Back Up The Children

Post traumatic stress disorder (PTSD)
in childhood

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Production:
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FENESTRA/Slovakia
NANE/Hungary
NPO Women's Shelter/Estonia
RHESO/France
Therapeutische Frauenberatung/Germany

This publication has been produced with the financial support of the Fundamental Rights and Citizenship Programme of the European Commission.

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How it all began

The symptoms of trauma and posttraumatic stress disorder – **PTSD** for short – have been under investigation for a long time. Women with inexplicable and stressed-out behaviour were declared malingerers. They were usually considered to be hysterical.

It was primarily the French neurologist Jean-Martin **CHARCOT**, who closely examined their symptoms. His results led him to the conclusion that the women were NOT malingerers, but actually neurologically, mentally, ill. His student Sigmund **FREUD** later made a connection between the women's enigmatic behaviour and early harmful sexual experiences. These conclusions were frowned upon by the society of his time. As a result, trauma research practically came to a standstill.

However, the shell-shocked soldiers of World War I brought trauma back on the agenda, though it was not until the **1970s** that the attitude towards trauma changed. An important landmark in the history of trauma research was the integration of posttraumatic stress disorder into the classification system **DSM-III in 1980**. At the end of the 1980s trauma therapy was founded as a specialised field in research. It was notably Judith Lewis **HERMAN** who implemented trauma as part of the research of violence in social relationships – especially concerning women and children.

Finally attention was being focused on the specific needs of children Research was carried out to determine specialised **pedagogical approaches**.

- Which symptoms do traumatised children show?
- How do they affect a child's development?
- Which pedagogical methods can be applied in the daily working life?

This was the origin of another independent specialised field, **trauma pedagogics**.

It is undisputed today, that children are particularly vulnerable to developing PTSD as they are neither mentally nor spiritually fully developed. The consequences of experiencing trauma are far-reaching and manifold. The connection between early trauma and illnesses such as cardiovascular disease has been scientifically established. The detrimental effect on the infantine brain development is meanwhile allocated. But mainly traumatic experiences have a serious influence on the mental and social-emotional development of girls and boys. They can cause for example mental illnesses such as depression, dissociative disorder, or various addictions.

Although trauma research is still in its infancy, it can be said that, on the whole we have already asserted a positive influence in many areas including pedagogical settings.

What exactly is PTSD?

Traumatic experiences are unexpected and unpredictable, uncontrollable and shocking. They are always an existential threat to the victim, closely associated with a strong sense of their own helplessness. The victim's perception of his or her own identity and of the world around them is thoroughly shaken.

Children as well as adults can experience traumatic stress. However, children are much less able to deal with it, as the structure of their personality is not fully developed. The burden of this stress is particularly severe, when people, to whom the children closely relate, like parents or relatives, are the cause of it.

There are two kinds of traumata:

- First: the **singular traumatic event**. This includes natural disasters, accidents, or the loss of a parent, relative or friend.
- Second: **continuing traumatic situations**, such as child abuse, sexual abuse, neglect, or war.

Directly after the traumatic experience signs of an acute posttraumatic stress disorder may be detected. This is however, quite a normal reaction and is not categorised as illness.

On the other hand about 25% of adults and more than 30% of children show signs of reaction to life-threatening experiences for more than three months. In this case they are dealing with a posttraumatic stress disorder, PTSD for short. This is a very normal reaction to an abnormal event, which cannot be processed by the body, mind and soul. The symptoms that it causes can last for several months, indeed sometimes even years.

There are several **factors** which determine whether a child or adult is likely to develop a posttraumatic stress disorder.

Before the stress situation this includes personality traits such as age, self-confidence, illnesses, previous traumatic experiences, but also the general familial situation, which may or may not provide a feeling of love & care, security and respect.

During the stress situation the important factors are the duration and type of traumatic experience. The longer it lasts, the higher the probability is that the victim will develop PTSD. Traumata caused by people, such as abuse and neglect, result in the most severe consequences.

After the stress situation the determining factor is the quantity and quality of support provided for the victim. Additionally, the general reaction to the experience and the personal ability of the victim to cope with it are significant.

Basically the victim cannot control the processing of the traumatic event.

What is a trigger, and what is a flashback?

Incomplete segments of the traumatic experience are stored by the brain in the implicit memory, and thus cannot be consciously recalled.

