Chapter 1

Understanding Trauma

WHY TRAUMA MATTERS

If you are working with kids, chances are that you are trying to help them do better in some way: get in less trouble, do better at school, feel less angry or sad, not hurt people. So why not just focus on the problem? Why should we care about trauma?

Following is a partial listing of the kinds of problems kids might have that are potentially trauma related:

- Disruptive behaviors
- Poor frustration tolerance
- Depression
- Anxiety
- Poor concentration
- Loss of interest in activities/goals
- "Don't care" attitude
- Anger
- Fighting
- School absences
- Substance abuse
- Criminal behaviors
- Noncompliance with medical treatment
- Suicidal behaviors

This is not to suggest that trauma is the only reason kids have problems. But trauma can find the child's weak spot. Trauma is a powerful stressor that can either cause new problems or make existing problems worse. If we try to help kids but don't take trauma into account, we risk ignoring a driving force behind the problems. We risk being less effective.

A USEFUL DEFINITION OF TRAUMA

Trauma was previously defined as a horrific event "beyond the scope of normal human experience" (American Psychiatric Association, 1980). To qualify as traumatic, an event should be subjectively perceived as threatening to a person's life or physical integrity, and should include a sense of helplessness along with fear, horror, or disgust. Such events might include being in a car accident, house fire, or natural disaster; being raped; or being assaulted. Through research we have learned to identify a wider range of events as being possibly traumatic—for example, witnessing a parent or sibling being beaten; being diagnosed with a life-threatening illness.

The bad news is that traumatic events are not beyond the scope of normal human experience. Although not every child will be exposed to one or more traumatic events, most will. This is not just true for kids growing up in high-crime urban areas. Even our (presumably) best-protected

kids experience trauma. For example, a study of second-year college students (modal age of nineteen) found that 84 percent had experienced at least one major trauma (Vrana & Lauterbach, 1994). Among disadvantaged urban populations, very few escape exposure to major trauma events (see Greenwald, 2002b). Trauma during childhood and adolescence is now so common as to be normative. When working with a child or adolescent with any kind of problem, we can't afford to assume that trauma is not a factor.

Although the focus here is on trauma, it is important to note that other adverse life events can have a traumalike impact on kids. For example, a child's response to a significant loss can be virtually identical to a posttraumatic response, except that following loss, hyperarousal may not be present (Pynoos, 1990). Indeed, the research on adjustment disorder shows that many children do not adjust to or recover from a range of adverse events (Newcorn & Strain, 1992) but maintain some symptoms indefinitely.

When working with a distressed child, we do not ask if the event qualifies as a trauma before offering help. We will offer essentially the same treatment regardless of whether the source of the distress is an earthquake, a sexual assault, or a death in the family. In this book, the term *trauma* is intended to apply to major trauma as well as loss and other adverse life events, as long as the event has had a traumalike impact on the child.

WHAT MAKES AN EVENT TRAUMATIC?

Not every upsetting event is so intense and overwhelming that it is experienced as traumatic. The biggest factor pushing an event into the traumatic range is, not surprisingly, how bad it is. Several factors determine the severity of the exposure to trauma:

- The nature of the event itself
- Direct experience versus witnessing versus hearing about it or seeing it on TV
- Personal impact versus impact on a known person versus impact on a stranger
- After-event impact (e.g., lifestyle disruption)

Severity of the Event

Some events are clearly worse than others. For example, an open-hand spanking is not as bad as being whipped with a belt, which is not as bad as being beaten to the point of broken bones. In most cases, once the event has been described, its severity is readily apparent. However, children with special vulnerabilities may experience certain insults especially severely. For example, being punched in the arm will hurt a child who has hemophilia more than it will hurt a child who does not have this condition. Also, how the event is perceived contributes to its severity. For example, a child who does not understand the danger she was in may not experience a nearly fatal near-miss event as traumatic.

Proximity of the Experience

The more directly the child is involved in the event, the higher the risk of posttraumatic stress symptoms. For example, in a school shooting, children witnessing the event had the most severe symptoms, followed by children nearby who heard the shots but did not see the event, followed by children farther away who neither saw nor heard (Pynoos et al., 1987). However, even distant exposure can have impact, especially when children can personally relate or feel directly affected in some way. For example, younger children who saw the World Trade Center towers collapse on television, and who saw this multiple times, were exposed repeatedly to this event

because they did not understand that it was only the same event being replayed. They thought that many buildings had been hit and were coming down, and they felt more vulnerable.

