Trauma in children and young people

Philip Dutton introduces and discusses major and minor trauma in children, and how it is best addressed

Trauma might be described in terms of an event experienced, or the effects or consequences (symptoms) of the event. In the latter case, the American Psychiatric Association's DSM-IV-TR[1] is the most quoted source for defining post-traumatic stress disorder (PTSD). This collection of symptoms is helpful in indicating when trauma is severe enough to need serious treatment. Smaller trauma, on the other hand, is often neglected by therapists, doctors and the general population as something we just have to cope with. But the effects of even small trauma in childhood are seriously accumulative and often underrated. It is also arguable that untreated attachment difficulties in early childhood can increase the likihood of PTSD – but this statement still rests on anecdotal evidence.

Whatever the type of trauma, its perceived intensity and responsiveness to treatment will vary due to factors such as:

- age of onset
- duration and repetition of the trauma
- whether or not the child knows (or loves) the perpetrator of the traumatic event.

This latter will influence the treatment focus. Trauma induced by an unknown attacker causes fear due to its unexpectedness, but a repeated trauma from a known source still has an unpredictability factor – along with a fear of there being 'no end to it'. Also, the extent to which the child feels responsibility for the events can be harder to deal with when there is a known perpetrator and a repeated pattern. One-off events tend to be easier to treat and resolve more quickly than do years of repeated trauma that started in early childhood. And repeated trauma tends to have a greater influence on cognitive beliefs such as worthlessness. Issues of trust, attachment or even bereavement always complicate the traumatic response and perceptions.

Major and lesser traumas – same effects

I have worked with survivors of the Dunblane shooting in 1996, the Turkish earthquakes of 1999 and the earthquakes in 2002 that demolished a school and killed many of the children in San Giuliano di Puglia in Italy. I have also worked with many survivors of individual, human-perpetrated trauma, which leaves its scar on so many children and adults. Survivors of larger-scale disasters, such as earthquakes, shootings, explosions, mass accidents, mining accidents or air crashes can exhibit very similar symptoms to survivors of individual chronic or repetitive trauma, including abuse after years of grooming, neglect or assault, accident, medical trauma, severe embarrassment, school bullying or racial abuse. There are, of course, additional practical considerations for large disasters, such as surviving homelessness or finding a new home and losing parents or siblings. But some apparently minor traumatic events seriously affect children for the rest of their adult lives. Without treatment, the trauma will leave them vulnerable to over-reaction in many less threatening situations.

Bereavement can also result in a traumatic effect or aftermath for some. I have compared several treatments that seem to help following an unresolved or traumatic bereavement. I have successfully used play therapy, trauma-focused exposure therapy and EMDR for bereavement, sometimes combining therapies – but the process is arguably faster and more effective when using EMDR to unlock distorted beliefs.

Internal measures of trauma are hard to substantiate or compare from one case to another. Problems that tend to be hardest to treat are those that seem more invisible or bear no outward scars, and especially when perpetrators have involved a child in some action. Physical pain and treatment are more easily recognised and accepted than emotional damage – for example, after a car accident, a broken limb is more understandable than a 'near-death' experience with no broken limbs. But which leaves more lasting marks? There is also an erroneous belief that a person must have a 'near-death' experience to result in PTSD, but the fact is that the loss of one's integrity is usually enough to provoke similar, lasting effects.

The brain's reaction to trauma

Most clients understand the 'fight or flight' response where, after a traumatic event, the brain seems to prepare us to run for our lives or have the energy to fight for our lives. We can also experience a freeze response (like a deer in headlamps) when

we are exposed to trauma, for example rape, where it is arguably safer to stay still and cooperate to be able to survive the event, rather than fight (especially if we are heavily outmatched in strength or with a weapon). Small children are far more likely to freeze than fight in an abuse situation, as they are already pre-programmed by adults to do as they are told or suffer severe consequences.

This freeze response is interesting when we are comparing the effectiveness of different types of therapy: brain areas that control our bodies in an emergency (those that control heart rate, blood pressure, respiration and movement) also seem to act as a sort of emergency preparatory system and come on line quickly if needed, without us having to consider our actions carefully. If there is a fire

Case study 1: CBT

Work with Wayne, by Margot Levinson

An education agency became involved with 15-year-old Wayne when his school attendance plummeted. Six months earlier, Wayne had disclosed that a male relative had repeatedly sexually abused him. The police, on the advice of the Crown Prosecution Service, decided not to proceed with charges. Wayne's difficulties intensified and growing concern about his safety led to referrral.

