

# Trauma in Young Children

Colorado Association for Infant Mental Health

2nd Annual Robert J. Harmon Memorial  
Lecture

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## Historic lack of appreciation of effects of trauma on young children

- Lack of adequate pain medications for children
- “They won’t remember”

Infantile amnesia (long-term v. short term)

Lack of capacity for verbal representation

Before 18-24 months considered “pre-representational”  
(Piaget, Psychoanalysis)

# Traumatic events for children (Pynoos, 1994)

- Physical and sexual abuse
- Witnessing rape, murder, suicidal behavior, domestic violence
- Exposure to violence including terrorism, gang violence, war atrocities
- Severe accidental injury including burns, dog bites, falls
- Life threatening illnesses and painful medical procedures
- Train, airplane, ship, and automobile accidents
- Major natural disasters

## Incidence of trauma in infant and toddler period

- Estimated 40,000 children between 0-3 physically abused--43% of deaths less than 1 year, 86% less than 6 years
- Estimated 20,000 children between 0-3 years sexually abused
- 0-3 year-olds exposed to domestic violence probably in millions
- Accidental deaths in 0-4 years second highest age group (after 15-19 years)
- 350,000-400,000 in 0-3 age group hospitalized each year, and over 2 million seen in hospital ED's
- Terrorism—Oklahoma City, 9/11
- Natural disasters---Katrina

## Infants and toddlers do develop PTSD (Scheeringa et al., 1995; Scheeringa et al., 2001)

- **Traditional posttraumatic symptom triad is observed in young children:**
  - Reexperiencing
  - Numbing/avoidance
  - Hyperarousal
- **Modification to DSM criteria are necessary**
  - More developmentally appropriate
  - Emphasis on observation of external behavior, not internal states
  - Reducing number of items to fulfill diagnostic criteria

## PTSD Symptoms in young children

- **Reliving:** reenactment play, distress at reminders, nightmares, repeated references to trauma
- **Numbing/avoidance:** withdrawn/flat affect, loss of pleasure, constriction of play, avoidance of reminders
- **Hyperarousal:** irritability, labile affect, temper tantrums, sleep difficulties and night awakenings, decreased concentration, hyperactivity, hypervigilance, increased startle response

**Cases of children with trauma in preverbal period  
who showed later manifestations of memory  
(Gaensbauer, 1995; 2002; 2004)**

- **Case # 1: 15 months---skull fracture at 9 months**
- **Case # 2: 22 months---auto accident at 9 months**
- **Case # 3: 3 months 25 days---skull fracture at 3 months**

## Cases (Cont.)

- Case # 4: 26 months---accidental drug ingestion at 13 months
- Case # 5: 8 years---severe abuse prior to 7 months
- Case # 6: 4 and 1/2 years---mother killed by letter bomb at 12 months
- Case # 7: 9 months---severely abused by mother up to 4 months
- Case # 8: 25 months---witnessed mother stabbed by father at 11 months (Anne Garity)
- Case # 9: 29 months---severely abused and witnessed sibling's death prior to 13 months (Lenore Terr)

# Enduring symptoms of PTSD

Enduring representations of a trauma which last for weeks, months, and even years, manifested through recognition of traumatic reminder, emotional, and behavioral reliving, avoidance and other symptoms.

Prerequisite perceptual, affective, and cognitive attainments for PTSD are present by second half of first year, possibly earlier

## Caveats:

1. Representations are not veridical replications of traumatic events
2. Not all children will show this kind of memory

# Other manifestations of trauma, i.e, comorbidity\*

- Phobias
- Anxiety disorders—separation anxiety
- Attachment disorders
- Depression
- Hyperactivity/ADD
- Disruptive behavior disorders/Oppositional-Defiant
- Developmental disturbances

\*Effects of PTSD not limited to classic triad and all issues should be addressed in an effective therapy

# Changes in the brain

- Chronic stress reactions\*---dysregulation of SNS
- Hypersensitivity to stimuli, especially reminders\*
- Impaired startle reactions with impaired cortical control\*
- Effects on memory centers (loss of cells in hippocampus)
- Executive functioning problems---effects on inter-cortical and inter-hemispheric integration (Teicher)
- Attentional problems

\* Use of clonidine (Harmon and Riggs, 1996)

# Levels of Developmental Impact (Gaensbauer, 1994; 1996)

1. Characteristic PTSD symptoms
2. Associated personalized feelings and meanings connected to circumstances of trauma
3. Disruption of current developmental issues
4. Disruption of subsequent developmental phases
5. Effects of child's symptoms/behavior on interactions with others
6. Impact of trauma of other family members, independent of child's reactions
7. Triggering of previous traumas

# Evaluation

- Parental interview (primary source of information about symptoms)
  - Trauma history and post-trauma adjustment
  - Developmental history, including previous trauma
  - Attachment relationships
  - Family history
  - Parental reactions
  - Interactional effects

## Evaluation (Cont.)

- Parent-child interview
  - General observations
  - Spontaneous play: play themes, play inhibition
  - Structured re-enactment play (Levy, 1939; Gaensbauer, 2000; Gaensbauer and Kelsay, in press)
    - Creating scene and asking child “what happens next”
    - Window into child’s subjective world, memory, emotional reactions to scene