Personal Impact

Something that happens to the child or to someone he cares about is likely to have a greater impact than something that happens to a stranger. Children take it very personally when a parent or sibling is victimized or hurt. On the other hand, it is important not to underestimate the impact that an apparently distant event can have on a child.

- A ten-year-old boy's classmate drowned during a school outing. He did not even like the drowned girl, but felt guilty that he had not been friendlier toward her and irrationally blamed himself for her death.
- A five-year-old boy looked out the window and saw a neighborhood man getting beaten up. After that he was afraid to go outside; he feared someone might beat him up too.
- A nine-year-old girl's best friend's father died of cancer. She became obsessed with the fear that her own parents might have cancer.

After-Event Impact

This is a critical element of severity of exposure that is often overlooked. Imagine that two identical bombs are dropped. One explodes and makes a crater in the ground. The other explodes somewhere else and also makes a similar crater in the ground, but then some nearby buildings collapse into the second crater. Although both bombs had the same strength, the second bomb has had more impact and thus can be considered more severe. Life experiences can be like this too. A traumatic event is more than just the single terrible moment.

- A fourteen-year-old girl was in a car accident. After the crash, she did not know for a few minutes whether her aunt (the driver) was dead or alive. In the hospital, she had to wait by herself in a small room for almost an hour. The attendants cut off and discarded the bloody jacket she had been wearing in order to tend to her wounds; her boyfriend had given her this jacket and she treasured it. She was left with a scar on her lower arm and felt that she could no longer wear short-sleeved shirts or bathing suits.
- A four-year-old boy's father died in a work-related accident. His mother became depressed and withdrawn. Spring came around and the boy's father was not there to teach him how to catch a baseball. He'd already received a baseball glove for Christmas. Father's Day came. His birthday. His first day of school. (This could go on indefinitely, as major losses can have fresh impact at every developmental milestone.)
- An eleven-year-old girl lost an uncle in the World Trade Center disaster. Even a month later, her parents were upset all the time and couldn't seem to talk about anything else. Also, her school wasn't any good anymore; everyone there was angry now because hundreds of kids from some other school were all crammed in there too, until they could go back to their own school again.

In other words, it's not just the event itself but the circumstances surrounding and following the event that may make it traumatic rather than merely upsetting. Personality, social support, and other factors (discussed later in this chapter) also help to determine whether a child can handle an event or will be overwhelmed.

THE "TRAUMA WALL"

A popular saying is that "What doesn't kill you makes you stronger," or, less colloquially, that we grow from adversity. Although this certainly can be true, it is not always the case. Sometimes what doesn't kill you may still hurt you or cause damage. So how does this work—why does it go one way rather than the other?

Here a food analogy is helpful. Usually, we chew food, swallow it, and digest it. It becomes part of our nutrition, something we can grow from. Ideally, we do something similar with an upsetting experience. Kübler-Ross (1969) described a similar process in the stages of processing grief.

For example, let's say your dog dies. Maybe you don't think about it or process it every minute of the day, but now and then you do think about it, remember different aspects: how frisky she was when you first got her, how she liked to have her belly scratched, how badly you feel about having let her out the day she got hit by a car. You remember, you talk to others, you take a walk, you write, you cry, you laugh. Little by little—or bite by bite—the hurt becomes smaller as more gets processed, integrated, "digested." When an upsetting experience is digested, it becomes your nutrition, something you grow from. Then it becomes part of long-term memory, part of the past. It is not as fresh or upsetting anymore. Along with the emotional processing, we have organized the elements of the experience into a coherent story, including a perspective that allows us to move on. For example, you might say to yourself, "Well, she loved to play outside. I guess there was always the risk of an accident, but she would have been miserable tied up," and "She was a great dog. I'll always love her."

