Self - Regulation: Three Common Presentations

☑ Presentation #1: The Overly Constricted Child

The Overly Constricted Child	
Presentation:	The overly constricted child is often quiet, with difficulty initiating conversation, activities, and interaction in general. They are not oppositional, and in fact may be overly compliant. These children have difficulty describing any emotions, and a typical response to, "How are you doing?" is "Fine" or "I don't know" (which for these children, is a realistic response). Constricted children appear defended against emotional experience in general, and often lack an understanding of how to connect emotionally with others. A common adaptation to overcome this is to engage in "other-pleasing" behavior: constricted children may appear to subordinate their own needs, opinions, etc. In younger children this difficulty with self-expression may include failure to engage in imaginary play. These children may at times have explosive outbursts of emotion, in response to what appears to be minor stressors, as their intense control becomes overwhelmed or challenged. In the aftermath of this intense emotion, however, these children return quickly to a constricted state, and have difficulty acknowledging or processing the emotional experience. This appearance is often consistent with that displayed by the avoidantly attached child, and is common among children who have experienced some degree of emotional rejection and/or neglect (including that created by caregiver impairments, such as depression).
Primary Skills Deficits	(a) Limited emotional vocabulary (b) Limited skills to cope with and manage emotional experience, including positive emotions (c) Deficit in ability to seek social support, particularly in the sharing or management of emotional experience.
Function of this Adaptation	Constriction represents a child's strategy for coping with overwhelming emotion. In the absence of regulation skills and/or social support, the child relies on denying and withdrawing from emotional experience.

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The Overly Constricted Child	
Therapeutic Considerations	(a) Initial work should be displaced; gradually shift from external to internal (for example, help child identify affect in a television show or book character). (b) Help child identify cues associated with the affect. Behavior is often a good starting point, and less threatening than the feeling itself. Other children may respond to identification of body states or thoughts.
At Risk For…	Elimination disorders (constipation, refusal to urinate, urinary tract infections); eating disorders (particularly over-control of intake, such as with Anorexia Nervosa); substance use/abuse (particularly those which dampen emotional experience); anxiety disorders; mood disorders (primarily depression, dysthymia); revictimization

☑ Presentation #2: The Externalizing Child

The Externalizing Child	
Presentation:	The externalizing child relies on a "front" to prevent others (and often, themselves) from awareness of vulnerability and damage. This child generally has access to the "powerful" emotions – anger, injustice, blame – but little ability to acknowledge more vulnerable feeling states such as fear or sadness. This child often has a deep-rooted sense of shame and self-blame. At a feelings check-in in therapy, this child may readily acknowledge being angry at someone else, or upset about something that has happened that day, but will deny feeling hurt or worried about the incident. These children frequently externalize; emotion is generally connected to outside events, rather than their impact on the child. Perceived injustice is often a powerful trigger for these children, and injustice will likely be perceived relatively frequently. Their presentation may be oppositional or argumentative with people in authority, although they are often able to build relationships with people they perceive as less threatening or demanding. These children appear to desire connection, but seek it in ineffective ways (i.e., as the "class clown", through negative behaviors). They have a profound sense of mistrust in relationships, and have difficulty believing that others truly care about them. Because of this, these children may "test" relationships, to see if others will abandon or harm them. This relational reenactment may represent both their attempt to control anticipated negative interactions, as well as to confirm their perceived sense of self and other. This presentation is often associated with children who have experienced explicit harm (i.e., physical, sexual, or psychological abuse).
Primary Skills Deficits	(a) Acknowledging and coping with vulnerable emotions. (b) Modulating intense emotion, particularly in the face of key triggers like injustice, shame, etc. (c) Accepting responsibility for actions in social conflict. (d) Empathy and perspective-taking in difficult relationships.
Function of this Adaptation	Externalizing emotion and responsibility allows children who feel intensely shamed or damaged to protect themselves from those overwhelming feelings. With limited skills to cope with intense affect, these children are unable to tolerate any feelings that threaten their already fragile sense of self.

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The Externalizing Child	
Therapeutic Considerations	(a) Forcing these children to acknowledge difficult emotions before they are ready is likely to lead to power struggles and increased shame. (b) With these children, normalization of denied emotions is a key intervention. Often, this is done in displacement (i.e., "I could understand how someone might be very worried if ___ happened to them.") (c) Psychoeducation about triggers and the trauma response may be very important for normalizing the anger response, and is a foundation for helping children learn to differentiate "true danger" from perceived danger.
At Risk For…	Impulse control disorders (i.e., oppositional defiant disorder); risk – taking behaviors (demonstration/validation of invulnerability); bullying and/or repeat victimization; gang involvement

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☑ Presentation #3: The Labile Child

The Labile Child	
Presentation:	The labile child's presentation is changeable. These children are strongly affected by environmental triggers, others' emotions, and internal states. Clinical assessment is often complicated, because their presentation can vary from day to day and hour to hour. Their emotional reactions appear unpredictable, and may be disproportionate to the apparent stressor; they may go from 0 to 60 in a matter of moments, or completely shut down just as quickly. Because of this, presentation in therapy is inconsistent: on some days, these children may appear very well put together, while on others they are reactive, withdrawn, or overwhelmed. Distress is experienced as diffuse, with difficulty differentiating both the type of emotion and its source. In addition, they have difficulty judging degree of emotion—irritability feels like rage, and sadness feels like despair. Emotional states are disconnected, and it is difficult for these children to access an emotional experience when no longer in the midst of it. When they are in the midst of it, however, they are unable to think past it. These children's lives are driven by emotion, but they have little cognitive framework for understanding it or ability to cope with it in healthy ways. These children have frequently experienced interpersonal trauma over an extended period of time, and have relied heavily on dissociative coping. As a result, their sense of self – and therefore of emotional experience - is fragmented.
Primary Skills Deficits	(a) Modulating emotional experience (rapid escalation or numbing, with difficulty returning to baseline) (b) Misreading environmental cues; low threshold for perception of threat. (c) Inability to integrate experiences into a cohesive narrative and/or sense of self
Function of this Adaptation	These children have developed a heightened biological alarm system. In the face of *any* emotion-inducing stimulus (internal or external), their bodies provide them with the fuel they would need to survive if they were in true danger. However, this response has become as likely to occur presently with mild input as it did in the past with threatening. Their body's intense reactivity leaves these children at the mercy of their emotions.

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The Labile Child	
Therapeutic Considerations	(a) The goal with these children is not to necessarily alter their emotions, but to reduce the intensity to a realistic level, so that it is tolerable/manageable, and to help them identify where it comes from. Therefore, it is important to: normalize their emotions, teach them to recognize shifts in degree of feeling, and provide concrete emotion management strategies. (b) For these children, experience is state-dependent; they may be able to discuss their emotions and alternative coping skills in the aftermath of an incident, but will have a much harder time applying those skills in the moment, when their primary concern is survival. Because of this, repetition of skill-building and external cuing in their use are essential.
At risk for…	Dissociation/dissociative disorders, self-injury, substance use, eating disorders (Note that all of the preceding are in service of regulating emotion), suicidality, Axis II disorders

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