Wayne was the eldest of six children in a poor family. Following Wayne's disclosure, mother felt guilty because the alleged perpetrator was a member of her family whom she had naively encouraged the reluctant Wayne to visit. The extended family became conflicted around the allegation. Wayne's family had bricks thrown through their windows and malicious gossip was spread that Wayne was an abuser.

Cognitive-behavioural assessment revealed panic attacks, irritability, mood swings, intrusive memories and flashbacks, disturbed sleep and nightmares, poor concentration, impaired memory, hypervigilance, suicidal ideation and dissociation. Wayne blamed himself for what had happened and for the devastating effect of its aftermath on his family.

A collaborative formulation identified PTSD maintained by hyperarousal, dissociation and avoidance. Wayne tried to suppress his cognitive symptoms, which he interpreted as evidence that he was 'weird' and 'crazy'. Behaviourally, he avoided school, peers and the abuse location. Wayne's sense of shame and guilt at the family's predicament also acted as maintenance factors – Wayne felt unable to discuss his distress with his parents or ask for support in case it upset them. Suicidal intent was assessed and a risk management plan collaboratively agreed.

Wayne's goals were to:

- reduce the number of times I lose my temper at home over trivia for the next three months
- get to sleep at night within an hour for six weeks
- be free of intrusive memories by the end of treatment
- pass my exams and go to FE college to study art.

A PTSD scale was utilised along with an Automatic Thoughts measure to offer a baseline and track progress.

There were 14 sessions. Each started with a mood check. I shared a model enabling him to understand PTSD and multi-level information processing, and provided education about abuse, grooming and informed consent to promote cognitive restructuring about feelings of responsibility and shame, and to normalise his reactions. We scheduled activities to give his life some structure and reduce opportunities for rumination. And I helped him understand dissociation and develop 'grounding' techniques before reliving the experiences that had led to the PTSD.

When a relationship of trust had been established, 'imaginal reliving' in session followed – promoting reintegration of the fragmented, involuntary trauma memories. 'Imagery restructuring' was used to encourage Wayne to see that his life was not 'ruined' and that he could 'have a future'. Graded exposure, using a fear hierarchy and a SUDs (subjective units of disturbance) scale, was used to overcome his avoidance and habituate him to anxiety-provoking stimuli. And sleep hygiene principles and relaxation exercises were introduced to help with hyperarousal and sleeping problems.

After some difficulties, the family engaged and offered support to Wayne, demonstrating that they could cope with his distress. Joint work with community agencies developed a planned return to school and application for college.

Initially, Wayne continued with his avoidance strategies, dissociated and experienced high levels of anxiety. By the middle phase, his symptoms started to remit and his confidence and his self-efficacy started to return. He returned to school and faced the gossip until it subsided, and coped when walking past the location of the abuse. He restarted sporting activities, and, eventually, his symptoms disappeared and he gained a college placement. He no longer blamed himself for the abuse or saw the police inaction as confirmation that they thought him a liar. Wayne was able to ask for and gain support from his family. His perception now was that he had survived a trauma and coped, and through this process had matured and become a stronger person.

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we tend to run, without stopping to admire the architecture or fancy light fittings. In short, we escape efficiently. After a car crash, we might tend to survivors in a mechanical way (on automatic pilot) and do what we have to do to survive. We might get home without realising what we have done and have significant blanks regarding the events later. Our brains can act in an emergency with minimal conscious thought. In the light of this, it is interesting to speculate what happens during therapy: one view is that when we become relaxed, the emergency-regulating parts of the brain go off line and the cortex (the thinking, problem-solving and creative parts) seems to come back on line. It is therefore hard for us to be relaxed and at the same time access the fearful sensations. Conversely, when we are stressed after a trauma it is hard to switch off, relax or concentrate, learn or think clearly. We can see that it is therefore important that our chosen therapy can enable both of these systems (or areas of the brain) to come on line together – without over-stressing us. (It almost goes without saying that, for very serious trauma, we need to learn to regulate our feelings and behaviour before we can access these more intense therapies.)

> "I have found in practice for the past 12 years that where CBT will work, EMDR is likely to work even better and be more easily tolerated by children"

NICE guidelines

The National Institute for Health and Clinical Excellence (NICE) recommends two trauma-focused therapies for adults: cognitive-behavioural therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).

For children, the guidelines are currently less specific, nominating only CBT as a therapy of choice. However, a colleague who is conducting a meta-analysis (not yet published) suggests that EMDR is equally if not more effective for children. In 27 years of clinical experience, I have compared several clinical approaches to trauma and I have found in practice for the past 12 years that where CBT will work, EMDR is likely to work even better and be more easily tolerated by children. It also appears to act much more quickly and effectively. I have had some children return for additional therapy after exposure-based work that had seemed helpful at the time, but none has come back for more treatment when EMDR has been effective. Although the end result after EMDR appears highly satisfactory, it will naturally be important to study further the length and strength of its effectiveness.