However, sometimes upsetting experiences do not get processed in this ideal way. Sometimes it's just too much to face, to take bites out of. Maybe the event was too upsetting and overwhelming; maybe you try to talk about it and are punished for that (perhaps by parents getting upset or peers teasing); maybe just when you are ready to take a bite out of this upsetting memory, another one comes along. It can be so difficult to face this upsetting memory, to tolerate it, that many people try to push it aside, push it behind a wall. That brings quick relief, so the strategy is experienced as helpful. Unfortunately, it provides only a temporary solution.

Back to the food metaphor: Imagine that you have eaten some food that is bad for you or poisonous. Ideally you will be able to get rid of it somehow. Maybe you'll be shaky or sick for a little while, but it'll be gone from your system. Unfortunately, with an upsetting experience, you can't just reject it and flush it down the toilet. The only way out is to go through—through the memory processing system into long-term memory. Until the memory is processed, or digested, it stays behind the wall.

Although the wall may provide some relief, this system has problems. First, the memory stays fresh and keeps its power indefinitely, until it is digested. I have worked with people months, years, and even decades after the trauma, and the quality of the undigested memory is the same. When asked to concentrate on the memory, they say things like, "It's so vivid it's like it just happened yesterday," or, even more telling, "I'm there."

Also, although the memory retains its freshness and power, it is still behind the wall, so we can't get at it with the rest of our psychological resources the way we can with processed memories. This means that the memory, or parts of the memory, can negatively influence us and we may feel helpless to stop it. For example, many rape victims will say, "I *know* in my head that it wasn't my fault, that I didn't do anything wrong, that I didn't deserve that. But I can't help *feeling* ashamed, dirty, to blame." In other words, the healthy part that knows better can't manage to influence the powerful beliefs and feelings that are shielded behind the wall.

Furthermore, the memories stored behind the wall are not content to stay there. They are always waiting for a chance to come out, go through the system to be digested, and become part of the past. It is as if the memory is seeing its chance and saying, "Me too! Can I finally be treated like a normal memory and get processed already?" When this happens, we say that the memory was "triggered" or activated by a reminder, something thematically related. Another way of explaining this is that the stuff piled up behind the wall is like a "sore spot," and when some kind of reminder hits that sore spot, the reaction is stronger than others might expect. This is because the person is not just reacting to what's happening right now; the old stuff is kicking in, too.

- Most of us who drive are at least a little nervous about driving. This is reasonable and inspires us to put on our seat belts and watch out for bad drivers. However, we are still able to enjoy conversations with our passengers, listen to the radio, and think about where we are going. Now think about the woman who experienced a car accident because she couldn't stop on a snowy road. Afterward, whenever she got into the driver's seat, she had the usual amount of nervousness, plus all the extra fear from behind the wall. You've probably seen people like her on the road, clutching the wheel and gritting their teeth as if they are expecting an accident to occur at any second. On rainy or snowy days, so much of the fear piled on that she could not manage to drive herself to work.
- Most of us, when accidentally bumped in the hallway, will be slightly irritated, perhaps make a comment, but forget about it five minutes later. Now think about the twelve-year-old boy who has been routinely physically abused at home. Behind the wall is piled-up fear of being attacked, a sense of helplessness, and rage. When he is bumped in the hallway, the "sore spot" reaction from the stuff piled up behind the wall is so strong that he believes he is being attacked. Naturally, being angry and not wanting to feel helpless anymore, he defends himself. When he is sent to the assistant principal's office for "punching a peer with no provocation," he insists that the other kid started it.

Note that it is not necessary to be aware that an unprocessed memory is being triggered for it to be happening. Sometimes the person will be acutely aware of it, as unwanted images from the memory itself come back. For example, one thirteen-year-old girl said, "Every time my boyfriend tries to kiss me, I freak out. I see the face of that guy who messed with me when I was little." However, often the person is unaware of the impact of the behind-the-wall memory and just subjectively experiences a strong reaction to the present situation. For example, a sixth-grade boy who has experienced several events involving helplessness may give up too quickly when he does not immediately grasp how to do his math homework. He may say, "It's too hard—I can't do it" when he probably could do it with a little effort—if he weren't overwhelmed by the "sore spot" helplessness from behind the wall.