Triggers are key stimuli and can be images, noises, and smells. They are able to re-activate the trauma memory. As a result the victim is subject to sudden memory flashes, which bring him or her disturbingly close to the traumatic event.

They are emotionally overwhelmed and have difficulties distinguishing between the "Here and Now" and their traumatic experience.

This re-experiencing of earlier emotional states is called **flashback**.

Any unwanted memory of the trauma may worsen the state of panic and reinforce the trauma symptoms.

Through early intervention and appropriate support and care, traumatised children may be able to regain confidence and trust and integrate the experienced trauma into their lives.

What are the symptoms?

There are as many different reasons for posttraumatic stress disorder as there are **reactions** to it and subsequent **symptoms**. These are not only influenced by the type, the severity, and the duration of the traumatic experience, but are also strongly dependant on the child's age.

According to DSM IV, the symptoms are classified into three categories:

- **increased arousal**
- **re-experiencing (or intrusions)**
- **and avoidance.**

Traumatised children can experience a perpetual state of **increased arousal** in which case they show similar symptoms to adults.

These mainly include:

- sleep disorder or insomnia,
- irascibility and rage,
- difficulties to concentrate,
- hyper vigilance, i.e., an increased watchfulness, and
- exaggerated startle reactions

Due to their high excitability children often show **hyperactive behaviour**. They can appear to be defiant and rebellious. Moreover, their mental states are very volatile and change rapidly.

Because of the growing difficulty to concentrate, their performance at school can deteriorate. Furthermore their relations to adults and their peers suffer badly as a result of a permanent state of hyper arousal. Negative feedback on aggressive and "annoying" behaviour can result in social withdrawal and isolation of the traumatized child.

Another direct consequence of a traumatic experience can be the **re-experiencing.**

Adults often have recurring and depressing memories of the traumatising event, which are perceived as extremely troubling. These memories are called **flashbacks.**

Adolescents also experience flashbacks, which are often accompanied by panic attacks and a feeling of desolation, tachycardia, and attacks of sweating.

Infants however frequently play a **compulsively** repetitive and persistent game which reflects a re-experience of the traumatic event. In this situation they often appear „not there", catatonic, and seem to stare into nothingness.

On the whole children frequently experience frightening dreams, that are indescribable, or nightmares.

The symptomatic of avoidance is understood to be the logical consequence of the stress symptoms of increased arousal and re-experiencing.

Thoughts, emotions or activities that could recall the trauma are avoided. In this class of symptoms specific behaviour in children is evident: a general degeneration of their ability to react is noted they show a reduced ability to play, they avoid periods of rest.

Getting infants to go to sleep can be a particularly challenging situation. The process of "calming down" appears to be closely associated with a deep fear.

Other children avoid social contacts to protect themselves from a renewed traumatic event.

General development deficits are often noticed. Sometimes children revert to old behavioural patterns.

Many traumatized children possess the ability to dream themselves away into a safe fantasy world and thus avoid confrontation with the traumatized reality.

It is important to be aware of the **different symptoms** and to observe in specific cases, how the heavily traumatised child copes with the stress-situation and which trauma-specific reasons could be the cause.

What are the impacts on development?

Trauma can have a fundamental impact on all areas of a child's development.

Suffering existential angst changes the brain extensively. This has been proved beyond doubt by neurological examinations and research in the last years.

Although brain research is still in its early stages of development, we know today that:

At birth, every brain consists of about 100 billion neurons. Basic connections between the neurons drive the **basal body functions** such as breathing, heartbeat, and general perceptions.

The young, not fully developed, brain reacts sensitively to all impressions in its environment. This stimulates the neurons to grow. **New and improved pathways** to neighbouring neurons are continuously being formed and **grow** into a veritable network of connections. Their structure is the result of the individual learning process and the experiences of a child, whose personality is shaped by this.

How exactly are experiences processed?

Impressions of something new or unexpected – whether positive or negative – act in the brain as stimuli that trigger a stress reaction. The brain is stimulated to a high state of awareness and attentiveness.

The L**imbic system,** which is particularly responsive to this, is involved in the control of the vegetative functions, mood and emotion, and memory.

Amygdale and **Hippocampus** are important structures of the limbic system.

The amygdale, which is the "alarm" or fear centre of the brain, distinguishes in a first rough screening between dangerous and harmless. If an impulse is interpreted as dangerous, an alarm situation follows immediately.