# Importance of Involving Parents

- Parents are best historians
- Threatened or actual harm to one's child among most painful experiences in human existence
- Long-term outcomes in childhood trauma correlated with parental/family support
- Helping parents with child's symptomatic behavior in the home environment is crucial--- balance between empathy and disciplinary actions is difficult

# Types of caregiver responses to early trauma (Green and Solnit, 1964)

- Overprotective/constricting
- Reenacting/frightening
- Unresponsive/unavailable
- Overindulgent/guilty
- Angry/impatient/punitive
- Deeper psychodynamic meanings (including being retraumatized)

## Treatment goals and principles (Scheeringa and Gaensbauer, 1999)

- Establish a sense of safety both in real life and within the therapeutic setting
- Reduce intensity of the overwhelming affects associated with the traumatic experience
- Help the child develop a coherent narrative from the often fragmented memories elicited by the trauma and to place it in a larger context rather than a personalized attack
- Help the child integrate the traumatic events and obtain a sense of mastery over them
- Address the numerous ripple effects, including behavioral problems and/or developmental disturbances
- Provide support and guidance to the patient's family so that they can both help the patient and deal with their own reactions to the trauma

Appropriate label for preschool PTSD treatment  
(PPT), given its therapeutic elements:  
CBT vs. C-BREPT ?!

- C=Cognitive processing/internal representations
- B=Behavioral management
- R=Relational context/Attachment
- E=Emotional Expression/Abreaction
- P=Psychodynamic
  - Empathy
  - Attachment relationship
  - Play techniques
  - Narrative
  - Psychological reworking/integration
  - Recognition of defenses

# Overview Features of PPT

- Parent and child together
- Single trauma vs. multiple trauma: more applicable for single traumas
- Education
- Safety planning
- Dealing with resistance, i.e., psychological defenses

# Important elements of PPT protocol: Working with the child

- **\*Structuring situations which evoke traumatic memories and feelings: verbal descriptions, drawing, story-telling, puppet play, revisiting trauma scenes (symbolic play with toys, structured behavioral reenactments not utilized but mentioned)**
- \*Fundamental elements of play therapy: finding a vehicle that works for the child provides basis for ongoing psychotherapy (Gaensbauer and Kelsay, in press)**

## Working with the child (Cont.)

- **Expression of affects associated with the trauma**
  - Identifying and labeling traumatic feelings
  - Abreaction and sharing, i.e., “Talking about it”
  - Desensitization/reassurance
  - Psychological reprocessing with each exposure
  - Mastery

## Working with the child (Cont.)

- Management of the overwhelming affects/arousal
  - Facilitation of parental soothing/reassurance
  - Relaxation/self-calming techniques not dependent on parent
  - Desensitization/gradual exposure

## Working with the child (Cont.)

- Restoring trust/attachment bonds

“Shattered assumptions,” i.e., the parent failed to prevent the trauma

- Empowering parents
- Parents empathizing with and validating child's feelings, especially anger
- By being there as child is re-experiencing the trauma, parent is able to provide comforting that was not available at time, rebuilding trust

## Working with the child (Cont.)

- **Developing a narrative: “Telling their story”**
  - **Creating a coherent, more accurate understanding of the trauma, including its larger context**
  - **Correcting distorted personalized meanings: having been attacked, feeling responsible, blaming**
  - **Finding meaning and integrating the experience**

## Working with the child (Cont.)

- Behavioral management
  - Not just oppositional-defiant, but whole range of behavioral problems (sleep, anxiety, etc.)
  - Two layered approach (Gaensbauer, 2004)
    - Develop behavioral management techniques
    - Interpret traumatic source (“I think you are scared because you are remembering...”)
    - Each symptomatic reliving is an opportunity for psychological reworking

## **Working with parents (Gaensbauer and Siegel, 1995)**

**Parents provide important information about meaning of child's verbalizations and play**

**Parents observe child's memories and feelings**

**Restore trust as parent's are able to comfort child in ways they were not able during original trauma**

**Educate parents and model therapeutic approaches that can be used at home**

**Monitor parent reactions and provide support and advice**

## Working with parents (Cont.)

- **Helping parents to provide support into the future**
  - **Establish ongoing verbal dialogue about trauma through co-constructed narrative**
  - **Anticipate possible impact at subsequent developmental stages (Oedipal/body integrity)**
  - **Reprocessing of the trauma at different stages**
  - **Support parents fundamental role in child's long-term functioning and prognosis**

## Behavioral reenactments

- **Persisting behavioral reenactments of traumatic experience (aggression, sexual behavior, risk taking, etc.)**

**Perhaps the most disturbing behavioral feature of early trauma**

## “Mirror neurons”

- Neurons in the pre-motor cortex of primate brain that fire not only when an individual makes a goal-directed action, but when an individual observes somebody else making the same action (Rizzolatti, Galese)
- “Common neural substrate that directly translates sensory experience into action or schemas of actions” (Decety)
- Pre-motor neurons also fire if subject simulates the action in his or her mind
- Infants can imitate from birth (Meltzoff and Moore)

## Mirror neurons and traumatic reenactment (Gaensbauer, 2004)

- Help explain the mechanisms underlying the intensity and persistence of posttraumatic reenactments
- Relationship to evocative memory and carryover in preverbal infants
- Ability to act out a retained image at a later time
- Reenactments are not veridical---are creative expressions utilizing a range of vehicles and different perspectives (?based on capacity for “supramodal representation” --- Meltzoff)