We all understand this phenomenon. We understand that people have their wounds, their sensitive areas, their sore spots. We say, "Don't mention John around her, unless you want her to start crying," or "Don't joke like that with him—he'll go ballistic." What we mean is that there are unprocessed memories piled up behind the wall that can get triggered by thematically related events in the present. We understand that people can be more reactive than the current situation warrants when they are hit on their sore spot. This is one of the consequences of carrying trauma memories that are not fully processed.

RESILIENCY AND VULNERABILITY

Beyond the objective severity of the event itself, several factors contribute to determining whether a given upsetting experience is ultimately processed or pushed behind the wall.

Social Support

The choice to face and digest an upsetting event versus pushing it behind the wall occurs in a social context. Children may not want to talk about upsetting thoughts and feelings around their peers for fear of being rejected and isolated. At home, kids may not want to worry their parents or other family members. When a parent says, "Don't talk about that. It'll only upset you!" the child learns, "Wow—this is so bad and scary that even Mom/Dad can't handle it!" So unless kids are in an accepting and supportive environment, they may be getting messages that do not provide support for talking about the trauma and that discourage processing.

Temperament

Pain threshold is a familiar concept that can be applied to emotional pain as well. People are unique in the ways they experience events. The same event with the same severity will bother one person more than another. Extending an earlier analogy, two identical bombs might make different size craters for each person. Furthermore, even if the same size bomb is making the same size crater for two people, it might bother one person more than the other. For example, on a 0–10 scale of severity of emotional upset, two kids might each report the same event as being a 6. However, one child might experience that 6 as no big deal, and the other might find it intolerable. Obviously, the more difficulty a child has with tolerating pain, the more tempted that child will be to push the memory behind the wall.

New and/or Repeated Insult/Wound

Suppose a child has experienced a minor everyday type of upsetting event, such as a peer insult or a school-related frustration. She is on track to digest it and is just getting ready to take a bite when some new stressor comes along, and then another, and another, and another. Eventually so many of these small events pile up that the pile is experienced as "too much" and pushed behind the wall. This pileup of minor events commonly occurs in kids who have an untreated learning disability or attention deficit/hyperactivity disorder (ADHD); kids who are bullied; and kids who are subject to emotional abuse.

You might have noticed that we just expanded our definition of trauma. If it's behind the wall, it counts. If it's behind the wall, it's creating sore spot reactivity, whether the sore spot comes from one big event or a hundred smaller ones.

Attachment Status

Some preliminary research suggests that attachment status can, to some extent, predict the child's preferred coping style. This also makes sense. How do you become someone with a secure attachment? You do this by having a "good-enough mother" (Winnicott, 1965). This parent figure actually doesn't need to be a mother, but he or she does need to be good enough! When you have a good-enough mother, you learn, through repeated experiences over time, that if you're cold, soon you'll get warm again; if you're hungry, soon you'll get fed; and if you get so angry that you want to kill, your mother will survive and so will you; she will not retaliate or reject you. In other words, in the process of developing a secure attachment, kids learn that although they may not like to feel bad, they can handle it and things will come out okay.

When securely attached kids have to deal with a trauma memory, they have an experience base and coping style that favors facing it and getting through it. Incidentally, kids with secure attachment are also more likely to have good social support, because they are probably still in the family in which the attachment was formed, and because they are more capable of forming other supportive relationships.

On the other hand, how do you form anxious, insecure, or disorganized attachment? You do so by having a (subjectively experienced) not-good-enough mother, or a good-enough-sometimes-but-not-other-times mother. Kids with problematic attachments have learned, through repeated experiences over time, that feeling bad can be disastrous and overwhelming. If you are cold, you might get warm, or you might stay cold and miserable. If you are hungry, you might get fed, or you might just get hungrier. If you get so angry that you want to kill, you might get rejected or attacked. In other words, in the process of developing a problematic attachment, kids learn that feeling bad is a danger sign, to be avoided if possible. When such kids have to deal with a trauma memory, they have an experience base and coping style that favors trying to push it out of the way, to get rid of the threat.

The more severely problematic type of attachment status is known as failed attachment or reactive attachment disorder. Unattached kids may experience trauma in a qualitatively different way than other kids do; they also have some unique ways of responding to various interventions. The treatment of kids with the most severe attachment problems is beyond the scope of this book. The treatment approach presented in this book is still necessary in their treatment, but it is not sufficient; an additional specialized treatment component is needed.