Independent of this direct reaction the **hippocampus** is responsible for ordering impressions chronologically and spatially and transfers them to the subliminal memory, where a match with earlier experiences is made.

At the same time new energy reserves are supplied by the **brain stem**. This additionally builds up the activities of the limbic system. Every previous solution to the situation is searched for, and the body reacts accordingly.

If the desired result occurs, the system is normalised. The experience of a successful reaction leads to new or stronger connections in the brain.

Psychologically, this reinforces both self-confidence and emotional competence.

But what happens during a traumatic experience?

If there is no possibility for the child to end the dangerous situation, agitation increases. The body is swamped by stress hormones. This in turn leads to a state of hyperactivity, a state of hyper arousal. The **hippocampus** becomes blocked. Only the **amygdale** works at full speed. Angst and other terrible impressions are now recorded **in fragments,** uncontrolled and **without any coherence** in the subliminal memory.

However, the instinctive reaction of "fight or flight" is often very brief in children, especially if the chance of success is minimal. Instead emotions such as helplessness, panic, and despair predominate.

To cope with it all, a different strategy is employed.

An abundant supply of the hormone C**ortisol** is released. This can lead to a state of mental and physical numbing, so called freezing. Any feelings of identity, awareness, and perception of the environment are switched off.

But this triggered emergency programme of dissociation leaves the victim feeling insecure for a long time after the actual danger has passed. The body remains on **constant alert.**

As a rule, every disruption at any stage of the development of a child's brain carries consequences.....

Some children try to compensate unsafe feelings by **withdrawing** into themselves or an invented world. Thus foreign influences and stimuli are blocked. This of course can have adverse effects on their learning and social skills.

Other children behave in a **"socially over-adapted"** manner in order to prevent new and for them, negative stress situations.

The frequent use of impulsive reactions can, over a period of time, become a habit, and hence dominate a child's daily routine.

If a child is incapable of analysing simple impressions in a calm manner, this can result in a **weakening of the ability to process complex impressions**. Exciting or surprising situations will feel chaotic, new ones will appear dangerous or futile. The search for orientation and meaning in life becomes an insurmountable challenge.

The frequent and high **Cortisol level** also hampers the immune- and other systems, or can actually cause them to degenerate. The ability to calm down after a stress situation is reduced. It is even possible that already existing or „learned" neuronal structures are destroyed and thus things already learned, might be forgotten.

A recovery can only be achieved if there is a successful disruption of the traumatic processes.

What can help?

„I think that at the core of every traumatisation there is extreme loneliness, extreme desolation." (Onno van der Hart, PhD)

A trauma always affects the whole person: **body, mind, and soul.** To regain trust, respect, and a feeling of confidence in oneself are the aims of trauma-work.

Children who experienced a traumatic event need, above all, people they can trust, who are clearly structured, predictable and reliable. Such people are called „attachment figures". **Confidence** has been lost through the experience and needs to be rebuilt. To do this it is necessary to approach a child with **understanding**, **empathy** and in a **responsible manner**. In order to build up a stable and open **relationship**, an adult needs **patience, empathy, and respect.**

It is crucial to **create „safe havens"** in the structural work with traumatised children and adolescents. Rage and helplessness lead to the feeling of a loss of security. The world around the children is no longer perceived as reliable and this deeply affects their inner feeling of security.

In order to create an „inner safe haven", one first needs an „**outer safe haven**". Therefore children need **protection** against renewed traumatizing experiences like for example, violence or neglect. In a pedagogical setting it is important to clarify which means are available for setting up an "outer safe haven".

In order to be able to cope with extreme recurring emotions of fear, helplessness or anger, traumatised children need **pedagogical support.**

By means of reliability and openness in their daily lives together, children can slowly learn to trust their environment again. Well laid out rules for use in their daily lives support this process, as do clear structures and routines.

Both boys and girls need encouragement to become stable and develop their **self-perception, self-control, and their awareness** of how they are perceived by others. It is important to develop, together with them, an understanding of the situation in which they find themselves. Younger children often have a hard time understanding what happens to them in stress-situations. It is important to help children to recognise their reactions on this and to support them in the slow process of changing their behaviour. **Therefore individual triggers** can be pointed out and avoidance strategies can be developed by pedagogues and children.

Working with the parents of traumatised children is a delicate matter, but a necessity in youth welfare.

First of all the nature of the parents' roles has to be pedagogically clarified: whether the parents are offenders, can be involved as confidants or remain in undefined positions.

