive regard affirms the tone, elaborates it, and by doing so makes the child's intrapsychic data materially present and real. It then becomes possible to reflect this back to the child in a "language" the child understands. The therapist may feel empathic horror, rage, outrage, contempt, shame, guilt, and fear of the child's trauma narrative and potential for violence transference. These reactions are sympathetic vibrations" intuited through empathic channels of therapeutic communication in order to understand the child from within.

Owning the traumatized child's grief, hurt, anguish, anxiety, fears, guilt, and shame is the sine qua non of adaptive intervention with intrapsychically unstable, environmentally terrorized children. Unless the therapist can say of the urban child, "This part of you is I" and "This part of me is you" (Racker, 1968, pp. 134-135), the inferred emotional distance from the child endangers the efficacy of the intervention.

Basically, PTCT seeks to achieve empathic understanding, child-sensitive communication, reconstruction, and the filling in of missing events. PTCT incorporates three phases that integrally utilize the therapist's responses. These are (1) ego stabilization and development of trust, (2) return to the scene," and (3) working through and completion.

#### Phase 1: Ego Stabilization, Trust, and Attachment

The post-violence assessment is critical to realistic treatment planning. Parents may be seen alone and then with the affected child. Family and extended family members are considered in the assessment process, and the therapist's relationship with the child's family is seen as critical to efficacious outcome. After these two meetings the child is seen alone in a separate interview.

The formal assessment involves a structured interview to determine the following: (1) presenting complaints; (2) mental status (examining the child's orientation, motor and sensory functioning; mood, memory, judgment; and delusional or hallucinatory symptoms and behavior); (3) demographic information, medical history, developmental milestones and stress points, parental assessment, academic functioning, social behavior, the degree of impairment or disability, and the history of exposure to familial and community violence; (4) the specifics of the violent stressor event (e.g., shooting, stabbing); (5) post-violence psychological screening; (6) who was harmed and how the victim responded ("Children who witness injury to others and hear their cries for help appear to be especially vulnerable" [Pynoos & Nader, 1988, P. 447]); (7) the child's violence stress response symptoms; (8) the nature and cohesiveness of social supports (children recover with appropriate social support [Sander, 1967]); (9) the impact of parental trauma (Haley, 1987); (10) deleterious societal forces on the child's symptomatology; (11) the possible relationship between trauma and borderline personality disorder in the child (Parson, 1988); (12) "steeling qualities" (Rutter, 1987, p. 326) (used by some children to protect themselves from mental breakdown and from being overwhelmed); (13) problem formulation; and (14) recommendations.

The child's stabilization depends upon a psychologically stable and competent therapist who models trust and attachment behavior. Here, the child learns to internalize the safe, nonviolent, and stable environment. The therapist sets the tone for the treatment, strives to establish a working alliance with the child, and approaches the child in a positive, inviting manner.

It is important to remember that the child did not come to therapy on his or her own but was brought, and that therapy was probably considered as necessary only after previous strategies did not work. The therapist talks to the child: the child is reassured that the therapist feels deeply about the tragedy, cares about the child's welfare, and that the ordeal the child went through is of great interest to the therapist. Additionally, the child is told that the therapist can help because of interest and experience in helping children in similar circumstances feel less fearful, have fewer frightening dreams, and feel more relaxed and in control.

In the process of clinical management, the therapist takes a good clinical history of the traumatic event(s) in a systematic, step-by-step manner, investigating what happened (the cardinal behavior or event the child witnessed), and when, why, and how the child survived and is surviving. These data are later framed and structured to assist in

achieving the cardinal task of Phase 2. The child is debriefed as a victim of violence by discussing the normality of violence stress responses and the ventilation of feelings, by detailing the fact about what happened, and by exploring and clarifying thoughts, sensory impressions, and emotional reactions.

In this phase the child is also given opportunity to release pent-up emotions, and to express fears, anxieties, phobic reactions, contents of nightmares, guilt feelings, grief over losses, blame, shame, punishment, and retaliation. These same issues will come up for exploration in Phases 2 and 3 as well. However, they are approached very differently. The emotionally immature child often expresses strong affect too soon and too intensely before sufficient ego maturation has occurred. For some children, this can be "retraumatizing" because the overwhelming nature of affectomotor responses bombard the sense of inner security and safety, resulting in hyperarousal and emotional constriction.

