

**Child-in-Family Services**  
**P.O. Box 2866**  
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**979-733-3232**

## **Evaluation Summary**

**Subject:** Peggy Sue Davis  
**Date:** 2/31/08  
**Date of Evaluation:** 2/24/08  
**Age:** 8  
**Evaluator:** Beth Powell, LCSW

### **Method of Evaluation:**

-Thorough Current and Past History/Observations (from Foster Parent and CPS Caseworker)  
-4-hr. Observation of Child Interacting with Others, With Self and With Toys  
-Neurobehavioral Observation and Screening

### **Diagnosis:**

**DSM IV:**       **Axis I:** Complex Post-Traumatic Stress Disorder with Dissociative Features (309.81)  
**Axis III:** Significant Proprioceptive Deficits; R/O Immature Differentiation

### **History and Current Findings:**

Peggy Sue is in a foster home with a strong foster mom who seems like she can establish safety-security for her. It is important that this child not be moved around in the foster care system as the establishment of safety-security is imperative right now. Before trauma can be resolved, trust must be established. This child must have physical stability along with strong, loving, consistent caregivers so that the biochemical cascading effects of stress, which worsen already present post-traumatic stress disorder, can be arrested as much as possible. Past trauma cannot be resolved until the brain can get off of fight or flight.

Peggy Sue is a Texas CPS-placed foster child. She has been in her current foster home for a short time. She has a history of trauma, abuse and neglect. She has proprioceptive deficits (brain's innate knowledge of where the body is in time and space). One who has suffered abuse, trauma and large doses of fear has developed the ability to turn the proprioceptors to varying degrees of off, allowing the individual to enter semi or complete dissociative states. Sue talks to herself out loud, has imaginary friends, uses fingers to show her age, looks ADD, but is likely in a dissociative state instead.

Peggy Sue was on no medication for this day-long assessment. She is on a class II stimulant for ADHD, her prior diagnosis. I strongly question this prior diagnosis and medicinal protocol without a Spect scan.

She hasn't yet shown imaginative, therapeutic play, indicating a lack of sense of self, desires, internalized concepts of self, others and the world. Her play with toys seems like more of an attempt to simply keep the fingers busy, controlling outward signs of anxiety and to keep a low profile, so as not to be very visible, nor very vulnerable.

The more visibility a traumatized child has, the more they draw attention to themselves and the more they can be hurt by unsafe adults or unsafe, dominant (alpha) children. Peggy Sue is not an alpha. Even though she is in a safe environment, the template for "laying low to avoid danger," is still present. This is also what makes her a follower, not a leader, at this point. If she "follows" the alpha child or adult in whatever it is they do to make life miserable for others, her risk of getting "eaten" by one more dominant than her, lessens. It's kind of a "If you can't beat them, join them" mentality.

### **Therapeutic Recommendations:**

- a. Spect Scan with interpretation via Brain Waves in Houston to determine which type of medication, dose and frequency this child needs to help her balance biochemically to alleviate neuro-behavioral and psychological stress, if she needs any medication at all. Proper medication or removal of unnecessary medication can help therapy go so much faster, thereby making a child more adoptable, faster.
- b. If birth siblings are stressful to be around because of their behaviors, then it is unlikely Peggy Sue will be able to successfully resolve complex post-traumatic stress disorder due to the fact that her brain and body do not perceive she is safe, when she is in self-protection mode. A stressed brain does not learn. It does not habituate. No amount of medication or therapy will make a difference, if safety-security has not been established first. If Peggy Sue is in a home environment where there is a strong, negative juvenile leader she can follow, she will do it right now for purposes of self-protection and keeping a prior brain template in place.

If negative bonding between siblings has occurred, this is worse than no bonding ever having been established. Negative, destructive bonding can keep children caught in a toxic trauma bond with each other that can severely get in the way of a foster/adoptive parent's attempts to establish a sense of trust and attachment with the child and the establishment of a safe and secure environment. Keeping birth siblings together in this situation may not be in anyone's highest and best interests.

- c. A home-based neuro-behavioral (applied neurology) individualized treatment program is needed to strengthen the sense of proprioception.
- d. Altruism and socialization training in the form of heavy-duty modeling, re-do's, pre-do's and test-runs. See the work of Dr. Katherine Leslie and Texas Christian University's Book: **The Connected Child**. Also see **Raising Courageous Kids** web site. That is a link from my web site.
- f. See Dr. Bruce Perry's book, which is a great reference for what this child is going through: **The Boy Who Was Raised as a Dog**. It's about what traumatized children can teach us about loss, love and healing. It really helps one understand templates and dissociation.
- g. Remember the importance of teaching affect and the recognition, appropriate feeling and expression of emotional states. Remember the mad, sad, glad, and past or present game that was created for her in the evaluation.
- h. Remember, "As a man thinketh, he becomes." Please carry through with the prayer map to slowly transform unconscious and conscious negative beliefs about the world, the self and relationships. This exercise really can help to establish safety/security, a positive sense of self

and help in turn develop a new brain template for future success.

- i. Restititional mediation (victim-offender mediation) to atone for hurting others or to receive atonement for others hurting her. See manual that can be downloaded from my web site.
- j. Remember, time out or strong sitting with power cards to stop behaviors, and hand-over-hand to start behaviors. She can be so dissociative. I'd definitely use power cards regardless of the form of "thinking it over." She is a strong kinesthetic learner, as many traumatized children are. Hand-over-hand, re-do's and pre-do's help get the proper movement habitualized in the body. So reactions to such things as "Pick up your toys, please," initiates more rapid automatic movement of the body parts necessary for the efficient picking up of toys.
- k. Caregiver attitude is so important. A neutral, consistent, responsive, teaching attitude on the part of the adult caregiver is imperative. Strong, emotional reactions on the part of the caregiver can push a child like this into her comfort zone: Hindbrain. Unfortunately, this a part of the brain where she has the most experience and may struggle to get back to because it feels "normal." Changing the brain, the heart and the attitude is no easy task.

### **Conclusion:**

We had a long evaluation and treatment option session and it was a lot to train on. The child-in-family therapy approach trains home and school caregivers to help their children heal much faster and more cost-effectively. I still recommend that the foster mom and child return to my office for a few more trips so that the foster mom can further internalize our beginning plan (listed above) with Peggy Sue. Beginning plans typically are in place for about 3-4 months. The faster the child makes internal change, then the faster plans are updated. If the child has had unpredicted, but significant secondary emotional trauma for whatever reason (i.e., death of foster dog, addition of another child to the house, foster parent becomes ill), then the plan may need to be updated within this initial period.

Thank you,

Beth Powell, LCSW