This means councillors and carers are confronted with the following questions:

- What is the parent's involvement in the traumatic process?
- Which social and emotional abilities do they possess?
- What is the present relationship between child and parent?

Parents acting as confidants should be fully informed about the trauma of their children. They need comprehensive support in coping with their children.

If parents are **involved** in the trauma experience, the protection of the child must have priority. Parents should be offered counselling and, if necessary, confrontational counselling. In such cases, it is crucial that the councillors are supported by other experts.

The co-operation with parents should always focus on the well-being of the child. Basically it is important for traumatized children, that adults take over responsibility, but never decide something without consulting the children.

The following behaviour can exert a positive influence on traumatised children:

„Loving care“

I am loving, caring, and comforting in my dealings with children – but within suitable limits! It is important to offer warmth and nurturing but, on the other hand, to recognise and respect the children's limits.

„Rules create reliability“

I support the children by providing a well structured daily routine by means of clear system of rules, structures, and orientation. This also generates a sense of security.

„The child is allowed to be difficult“

I respect this conduct and at the same time, try to keep my own inner distance and remain calm.

„Everyone has strengths and weaknesses“

I assist the children in discovering their own strengths and encourage developing these further, and at the same time I accept weaknesses. This is a means of positively influencing their personality.

„It may help to talk“

If the children want to talk about their traumatic experiences, I listen and support, comfort and provide answers.

If the children talk themselves into their negative experiences then I carefully **interrupt** and gently re-orient them back to the present.

People who are attachment figures for traumatised children have a huge task to accomplish but they can achieve a lot during their daily interaction with the children.

How to help ourselves

- Everyday we are faced with very difficult situations.
- Frequently we are not able to provide the support which is needed.
- We are totally understaffed cannot manage everything
- It is often difficult for us to see the results of our efforts.
- We seldom have the chance to talk about ourselves and our feelings.
- Even at home it is difficult to switch off as the problems are constantly on my mind.

Working with **children and young people in various institutions** is, no doubt, an extremely demanding job. Many of these children and young people are traumatised as a result of terrible experiences. The resulting problems demand a **high level of support** and care and quite often the intervention process is very challenging.

This requires both **expertise** and excellent **interpersonal skills** more so than is needed in other professions. Unfortunately, this invaluable work does not receive the recognition which it deserves.

In the course of time this can lead to lack of motivation, dissatisfaction, exhaustion and relational difficulties even outside work. In extreme cases this can result in a professional **burnout**.

The signs and symptoms of a burnout can be determined at:

the emotional level: apathy, dissatisfaction, depression

the professional level: feeling useless, inability to organise, submissiveness;

the intellectual level: forgetfulness, inability to concentrate

the behavioural level: emotional detachment, instability, isolation, medicinal self-treatment, absenteeism

and the interpersonal level: incapable of empathy, prone to illnesses, irritability, aggressiveness.

A certain amount of work-related stress can indeed be to our advantage. However, the danger arises when stress levels are too high, when they persist over a period of time and when the person affected is not in a position to handle them.

So what can be done?

Our **awareness** of our own physical and emotional well-being is crucial. It is often difficult to invest time in such matters. Nevertheless, by devising ways and means of self-reflection

we can **protect ourselves from stress**. And this in turn will have a positive impact on our daily work with children and young people.

What is needed here is self knowledge, in other words, **being aware of** (and accepting) our own limitations and knowing how to strengthen our potential. Additionally, we should be able to recognise the symptoms of burnout.

In this sense, each person has to take active responsibility for themselves.

The following are some **suggestions** that may be integrated into our professional lives.

- **Time management**
  Plan your day realistically and include breaks and time for dealing with unexpected situations
- **Realistic expectations**
  Set realistic expectations and take into account the working environment. Sometimes major achievements are undervalued and minor mistakes are overvalued.
- **Appreciation and recognition of colleagues**
  Show willingness to support and strengthen the team's activities, giving praise where praise is due and constructive criticism where necessary.
- **Supervision**
  Organise trouble-shooting meetings or supervision sessions. These will provide opportunities for exchanging opinions and suggestions. Feelings and emotions should also be shared here.
- **Personal and professional development**
  The more confident you feel, the more capable you will be of carrying out your job successfully.

As helpers it is very important not to forget that there is always someone waiting for our attention: Ourselves!