As the child's chief auxiliary ego or the person who will satisfy the child's post-trauma needs, the therapist provides an essential "affect-buffering function," by being a person who functions as protector against overstimulation. Children of trauma harbor strong aggressive feelings of retaliation or vendetta against people, things, objects, circumstances, and fate. Assisting the child early in therapy with feelings of guilt and vendetta rage can result in great psychosocial dividends of positive attitude and behavior change. Pynoos and Eth (1985) report that early in treatment children get the most benefit when drawings of their revenge fantasies are discussed.

As noted before, children with trauma bring to therapy intense fear, anxiety, feelings of inferiority, inner tensions, distrust, irritability, demanding and/or withdrawn behavior, low frustration tolerance, sleep problems, temper tantrums, fear of sleeping alone (in younger children), and a fear-based avoidance to becoming emotionally connected with the therapist.

The notion of therapy as an exclusively child-sensitive enterprise suggests that the child is accepted as he or she is, the child is offered freedom from inhibitions, the child is sufficiently understood to make identification and interpretation of feelings possible, and the therapist sustains empathic attunement over personal CTRs, keeping a focus on the child's needs and welfare, not on the therapist's unconscious feelings. Like other children, Toby in Case Example One was distrustful of adults because she had witnessed adults engage in kidnapping, stealing, cheating, lying, inflicting pain on children and adults, killing, and going to jail.

Denial of the trauma may still be present, and numbing may make it very difficult for traumatized children to get in touch with feelings in therapy. Such children are usually unable to express feelings directly. They are reluctant or unable to recall elements of the trauma and are intensely fearful of losing control over painful intrusive and repetitive images, ideation, affect, and memory. They also may fear "affective returning" and may have problems regulating their pessimism, depression, and inner world of confusion and chaos. This emotional chaos is in part caused by a "disturbance of affect- (Krystal, 1978) that makes it difficult for the child to know what he or she is feeling and to experience sharp, definite emotions. Associated with this disturbance of emotions are the underlying pathophysiological mechanisms and chronic family and community violence stress.

Some violence-stressed children may have a compulsion to move, and to keep moving to control hyperarousal, anxiety, and the associated fear of the "return of the dissociated" (Parson, 1984). A deep sense of insecurity (or defenses against it) is evident in these children: they never seem sure that the past will remain in the past. Therefore, like Toby, they anticipate new tragedies-new shootings and killings, new losses, new fears, and more disappointments-and they see life as short and their self as irreparably damaged.

Many indigent minority and white "multiple-problem" patients at first require concrete services as vital adjuncts to therapy. In Toby's case, therapeutic planning and implementation included local, community based medical and social services organizations as an extension of her therapy. Food stamps and other social welfare services are essential for poor inner city families, particularly in those family systems where parents are not able to provide food and shelter for their children. An example of an external therapy-bolstering intervention (i.e., coming from sources outside the therapy relationship) is Friedlander's (1945) child guidance work in Great Britain after World War II. She found that the child's conflicts and difficulties were remarkably improved when she applied psychoanalytic theory to the entire child guidance process, and focused on prevention and on a program of education for parents, professionals, and the public.

## **Specific Treatment Techniques**

Useful techniques for Phase 1 include stress management (particularly essential for entering Phase 2), therapeutic drawings and art, structured drawings, role-playing, and approaches that deal with desensitization of fear and cognitive restructuring. These latter approaches are utilized primarily to manage angry feelings to irrational thinking, which interfere with healing and recovery. As time progresses, psychological consolidation takes place as less internal fragmenting and dissociation are noted in the child's cognition, affect, and behavior. Reducing the child's sense of unpredictability and uncontrollability, both of which lead to "persistent arousal and increased generalized fear" in animal and human studies, contributes to the consolidation of intellectual, perceptual, emotional, and behavioral functions of the child (Foa, Zinbarg, & Rothbaum, 1992). Psychopharmacological agents for anxiety, depression, and other symptoms may be used as adjunctive therapy to the overall clinical strategy.