I have used play therapy, trauma-focused CBT and EMDR to treat various traumas in children, and, of these treatments, the only one I have used in isolation for children is EMDR. Virtually all children I have used EMDR with have benefited quickly as long as there is careful preparation.

Family work first: routines and predictability

Regardless of choice of treatment, work with the whole family is almost always essential following any trauma to a child or young person. One of the things that always happens following trauma is that our 'certainties' are no longer certainties and everything seems unpredictable, as we trust nothing and no one. Our beliefs are changed markedly and possibly for life. However, when predictable routines are lost for children, their lives are destined for a very rough ride, full of anxiety and consequent behaviour problems.

Therefore, one of the first things I stress with any trauma, or following any disaster, is the importance of assisting the child's life back on track with as many normal and consistent routines as possible. Bedtime and meal times become essential markers and milestones for the day. A child must feel protected and contained by consistency and limits on behaviour to attain security again. A careful behavioural programme[2] can become the lifeline for a family and it is the first and most essential part of trauma treatment. For some, it might be the only necessary part of treatment, because when a child experiences life as predictable again with the parent in charge, sometimes the need for therapy disappears or is greatly reduced.

The contribution of EMDR to trauma treatment

EMDR was developed by Francine Shapiro in the late 1980s. Shapiro's Adaptive Information Processing model[3] assumes that humans have an inherent ability to process traumatic experiences to an adaptive state. It is generally accepted that the body self-heals with a little help, both physically and psychologically. Memory is thought to be stored in linked networks (comprising related thoughts, images, emotions, and sensations) that are organised around the earliest related traumatic event (and its feelings). The model suggests that if a distressing experience is not fully processed, the initial emotional information (and distorted thoughts) remain stored in an inaccessible way that creates later difficulties. The unprocessed experiences become the basis of dysfunctional reactions and the root of many behaviour problems and strong reactions. EMDR successfully alleviates these problems by helping us reprocess distressing memories, so that experiences are accessed and re-stored in a more accessible (and non-threatening) form, along with appropriate emotions to assist us in the future.

What I believe EMDR uniquely does, once arousal levels are appropriate, is to allow significant areas of the brain to communicate with each other, as necessary, for self-recovery. Talk therapies often seem to access mainly the cortex (the conscious thinking and creative areas of the brain). EMDR helps to link the cognitive areas with the deeper emotional and sensory brain areas to assist communication and to reduce fear and prevent distorted thinking.

EMDR is in fact best known for its extremely

Case study 2: Integrative

Work with Tom, by Neil Harris

Tom is nine. He wakes every night, screaming loudly. He has his eyes open but does not seem to connect with his parents as they try to comfort him. The level of his apparent fear upsets them and they feel powerless. They try to wake him fully, talking as calmly as they can, holding him and stroking him while he struggles with them. Eventually, he settles back to sleep. In the morning, he cannot remember anything about the night. He has been doing this for a year. Before that, he was a happy child, settled in his class and doing well at school.

Then, out on a walk with his mother and his sister, he had a terrifying experience. He was ahead of his mother, and had passed a horse tethered to a stake in the ground. The horse lunged at Tom, knocking him to the ground. When he struggled up and tried to run, it pursued him until it reached the end of its tether. Tom then realised that the horse was between himself and his mother, who he wanted to be with. He was screaming, shaking and sobbing. His mother felt terrified as she tried to pass the horse and reach her son. A passer-by helped to shy the horse away from Tom, and mother and child were reunited. Tom suffered bruising and superficial lacerations, which required a trip to hospital for assessment.

Now, he is terrified at seeing a horse. Pictures of horses at school leave him shaky. His mother is working really hard to manage her own fear but she, too, sweats and feels shaky when she tries to model getting closer to horses to help either of her children overcome their fear. She cries and becomes incoherent as she tells me about what they are going through. They have never been able to talk about that day together since.

Listening, I think of attachment theory, and wonder whether the relationship between mother and son can properly act as a secure base at the moment. I wonder about the distinction between night terrors and nightmares and about what is going on for Tom in the night. I know that children who deal effectively with traumatic incidents have adults around who can process the fears calmly and offer reflective modulation of their aroused emotions. I also think of the benefit of working with his feelings through play and creativity in the here-and-now.

