Strengthening Families & Communities

WHAT IS TRAUMA?

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by Amy Stephens

The Trauma Queen

As we first learned about psychological disorders, many of us diagnosed friends and family members with each new psychological disorder about which we learned. Little Joey was a textbook ADHD case; he could never sit still. Your high-strung mother undoubtedly suffered from GAD. Before long, you'd developed OCD because of your obsessive tendency to assign psychological diagnoses to everyone you encountered. All joking aside, psychological disorders such as Attention Deficit/Hyperactivity Disorder, Generalized Anxiety Disorder, and Obsessive-Compulsive Disorder are a serious matter affecting many people today.

When we think of psychological well-being, the events of September 11 pose questions about "normal functioning." Did I have PTSD (Post Traumatic Stress Disorder) because I was still scared to fly home for the holidays, even if it was statistically safer to fly than to drive cross-country? What is the true indication of a psychological disorder like PTSD? How does it differ from trauma?

Trauma and PTSD

Most often, traumatic experiences do not result in PTSD. A trauma-producing experience is one that threatens one's life or physical integrity (see criteria #1 below). PTSD is a diagnosis that describes a troubling response to a traumatic event. The DSM-IV's (Diagnostic and Statistical Manual of Mental Disorders) criteria for diagnosing PTSD specify the exposure to a traumatic event in which both of the following are present:

1. A person experiences, witnesses, or is confronted with an event(s) that involves:
    - either actual or threatened death or serious injury (e.g., military combat, terrorist attacks, school shootings);
    - or a threat to the physical integrity of self or others (e.g., observing unnatural death, witnessing domestic abuse, rape).
2. The person's response involves intense fear, helplessness, or horror over time. Children may exhibit disorganized or agitated behavior.

The disorder may be especially severe or long lasting when the stressor is of human design; the likelihood of developing it may increase as intensity of and physical proximity to the stressor increase. In general, a psychological disorder is indicated when the behavior in question has hindered one's ability to live and function normally over time.

The American Psychiatric Association first officially recognized a specific trauma-related disorder in 1980 when PTSD was included in the DSM-III. Research revealing common symptoms among combat veterans and rape victims established

initial criteria for PTSD diagnosis. Since 1980, many developments concerning PTSD and its treatment have occurred. However, research has produced conflicting answers to many questions.

Child Abuse, Trauma, and PTSD

Though many of our clients experience loss, separation, or trauma, the severity of their symptoms may or may not rise to meet the diagnostic criteria for PTSD.

Even in the absence of catastrophic events, many children experience troubling feelings and behaviors in the course of placement. For example, a recent study compared PTSD rates of sexually abused, physically abused, and non-abused foster children (Dubner & Motta, 1999). More than 60 percent of the sexually abused foster care children were diagnosed as having PTSD. The physically abused group also showed substantial rates of PTSD (approximately 40 percent), as did nearly one fifth of the non-abused foster children. More girls than boys were diagnosed with PTSD, findings consistent with several studies. Children aged 8 to 12 exhibited more severe PTSD symptoms than older children, although other research contradicts this finding.

Research findings vary because of population differences, instrument variations, and methodological reasons (e.g., how abuse is operationalized). Although we cannot conclude PTSD is the core manifestation of sexual abuse trauma, much research has shown that childhood abuse, particularly sexual abuse, may be linked to PTSD. Research has related other psychiatric disorders to abuse including depressive disorders, attention deficit disorder, anxiety disorders and psychosis. Children may be more likely to develop problems when they already have experienced numerous stressful events. Therefore, addressing childhood trauma may be an important deterrent to the development of PTSD.

Symptoms of Trauma and PTSD

Many of our young clients may exhibit concerning symptoms. Professional collaboration with the child's service providers, understanding child developmental stages, and knowing the child's history are helpful tools in determining how the child is dealing with his or her experiences. The way in which children deal with their experiences is influenced by several factors, including personality type, parental psychological history, number/intensity of previous traumatic experiences, developmental stage, and support systems (including relation-ship with birth and foster families). One symptom of a traumatic experience is hyperarousal, where an expectation of danger causes the person to startle easily, react to small provocations, sleep poorly, or have nightmares. Hyperarousal produces an increased vigilance for the return of danger.