### Phase 2: Return to the Scene

Returning the violence-stressed child to the scene of the incident (either physically or through memory work) is a necessary dimension of play therapy for severe cases of U-VTS. Accompanying U-VTS are 'toxic memories,' which trigger mechanisms of cognitive, affective, and physiological arousal that prove tormenting to every aspect of the child's life. Children suffering from the traumatic information embedded in these memories require the application of direct action techniques. Such direct techniques involve taking the child in vivo to the place where the incident occurred (through an affectophysical return), or guiding the child through postviolence reconstruction procedures (an affectocognitive return), in a "frame-by-frame, slow-motion reworking process' (Frederick, 1985, p92)-that is, "a controlled regressive pathway to the traumatic experience' (Parson, 1984, p. 35).

Frederick (1985) is correct when he points out that "merely talking will not suffice in undoing serious psychic trauma in either adults or children." Consistent with my own experience and previous theorizing (Brende & Parson, 1985; Parson, 1984, 1988), Frederick states that "trauma mastery must be incident-specific for specific resolution of the problem' (p. 93).

Undoing traumatic information, amnesias, and the related affective rigidity and constriction requires a return to the scene of the traumatic violence. Cognitive, behavioral, and stress management techniques designed for children and adolescents are most useful in preparing the patient for Phase 2's psychological return. Additionally, experience has shown that such temporal factors as the days of the week, time of the day, month and season of the year, anniversary dates, and holidays associated with the violence are integral to therapy with traumatized children. These are important markers for understanding the child's experience, aiding the regressive process, and ultimately achieving integration.

Specific approaches to achieve this goal include the post-violence, mutual story-telling technique (a modification of Gardner's [1975] interactive approach with resistant children), play, therapeutic color drawings, kinetic family drawings, and traumatic dream script rewriting (for adaptive outcomes). Some children and adolescents may benefit from "in vitro flooding," a behavioral approach understood in dynamic terms as a regressive therapeutic technique.

Because witnessing life-threatening events depletes mature internal resources and may replace them with dynamically less mature forms of functioning, it is clear that oral dynamics become pronounced after violent threat or traumatic witnessing. This therapeutic regression instigates responses geared to protect the self from intense stimulation and sensations of fear; of ravaging, devouring rage; and of reliving the scene of violent action through repetitive-intrusive responses. For this purpose, offering warm milk, hot chocolate, snacks, and other oral supplies can, in addition to the nurturing and encouraging presence of the therapist, motivate the child to persist in the very difficult task of reliving the painful event.

### Phase 3: Working Through and Completion

In Remembering, Repeating, and Working Through, Freud (1914) spoke about the resistance against recollecting memories from childhood. He believed these memories lay at the root of his patients' neurotic illnesses. This process is also applicable to the treatment of U-VTS. Freud believed that, although uncovering, remembering, and repeating painful memories during the course of therapy were important objectives (as in Phases 1 and 2 of the present model), only working through them offered integration, long-term resolution, and positive lasting change.

In the working-through phase, many areas of Toby's life (Case Example One) were explored, including profound dependency, self-destructive propensities, impacted grief, bereavement, sadness, depression, accident-proneness, nightmares, stuttering, nervous tics, insomnia, and rage over her father's murder in her presence by cruel assailants. These data were often used to identify points of impasse and to gauge degree of ego integration.

Many of the transference responses in therapy are tainted with violence, and it is usually violence and threat in the transference that induce Type I CTRs in some therapists. Though there has been a history of debate about the validity of the transference concept in work with children, the significant clinical evidence points to its utility and inevitability in moving the treatment forward (Parson, 1994; Trad, 1988, 1989, 1990; Trad, Rine, Chazan, & Greenblatt, 1992). Only when trust has been established, and the therapeutic alliance is solid, can the therapist interpret transference and share with the child the therapist's counter-transference feelings.