So I gently enquire of Tom what happens in the night. He begins to draw a picture. He shows me a straight line that is a rope. He draws the sky above. Then a big dark mass covering most of the picture. It overwhelms the page. 'I'm looking up,' he tells me. I realise that from his position on the ground he sees the big horse above him and the rope behind. We talk about this and how in the moment of terror he remembers wondering if the rope would hold the horse. I think he can tell me about this because he isn't worried about my feelings, or my level of possible distress. His mother calms, too, as she listens. She joins in by drawing her own picture memory of the event. Tom plays at being with the horse in the room. Telling it to stop, and that he is safe from it.

Tom sleeps through that night. I decide to meet with both his parents together. In this session, I help Tom's father feel confident in supporting his wife in being with her feelings. He holds her in his arms, soothes her distress. The touch is important. She is able to tell him just how terrified she was that Tom would be killed, and the fleeting thought that 'it would be all my fault' that went through her mind. She is able to accept his reassurance and understanding. In subsequent sessions, I continue to work with mother and son together, and also meet Tom's sister, allowing feelings and memories to be processed in play and in discussion, with sensitive use of touch and holding encouraged. We plan some experiments in the 'real' world, to free them of their fear of horses. They select films to watch at home together, which they know include scenes of horses. The whole family goes together to some local stables to be shown a docile pony by the understanding owner. They take this at their own pace. The combination of systemic work, attachment theory, play, touch, and experiment leads to regulation of affect and processing of traumatic memories, and ultimately back to a normal developmental path for the whole family.

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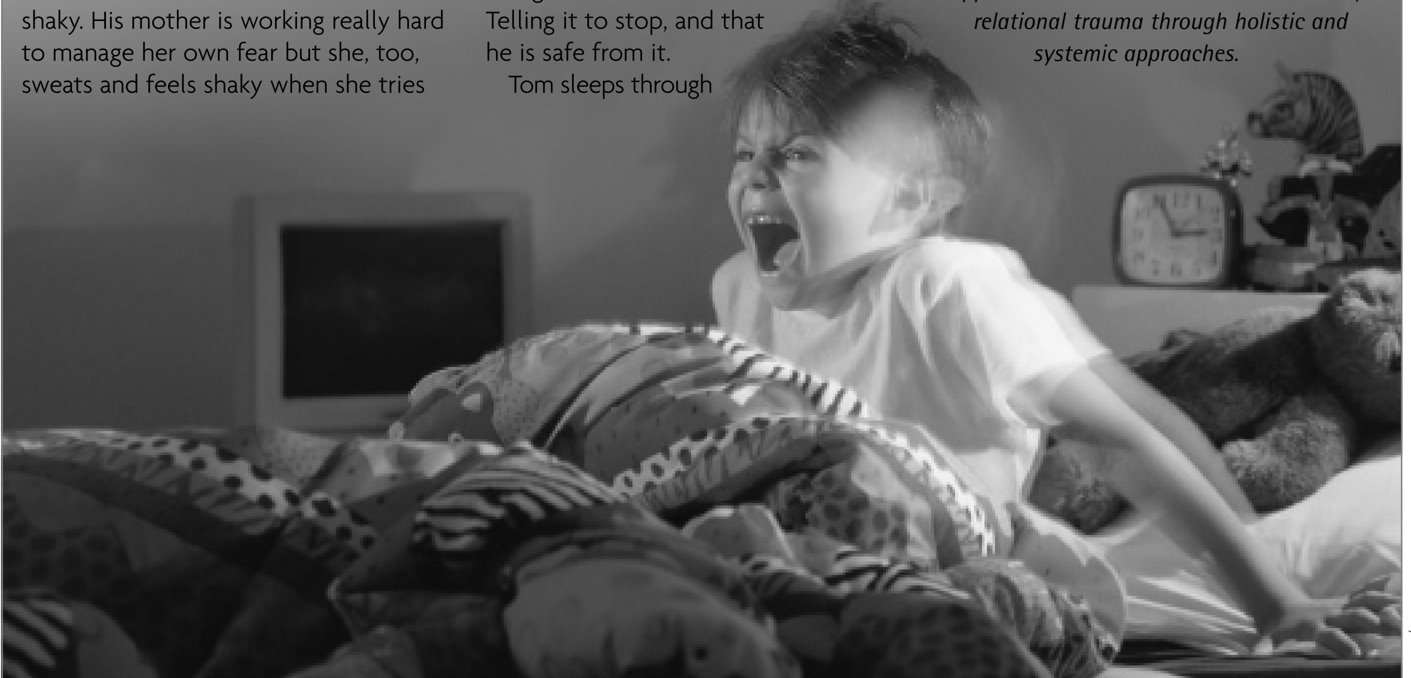

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effective treatment of the symptoms of PTSD. These symptoms include: sleep disturbance, nightmares, irritability, problems with physiological arousal or anxiety including jumpiness or over-alertness, hyper-vigilance, intrusive thoughts, images, flashbacks and avoidance of reminders of the event. EMDR is the most researched treatment for PTSD with more than 20 controlled outcome studies[4].

