Supporting Traumatized Children and Teenagers

A Guide to Providing Understanding and Help

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Preface

Up until very recently, the general assumption has been that children are affected by traumatic events only to a limited extent. The expression 'out of sight, out of mind' was presumed to be a reflection of a child's reality. If adults only avoided speaking about what had happened, the child would forget and grow out of any problems. This attitude remains prevalent, and adults will frequently deny children access to information, to participation in rituals or to knowledge about how adults are feeling.

Although children should have the right to forget and be permitted to decide for themselves how much they wish to speak about painful topics, we know that 'protection' from the realities of life can hurt more than help them.

This book is intended as a helpful tool for adults, both specialists and lay people, in their meetings with children who have experienced traumas, or as a form of preparation for such situations. Some parts of the text may seem obvious to those who already have a lot of knowledge, while other parts may be difficult for those who do not have experience of working with traumatized children. When interventions are described, the emphasis has been on including a number of concrete methods that can alleviate the impact of trauma. These are found predominantly in the therapy chapter (Chapter 9). Many of these methods can be used as self-help methods, without it being necessary for adults to have the expertise of trained therapists in order to be able to help children in using them. I have attempted to cover the field in such a way as to make it possible for many to benefit from the presentation. I hope I have been successful in this endeavour.

Although a single author is listed as responsible for this book, it is of course a product of collaboration and discussions with others working within the field. First and foremost, colleagues at the Center for Crisis

Psychology have been of great significance in my work on the book. The many discussions, and in particular the unique climate of mutual respect and professional inspiration found at the Center, have provided insight and energy for the writing process. Although all my colleagues have been important, Magne Raundalen must be singled out. His generosity and intellectual breadth have held a unique importance for my work with traumatized children in general and with this book in particular.

Professor Emeritus William Yule in London and his colleagues have given me valuable support over the course of many years. Although they are not responsible for what I have written in this book, the many conversations and discussions we have had, and everything that they have taught me, have influenced the presentation.

My dear wife has made extremely valuable contributions towards understanding the reactions of children and adults in confrontation with a potentially traumatizing death, in addition to the warm support she has provided on the home front. Without the added benefits of her professional experience in this field, the writing process would have been too great a burden to bear. My children and grandchild have also provided me with the energy for new projects.

I am also extremely thankful that we have received funding from Denmark for 'Grief center – a research project funded by the Egmont Fund'. This makes possible increased knowledge and improved assistance for the many children who experience traumatic death.

1

What is Trauma?

Words such as 'crisis', 'catastrophe' and 'trauma' have become a part of our daily vocabulary, although in our usage of these words we do not always necessarily have an awareness of their actual meaning. Most people associate such words with sudden readjustments, dramatic events and psychological stress and strain. The word 'crisis' is perhaps the least potent, because some crises do not occur suddenly or dramatically, but instead develop gradually or in connection with transitional phases in life. In the latter case, the crisis is called 'a developmental crisis'. But the word 'crisis' is most frequently used in reference to changes that occur suddenly and unexpectedly, without allowing time for any particular emotional preparation. The words 'catastrophe' and 'trauma' are used almost exclusively in reference to sudden and dramatic events. Catastrophes signify large-scale events that have an impact on many people, such as accidents where a large number of people are injured or killed. But individual accidents and events are just as catastrophic for those who are affected – these are sometimes called 'private catastrophes'.

This book is about trauma. Within the field of medicine, the word 'trauma' is most commonly used to describe bone fracture injuries. Usage of the term has gradually evolved to refer to overwhelming psychological strain. Psychological traumas will almost always entail a crisis situation, although a crisis situation is not necessarily always a traumatic situation. We know that many incidents, in spite of their being extreme in nature, do not necessarily inflict long-term reactions in those who experience them. The expression 'potentially traumatic events' is therefore the correct term. This is, however, such a cumbersome expression that I have chosen instead to use the word 'trauma' for these events too, fully aware that not everyone will subsequently suffer long-term problems. The expression

'psychological trauma', or 'trauma', as it is used in this book, refers to overwhelming, uncontrollable incidents entailing an extraordinary psychological strain for the child or young person exposed to them. Usually such incidents arise suddenly, and unexpectedly, but some are repeated in a manner that is more or less identical (maltreatment, sexual abuse, etc.) without the child having any possibility to prevent this. Such incidents often lead to the child feeling helpless and vulnerable.