Dyson (1990), an experienced therapist with inner city children of trauma, recommends "intensive psychotherapy programs ... on a wide scale within the black community, as these children do, in fact, benefit from insight-oriented and supportive counseling" (p. 21). This is consistent with my observations and experience with inner city children. As both Toby and Danny continued their work in therapy, they manifested greater insight, sharper ethnocultural identity, and a greater capacity to see nonviolence as an alternative to violence in solving problems.

Children's traumatic experiences usually catapult them into "premature entrance into adulthood" (Pynoos & Eth, 1985, p. 243). Child-sensitive interventions allow the child to be a child again, to restore the broken link between self and others through forming new human attachments (Emde, 1982; Field, 1985), and thus to achieve growth and maturation beyond violence trauma. Working through sadness, grief, loss, bereavement, and other emotions of the post-traumatic affective response syndrome (Parson, 1988) is also a worthwhile achievement for the child.

Working through traumas with Toby and Danny called for some form of "socioenvironmental engineering"-that is, engaging public and private social agencies in the child's behalf (e.g., by getting specific information on what children and their families could do to remain safe on their way to school). Contacts with family members, the school, the church, and other persons and agencies are important aspects of PTCT. These contacts function to help reduce high levels of therapy-subverting stress from the home, community, and school.

During the working-through phase in the treatment of an inner city, African-American male child with dangerous levels of internalized rage and self-hate, Trad et al. (1992) found that assisting the child "to make connections between his behaviors and intentions ... his actions and his feelings ... his aggressive behavior and his anger" (p. 653) proved to be illuminating and integratively constructive in managing self-destructive behavior and violent propensities.

## CONCLUSION

The concept of PTSD is inadequate to capture and describe the comprehensive nature of violence trauma in inner city children. U-VTS is a new term, which identifies a spectrum of violence-related responses in inner city children. Like PTSD, it occurs as a consequence of threats to a child's life and physical integrity, or of witnessing a person who was seriously harmed or in the process of being seriously injured. Unlike some forms of PTSD, U-VTS is totally "human-engineered." Violence trauma is injury to the self-structure of the child. Its consequences are often profound and severe.

In PTCT, the child succeeds in establishing a meaningful, supportive relationship in psychotherapy, so that the internalized violence structures of helplessness and vendetta rage may be transformed into structures of control and self-efficacy.

At this time, the effects of violence upon the minds of children are not well understood. Because of the impact of violence on behavioral adaptation, the child experiences internal disorganization and fragmentation.

Therapy aims to restore a sense of organization and cohesion. The general goal of therapy, then, is to assist the child to integrate violence trauma, and to effectively cope with subsequent exposure to violence and its psychosocial impacts. As long as the child remains in the atmosphere of violence, the more psychotherapeutic and psychologic support he or she will need over time.

Violence continues to be a major public health problem in the United States and in many parts of Europe, the Middle East, and Asia. We need to understand more about the root causes of children's exposure to ongoing violence and a world that creates jackals and predators who say, 'It's killing time.'

This chapter has focused on children's problematic responses to witnessing violence, on therapists' responses and on the importance of understanding children's coping abilities (Parson, 1994). It has acknowledged "that the occurrence

of the actual (traumatic) event ... fundamentally skews ego formation, and distorts affective growth while casting a pall over object relations development" (Schaer, 1991, p. 15). However, the following is also true: "Clinical practice informs us that despite the existence of overwhelming, frightening events in the lives of innercity children, they do not become marasmic, literally withering on the vine due to their submission to a hostile environment" (Schaer, 1991, p. 14).

Preventing violence from becoming a part of inner city children's life-style is an important social goal. For inner city children, preventing violence exposure means preventing violent behavior in the future. PTCT may reduce the power of internalized violence in the child through a living relationship with a therapist who commits to understanding U-VTS and PTSD, and who also commits to countertransference management during PTCT. The importance of addressing this issue of generational violence cannot be underestimated; left unchecked, violence will grow, with consequences yet to be realized. Effective social policy and interaction may not only save the lives of children, but also offer new paradigms of mental health service delivery structures. What is at stake is the well-being of the next generation of Americans, those subjugated to the perils of injustice, and often to the ills of economic and political inequity.

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