The model uses an eight-phase process to examine and work through past events that contribute to and influence how we deal with present problems. All past and current sources of distress are 'targeted' and desensitised. When past and current issues are dealt with, future events are considered (for example, a flying phobic might focus on a forthcoming flight) to assist in acquiring the skills for continued adaptive functioning.

In addition to being used to treat PTSD, EMDR has been successfully used in the last 25 years with a wide range of what might be called 'small-t' child traumas. Minor embarrassments and ridicule from authority figures, for example, can very much affect children right through to adulthood and make them less likely to cope well with later trauma. We feel shame and embarrassment to admit that common problems such as bed-wetting or name calling have happened but they can have a life-long effect. Virtually all kinds of trauma can be effectively resolved but, unfortunately, trauma is still vastly under-recognised and therefore often not treated, especially in children. (It is worth noting in passing that a new study[5] shows how EMDR assists even depression when this is brought about by a traumatic reaction,and although this paper has an adult focus, I believe it is powerful in regard to children also.)

Advantages of EMDR with young people

There are several practical advantages to using EMDR with children and young people compared to using other therapies. It is relatively fast and requires no homework. The subject can 'feel' the progress (sometimes almost instantly) and know quickly when this therapy is helpful. Another thing that all clients and especially children appreciate is that, when there is a highly personal trauma (for example, rape, where discussion might provoke intense feelings of shame and embarrassment), EMDR allows treatment without full discussion of the details. (However, treatment is never blind and there is always an acknowledgement of the issue being treated.) At strategic points during processing, the therapist will ask children how they are feeling, but there is no expectation to discuss the problem – in fact, the reverse is true. Discussion during the desensitisation phase of EMDR would slow down both the thought processes and the therapy. The therapist only checks that progress is being made and whether any help is needed to move past a difficult image or thought.

> "One of the first things I stress with any trauma, or following any disaster, is the importance of assisting the child's life back on track with as many normal and consistent routines as possible"

Two or three EMDR sessions can sometimes allow a traumatised child to revert to their previous sparkling condition. Therefore, speedy access to a good practitioner can prevent many months of needless distress for a child. Time is of the essence with childhood trauma for at least two reasons:

- The first is to do with the proportion of a child's life the problems are evident. For example, if we compare a child of six years of age to an adult aged 50 years, depression lasting just six weeks for the child is equivalent to depression lasting for one year in the life of the adult. Similarly, five years of abuse for a 10-year-old is half the child's life. Some Dunblane children (aged about five or six) had one year of treatment which is equivalent to over eight years' treatment as an adult.
- The second, and perhaps more important, reason is that if one delays treatment for a child (especially in an educational setting) there is likely to be a 'Trauma Membrane'[6] effect, which is where the authorities and adults in the child's life act in a protective way that might ultimately restrict therapeutic access to the children.

Fortunately, in the following example, the staff had the foresight to restrict over-access to the children but allowed the necessary therapeutic work at just the right time.

Trauma work in Italy

At San Giuliano in Italy, in 2002, an earthquake demolished a school, killing all the six-year-olds. Teams of EMDR specialists were invited to work with the survivors at one month, three months and a year after the earthquake. The results of all the therapy are detailed by Isabel Fernandez[7], but an edited sample transcript of two sessions with a child will serve to illustrate the speed and method of the EMDR process. The transcript that follows is reproduced with changes to protect confidentiality, by kind permission of the EMDR Italy Association.

Case example, Sandy

An 11-year-old, Sandy (not her real name), who lost a brother in the school's destruction, suffered not only due to the death of her brother but also because of her parents' sense of despair. When her distress was processed (over two sessions), the natural mourning and grief process was facilitated. EMDR helped stop the intrusiveness of the worst images of the loss and appeared to resolve the dysfunctional thoughts or blocked processes, which in turn let the natural grief process continue in a normal and more peaceful way.

First EMDR session

It was explained to Sandy how memories of a strong traumatic experience are stored in the brain, and she was offered a simple model of how EMDR treatment works. She was then helped to identify a 'safe place' – which also allowed her to become

Case study 3: Emotional Freedom Technique

Work with Charly, by Lynn Martin

Charly (not her real name) was travelling in her mother's car when they were involved in a fatal car accident, and although neither Charly nor her mother were seriously hurt Charly witnessed the traumatic aftermath.

Over the next few weeks, Charly began having nightmares, did not want to go to sleep at night, would not sleep in her own bed, her appetite was reduced and she became fussy about what she ate. Her concentration at school diminished and her behaviour deteriorated. She also became the victim of a certain amount of bullying at school and when she went out to play with friends. She refused to travel in the car and constantly talked about the train crashes and monsters in her dreams.