Another characteristic of trauma is intrusion, a reflection of the permanent imprint of the traumatic moment. The person relives the event as if it were continually recurring in the present. The trauma repeatedly interrupts the person's life via

flashbacks, nightmares, and even in child's play. Instead of typical carefree play, the child may engage in grim, monotonous, obsessively-repeated play, which does not stop easily when traumatically inspired; this type of play indicates the type of trauma experienced.

A third indicator is known as constriction, or the numbing response of surrender. Think of the "deer in the headlights" reaction that occurs when a person is completely powerless. Self-defense shuts down entirely, and a kind of detachment occurs to help the person escape psychologically from what happened. Efforts to dissociate or produce a numbing effect through artificial means may result in alcohol or drug dependency.

Physical symptoms of trauma may include headaches, gastrointestinal and immune system problems, dizziness, and chest pain. Other physiological changes related to PTSD have been detected in the central and autonomic nervous systems, thyroid, cortisol levels, epinephrine and norepinephrine levels, and levels of natural opiates. People experiencing trauma or PTSD may have varying combinations and degrees of these symptoms. When in doubt about how to interpret symptoms, consulting a psychological and/or medical professional may be helpful.

Also, the American Psychological Association is an excellent online source to answer some of your psychological questions (www.apa.org).

Treatment

As service providers and parents, we play an important role in the psychological recovery of the child by recognizing trauma symptoms, helping children with trauma, and/or referring them to appropriate outside services.
Currently, the treatments scientifically proven most effective for PTSD are cognitive behavioral therapies, including exposure therapy. Drug therapies may be an option for some patients, and group and individual therapy may prove helpful as well. Probably the most controversial treatments include debriefing and EMDR (Eye Movement Desensitization and Reprocessing). Although debriefing may help prevent PTSD, critics warn it may stir up old memories without providing patients tools to cope with them. EMDR has been shown effective in many studies, but other research indicates it is no more effective with eye movements than without, claiming the therapy is only a 'doctored up' version of existing, effective therapies.

Trained professionals generally provide the above-mentioned treatments for PTSD. These are recommendations for helping children deal with trauma, provided by the International Society for Traumatic Stress Studies:

- Spend more time with children, and let them be more dependent on you after the traumatic experience (e.g., child may be more clingy or need more affection).

- Provide play experiences. Children may be able to freely express feelings and ideas more easily through non-verbal activities like drawing, painting, or dance.
- Encourage older children to talk with you and others about their thoughts and feelings. Answer their questions to reduce confusion and anxiety, and to reassure them that you care and understand their fears/concerns.
- Keep regular schedules for activities such as eating, playing, and going to bed to restore security and normalcy.

Online resources provide information on helping children who are experiencing trauma or PTSD. While recognizing the differences between trauma and PTSD, it is also important to recognize that significant stress may be present for children, even when trauma is not. Establishing a trusting relationship is one key in encouraging children to talk about their stressful experiences, which can be a therapeutic exercise in itself.

Also remember the importance of caring for oneself. Continuously caring for others can be taxing over time. Utilize other workers, friends, family, or therapy to develop a support network for yourself.

Resources

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. (1994). American Psychiatric Association, Washington, D.C.

Dubner, A. & Motta, R. (1999). "Sexually and physically abused foster care children and post-traumatic stress disorder". *Journal of Counseling and Clinical Psychology*, 67, (3), 367-373.

Goode, E. (2001, November 20). "Treatment can ease lingering trauma of Sept. 11". *The New York Times*, pp. F1, F6.

Herman, J.L. (1992). *Trauma and Recovery*. Basic Books. The International Society for Traumatic Stress Studies. Resources for the Public, Children and Trauma Fact Sheet. Retrieved December 17, 2001, from http://www.istss.org/.

National Center for PTSD. *What is Post-traumatic Stress Disorder?* Retrieved December 17, 2001, from www.ncptsd.org/facts/general/fs