What is traumatic for a child depends on a number of factors. The situation or context in which the incident occurs is of significance; for example, should a bomb explode in London, this would be experienced differently from the way it would be in Gaza. If a child experiences a threatening experience while accompanied by parents who react calmly, the incident can be experienced as simply stressful, while those who are not in the presence of their parents, or whose parents are extremely anxious, can experience the situation as traumatic. The significance that the child attributes to the event, the child's developmental stage, temperament and previous developmental history are other contributing factors that determine the extent to which the situation is traumatic for a child. Children who are prepared in advance for a medical procedure, for instance, or for hospitalisation, can master such experiences well, while children who are unprepared can experience the situation as clearly traumatic. It is therefore not the case that a given situation in itself can be clearly said to be traumatic or not for a child: the child's interpretation of the situation and other factors in the situation contribute to determining how traumatic it is.

The American child psychiatrist Leonore Terr (1991) distinguished between two different types of traumatic situations. She called one of these 'type I trauma'. This involves individual events such as an accident, a sudden, dramatic fatality, violence, rape or another kind of dramatic, isolated event. The second type of trauma she called 'type II trauma', which covers situations where people live through a series of traumatic events such as sexual abuse, maltreatment or war. It has also been shown that painful medical treatments, associated with some serious illnesses, can be the source of post-traumatic reactions (Kazak *et al.* 2007). Type II traumas can also result if children witness violence and abuse in the home, regardless of whether or not this leads to a splitting up of the family. It is also believed that exposure to bullying during childhood can lead to post-traumatic reactions in children, although little systematic investigation has been carried out on this subject.

Children need not personally be the victims of dangerous or frightening events in order to be traumatized: being a witness to frightening events, such as the death or serious injury of others, can also result in post-traumatic reactions. In particular, witnessing violence against a parent is a traumatic experience for many children. Saigh (1991) has also shown that hearing about a serious threat that affects the child's immediate family or friends can traumatize children. Research on world events, such as the terrorist attacks on 11 September 2001, has shown that children's indirect exposure through television and the internet can also lead to an increase in post-traumatic symptoms among those who are not affected personally and who are far away from the site of the disaster (Lengua *et al.* 2005, 2007).

Children who experience potentially traumatic situations do not necessarily develop long-term post-traumatic problems. If the living conditions in their environment are good, if they have good internal resources and a good caring environment, very many children cope well both during and after traumatic events. A number of children, on the other hand, develop problems or symptoms that collectively fall under the definition of Post-Traumatic Stress Disorder (PTSD), which will be described in further detail in Chapter 2. A traumatic situation can of course also result in after-effects other than PTSD, such as strong feelings of guilt, phobias, depression or behavioural problems.

The type, scope and duration of post-traumatic reactions will to a large degree depend upon whether the child experiences an isolated event, or is exposed to a series of traumatic events. An isolated event does not involve the same degree of change in the psychological make-up as do repeated events (cumulative traumas). With a good caring environment to provide support in working through what has taken place, an isolated incident can be more easily confronted, expressed and integrated into the child's emotional life than is the case with long-term, repetitive trauma situations.

If children live under the constant bombardment of traumatic events, different emotional mechanisms will be activated to help them live with or defend themselves against what is happening. As a defence against the intense inner feelings that are produced, children who experience such cumulative traumas will often employ denial, rejection and repression of their own emotional reactions. In addition, children can employ so-called dissociation, which means that a division is automatically created between feelings, behaviour and thoughts. Dissociation is an effective

mechanism for protection against psychological pain, and once it has first been implemented is often employed with increasing frequency over time.

> A girl who experienced living in constant conflict due to domestic violence in her home relates that to survive she imagined that she was at the movies, and watching everything from the outside. This permitted her to be a kind of observer of it all without being obliged to react emotionally.

Such dissociation provides distance from the event, but it can also be accompanied by the sense of not being whole as a human being. In adulthood, those who have employed dissociation frequently as children may find that they continue to protect themselves from feelings in the same manner. Children who have experienced sexual abuse can describe how they employed 'self-hypnosis' in a manner that enabled them to avoid feeling pain in the situation. Regardless of which mechanisms children employ to master such a situation, the result of long-term traumatization appears to be an increasing emotional constriction, whereby they gradually lose the ability to register their feelings. Diseth (2005), who has presented a good overview of dissociation in children, maintains that a high percentage of patients within child and adolescent psychiatry show dissociation symptoms, and that many of these are mistakenly diagnosed with a number of other disorders. The dissociation reactions to a large extent reflect the relatively large number of children who experience psychological or physical maltreatment and sexual abuse.

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2

Children's Reactions During and After Traumatic Events

Immediate reactions

Figure 2.1 depicts some of the mechanisms that are activated when children and adults experience traumatic situations.

Physical

- Mobilization of the body
  - Adrenaline
  - Nor-adrenaline
- Physical mobilization
  - Rapid reaction
  - Ready to handle danger
- Block/reduce pain

Mental

- Mobilization of the mind
  - Previous experience and knowledge available
  - Increased sensory awareness
  - Focused attention
  - Strong memory formation
  - Rapid processing of information
- Emotional suppresion

Figure 2.1 Immediate reactions