Trauma is one of the most difficult issues to address in therapy, as the risk of re-traumatisation is a real possibility, potentially causing the client to suffer panic attacks and flashbacks and become completely overwhelmed. This is particularly so with a young child, whose coping resources are still relatively limited and underdeveloped. Working within BACP's ethical guidelines of non maleficence, I am well aware of my duty, within the therapy, to avoid re-traumatisation of the child by asking her to recount the event.

Like many therapists, I believe the therapeutic relationship is paramount when working with clients of any age, and it is within this relational framework that I describe my use of the Emotional Freedom Technique (EFT) as a tool for healing the aftermath of Charly's traumatic experiences.

Based on Eastern wisdom that has been accepted for the past 5,000 years, EFT suggests that the cause of all negative emotions is a disruption in the body's energy system. It has been described as 'an emotional version of acupuncture except needles aren't necessary. Instead, you stimulate well-established energy meridian points on your body by tapping on them with your fingertips' (www.emofree.com). There is a 'Basic recipe' – used for addressing all issues – which involves a set-up phrase, a reminder phrase and a series of tapping points on the body. Even very young clients are taught the simple protocol, which empowers them to take control of their own healing.

I began this work with Charly by identifying the various aspects of her problem – her nightmares, sleeping alone, her appetite, the bullying, her concentration and fear of travelling in the car. At no time did we need to directly address the actual accident, thereby avoiding the danger of stimulating a re-experiencing of the event.

When using EFT with young children, I involve parents in the treatment wherever possible. Partly so that the parent can tap by proxy, thereby enhancing the power of the work, but also so that the parent can use the technique in between sessions with the child, as well as to deal with any issues they may have themselves that may be affecting the child.

Mum told me that the nightmares were the worst of the symptoms and I asked both her and Charly to rate the intensity of the nightmares. Mum gave them a rating of 9 out of 10 (10 being the most severe) – Charly was asked to show me pictorially with her arms. She flung them as far back as they would go and said, 'They are this big!' So in the first session we tapped on her nightmares using the phrase 'Even though I have these horrid dreams, I'm still a lovely girl'.

I suggested to Mum that she tapped with Charly before bed each night on anything that was bothering her. I also suggested that Mum tap for herself, on the trauma of the accident.

When Charly and Mum returned the following week, they were both pleased to report that Charly had only had one bad night during the week and they had coped by tapping when Charly had woken up in distress, and she readily went back to sleep. We continued to work through all the aspects of the problems, and after five sessions Charly was sleeping in her own bed with only occasional bad dreams. When she woke up in the night she would go to her mum's bed and ask to tap on her bad dream. Her appetite was back to normal and she was eating healthily again. Her behaviour at school had settled down, although she was still experiencing some bullying and we spent some time working on this aspect using puppets.

Because I use EFT as a tool within the wider context of the therapy I practise, we continued with other ways of working, using EFT whenever a new aspect of the trauma arose in our work.

EFT puts the power in the hands of the client, even a six-year-old, and provides them with a resource for life.

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familiar with the bilateral stimulation element of EMDR and experience the gentle processing of information, starting with positive imagery. After careful preparation, the next step was the identification of the worst or the most disturbing part of the earthquake event.

Sandy chose the following *image*: 'The school fell and everyone is escaping.'

The *negative cognition* that accompanied this image was 'I'm helpless'.

(This translated more directly from Italian as 'I am impotent'.)

The *positive cognition* about herself was a belief that she wished to but could not yet hold, and this was 'I did all that I could'.

She expressed the *value of this positive belief* on a scale from 1 to 7, as a 2.

She felt the distress, and she placed this emotional disturbance on a *Subjective Units of Disturbance* (SUD) *scale* – which ranges from 0 to10 – as a 10.

She then *located the emotional disturbance* in her body, around her chest.

She was assisted to link these elements at the start of processing, and after a first set of eye movements (referred to as a set), Sandy said: 'I remember when I saw my mother and I was told my brother was dead.'

During the next set, various details were recalled, including tumbling, escaping, looking back, the noise and the shouts. After several more sets, she began to access more positive memories and said she remembered a summer when she taught her brother to swim and she felt very happy.

It seemed appropriate to break the first EMDR session at this point after about 20 minutes of eye movements, as the child had been working for one hour. At the end of the first session, Sandy said she was thinking about the earthquake day and now she felt an emotional disturbance at a lower SUD level of 6.

Second EMDR session

We started with the same target memory of the earthquake day and rechecked the SUD level which was still 6. The session was started as before, and after a few sets of eye movements, Sandy said: 'I'm not sure if I really did all that I could. I should have told my mother not to take my brother to school. There had been a tremor that night.'

With EMDR, the therapist does not comment or try to interpret the content, which in this case seems to be an expression of her feelings of responsibility. In contrast, after each set, the child is invited to comment, and the comment would be typically acknowledged with the therapist saying something simple like 'notice that'.

After several more sets, Sandy commented: 'I remember all the people who arrived to help.'

After several more sets, Sandy said: 'There were a lot of people but they couldn't rescue the children. So I couldn't help more than the rescue team. I did all that I could.' (This eloquently resolved her own issues of responsibility.)

After several sets...
Sandy: 'I did a lot of things with my brother. I taught him a lot of things...'
After several more sets...
Sandy: 'I think about my brother's face, when we played together.'

When Sandy was calmer and had seemed to have worked through most issues, we continued:
Therapist: 'Now think about the original moment (target) – what do you feel?'
Sandy: 'It is a more separated image, distant. I don't feel anything particularly.'
Therapist: 'From 0 to 10?'
Sandy: 'Zero.'
We then used another set of eye movements to consolidate this and moved to the Installation phase after checking that the positive cognition was still appropriate. (This process has been shortened for printing and the abbreviated results follow.)

Therapist: 'How much do you feel the words "I did all that I could" are true for you now, from 1 to 7?'
Sandy: '7.'
Therapist: 'Think about that day... and the words "I did all that I could" and link them together...'

After two further sets to *install* the positive cognition, Sandy was asked to close her eyes and think of the original event (target) and the words 'I did all that I could' and scan her body to see if she had any tension or unusual sensations.

Sandy: 'No, I'm relaxed because I have in front of me my brother's face when we used to play together.'

The session ended in a proscribed manner with explanations of the possibility of continued processing, and information about what to do and how to record sensations and feelings at home, following processing.

> "When a child experiences life as predictable again with the parent in charge, sometimes the need for therapy disappears or is greatly reduced"

A delight to work with

Children are a special challenge but also a delight to work with because they come without preconceived ideas that block progress in therapy. With careful preparation, they make very fast progress. To be fair, many treatments can work quickly with children, but none, in my experience, works so quickly or so well as EMDR. The more comfortable the child is with the therapist, the smoother the therapy session. Toddlers can sometimes do their 'processing' in a few minutes, primary school children might only require sessions of 30-60 minutes depending upon their attention span, and some older children require maybe 90 minutes per session. The youngest child I have treated was eight months of age and the

Case study 4: Transactional Analysis

Work with Emily, by Corrie van Halm

In Transactional Analysis, the notion of script is described as an unconscious life plan, reinforced by parents and parental figures. The formation of the script depends on messages given by parents and parental figures as part of daily life, conclusions the child draws, and decisions she makes consequently about herself, others and the world. Traumatic experiences, such as the loss of the primary attachment figure, as in Emily's case, shatter the child's experience of security and continuity and can lead to a profound change in how the child sees herself (I am bad, it's my fault), others (they leave me) and the world (it is an unsafe, unpredictable place).

My task as a Transactional Analysis psychotherapist was to help Emily to make sense of the traumatic events in her life, help clarify fantasies and alleviate feelings of guilt and self-reproach. This may take place through play and interpretation or in a straightforward validating way – with adaptation to the individual child's pace being paramount. We may have thoughts about theory, while working with the child, but I do think that interpretations and/or other interventions should never be more important than the child and should not be imposed upon her. While keeping the notion of script development in mind, the immediacy of the therapeutic work is with what the child brings.

Emily was eight years old when she came to see me with her dad, just three months after her mother's unexpected death. She looked alarmingly unwell. Father was barely coping with the chaos the family had plunged into. Emily had been an 'afterthought' and was much loved by her parents, siblings and grandparents. Although enough help was available, it seemed that each person was struggling with their own private grief and finding it hard to reach out to Emily and help her unlock her feelings. The family's GP had been consulted about Emily's withdrawn state and psychotherapeutic help had been recommended.

During the first session, Emily's dad told me briefly the story of his wife's death. Emily was sitting in a corner of the sofa, rather like a little plant, deprived of water. There was a listlessness about her. I asked Emily if she knew why she was here and, indeed, did she want to come and play and perhaps talk for a while each week. Avoiding eye contact, she murmured consent and then further collapsed into the cushions of the sofa, closing her eyes and beginning to suck her thumb.

The first weeks of her work with me were difficult, in that Emily's collapse and withdrawal continued and there would be barely audible answers to gentle questions. In order to create a sense of continuity and predictability, I made sure that a carton with drink and a biscuit were in the same place each week, as were the boxes with toys, dolls house and other play materials. Emily would glare at all these items in the room, but not move from her corner on the sofa. After a while, I remarked that everything was in the same place each time, just like she was. She nodded. I felt this was a minute beginning. I decided to move a little further and picked up a soft toy, a particularly appealing monkey, with a soft, almost empathic expression on his face. I sat at the other end of the sofa and placed the monkey on my lap. Moving his long arms toward her, I gently put one of his paws lightly onto Emily's hand. Colour appeared in her face and she looked straight at the monkey. We just sat like this for a little while, saying nothing. This was our first point of contact and the very beginning of her coming out of her state of shock.

As time went on and our work progressed, Emily was gradually able to express her feelings. Her intense longing for her mother's return and fantasies about her death were among the many experiences that needed to be aired, put into words and strung into a containing and manageable narrative. I continued to positively stroke her growing understanding of her loss and, in doing so, I helped her to come out of what had seemed like a fortified place within which she had experienced herself as so bad. The script decisions-in-the-making, with all their magical qualities of her chronological age, were stopped from further developing.

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TAXI/GETTY

EMDR session lasted for 20 minutes. In fact, children often require more preparation time than active treatment time. Full explanations are given to parents and children and, with young children, at least one parent is encouraged to be with the child during therapy.

Children and young people vary in the number of sessions they need, dependant on their particular trauma and developmental stage. For example, after preparation, the symptom of nightmares might respond in a single session. However, even when you see a good result in one session, it is essential to follow this up and re-evaluate to ensure complete resolution of all related issues – EMDR is not a single-session cure method. And even when all symptoms appear to be resolved, re-evaluation and careful checking are essential to find anything that might have been missed so as to prevent 'incubation' or later re-activation. As with antibiotics, it is essential to complete the full course of treatment to prevent later complications.

Although the technique of EMDR appears

relatively simple, the methodology is complex and only child specialists should apply the technique to children. All who are appropriately trained in EMDR should know to work only with a population with whom they are familiar, and the public should be encouraged to check a therapist's credentials.

Conclusion

In conclusion, there are several ways of treating trauma in children with various advantages and disadvantages. The NICE guidelines recognise EMDR and Trauma-Focused CBT as worthwhile therapies for the treatment of PTSD. However, take note of the use of the words 'trauma focused'. This recognises the need for a specialist who knows how to apply the therapy, but of course a wise choice of child specialist, well grounded in the therapy of choice, is also essential, in that the care that the therapist takes in preparation and application of the chosen therapy is crucial. That preparation might well be play-therapy, behaviour therapy, family work or a whole range of skills to prepare and allow the child to comfortably and confidently work with the therapist. ■

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Trauma-i

Barbara Wizansky is among a growing number of

In spite of the fact that we now know a great deal about trauma in children, the symptoms that should alert us, and the best ways to treat them, it is easy to miss the clues. The child who comes to our clinic does not usually tell us about intrusive thoughts or disturbing memories. He shows us. He acts out or withdraws. He wets his bed or hits his brother. The connection between past events and today's behaviour can be unclear. By looking at the cases of three children and their treatment with EMDR therapy, I hope to illustrate clinically the importance of an alert, trauma-informed approach.

How do we understand a 10-year-old boy from a reasonably well-functioning family in a suburban neighborhood who behaves as though the world is out to get him? Or an intelligent three-year-old child who draws his face close to that of another child, stares and, with no warning, begins banging his head against hers? Or a happy, well-adjusted seven-year-old girl who over several months changes drastically, clinging regressively to her mother, becoming fearful of dogs and behaving as though there is danger around every corner for both her and her mother. The 10-year-old was diagnosed with an oppositional behavioural disorder. The seven-year-old with possible separation anxiety. The three-year-old has received a variety of diagnoses, from pervasive developmental disorder to oppositional disorder. Yet, a trauma-informed evaluation of each of these children leads to a much clearer understanding of their symptoms and the kind of treatment which can help them.

Roni, Ephrat and Etai are all reacting to traumatic events in their past. Each of these children has been exposed to situations that led to distortions in his/her development. Roni, at 10, and Ephrat, at seven, have already had these distortions hardened into cognitive beliefs about themselves and their worlds. Etai, at three, navigates his day-to-day life from a place of trauma-formed sensation and emotions, but a basis of strong negative beliefs about himself is being laid down within the foundations of his personality.

What is EMDR?

EMDR is an information processing model, developed to treat disturbances of post-traumatic stress. The model posits the theory that in most situations the brain, when confronted with a traumatic situation, follows a natural pattern of processing towards balance and healing, in the same way as does the healthy body. When this natural processing does