Safety and Attachment

There are also other consequences of traumatization. In Erikson's (1963) developmental theory, the first stage of development is trust versus mistrust. With a good-enough mother, the infant learns through repeated experience that he or she will be taken care of, that the world is a safe place. Trauma can alter that perspective, reverse that lesson.

We have understood this since the beginning of the modern era of trauma study. In the World War I literature on post-traumatic stress disorder (PTSD, which was called "shell shock" then), it was reported that soldiers under bomb attack would frequently call out either for God or their mothers. What is the significance of this? The first promise was being broken: "The world is no longer a safe place. I am not being taken care of. Mother, God, you lied to me."

Attachment and safety are inherently related, and when children feel unsafe they seek the comfort and protection of their primary attachment figures. The toddler at the zoo is not frightened by the tiger; he is safe with his mommy. However, trauma can disrupt attachment, in part because the attachment figures have, by definition, failed to protect and an unimaginably bad thing happened.

Some kids may react to this trauma-related attachment challenge by withdrawing, whereas others may seek out new attachment figures who are perceived as more likely to protect. For example, although there are practical reasons for affiliating with street gangs, the explanations kids offer are revealing: "We watch each other's backs," and "This is my family."

SURVIVAL ORIENTATION

When children are exposed to trauma, they learn that parents and others cannot be relied upon for protection; they learn that bad things can happen. They then make a profound shift in their worldviews, in their orientations to daily living. Instead of focusing on normal concerns and activities, the primary focus becomes keeping the bad thing (or other bad things) from happening again. When we say someone has "lost her childhood," this is what we mean. The child exchanges the healthy (if irrational or naive) optimism for a survival orientation.

POSTTRAUMATIC SYMPTOMS

Many posttraumatic stress symptoms can be understood from the perspective of the sore-spot reactivity, plus the survival orientation.

Reexperiencing

Reexperiencing, one of the primary posttraumatic symptoms, refers to instances in which the memory itself recurs or intrudes into awareness. The child might complain that he thinks of the memory "all the time" or that it comes to mind at random moments, without warning. However, on analysis, it turns out that such intrusions generally occur when they have been triggered by something in the present. Most people find these intrusions disturbing and disruptive. Flashbacks are an extreme and relatively rare reexperiencing symptom; nightmares and waking memories are much more common.

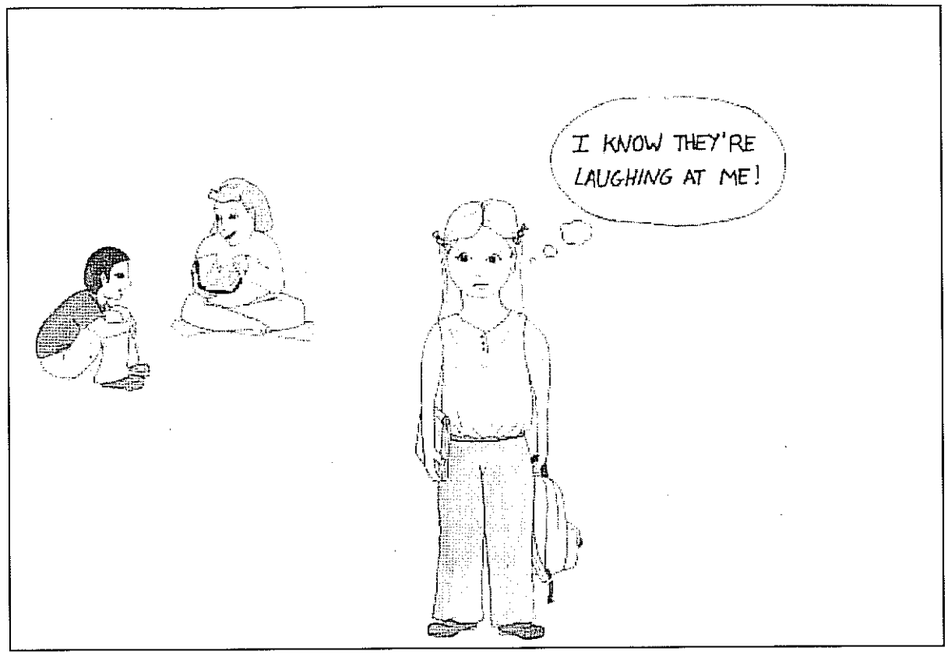
Avoidance

Avoidance, another of the primary posttraumatic symptoms, relates to both the sore-spot reactivity and to the survival orientation, the wish to keep any more bad things from happening. For example, a traumatized child might avoid walking down a certain street where she had been hit by a car, both to avoid a recurrence of the accident and to avoid being reminded of the memory. Avoidance can have significant impact on many areas of life:

- A fourteen-year-old boy, whose best friend had abandoned him during a street fight, says, "I don't have friends, only associates. Friends let you down." He is avoiding the possibility of being let down again by not trusting anyone anymore.
- A fifteen-year-old girl with exposure to multiple traumas is not doing much in the way of schoolwork, and she is having unprotected sex. She says, "What does it matter? Nothing's going to work out for me anyway. Why bother making the effort?" She is avoiding the possibility of feeling disappointed again by not getting her hopes up, not feeling optimistic, not setting goals for herself (the technical term for this is *pessimistic future*).
- A nine-year-old boy, who had been hit by a car while on his bicycle, has quit his baseball team. He says, "I just don't feel like going anymore." In fact, he's not going anywhere except school and home, because he doesn't feel safe anywhere else. He's learned that bad things can happen out in the world, and he doesn't want any more bad things to happen to him.

Hyperarousal and Hypervigilance

Hyperarousal and hypervigilance are also common outcomes of traumatization. Many children are in a constant state of alert, on the lookout for possible signs of danger. When kids are primed to expect the worst, they can be jumpy when startled or threatened. The problem is, when you think you're a nail, everything looks like a hammer. So many kids will interpret neutral or ambiguous social cues as being threatening (the technical term for this is *hostile attribution bias;* see Dodge & Coie, 1987). For example, a boy may notice a peer looking his way and assume that the peer is showing disrespect and trying to start a fight. Of course, this kind of assumption leads to problems!



Numbness

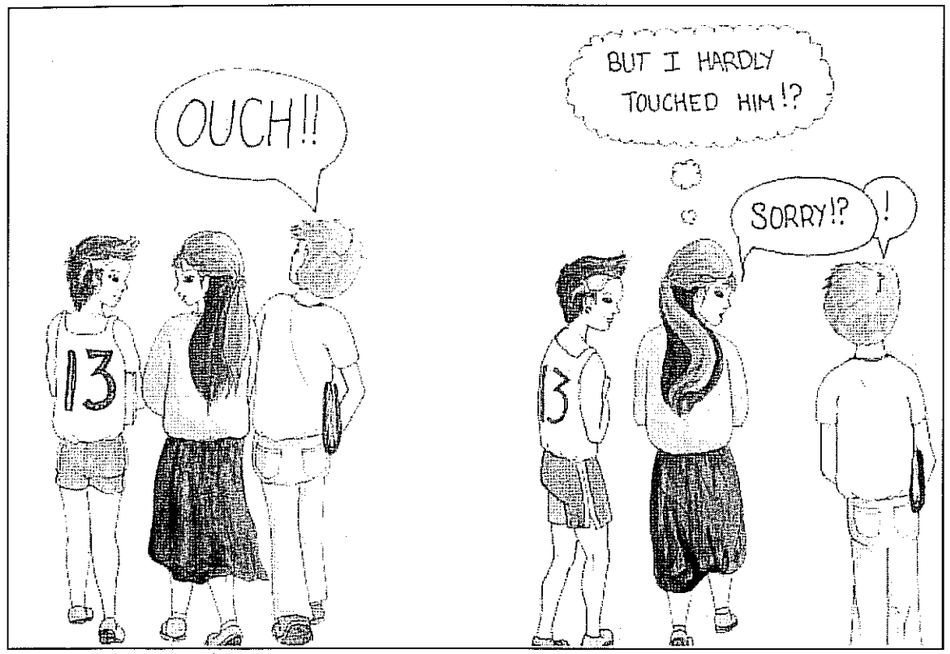
Many traumatized kids find themselves "numb" or unable to feel certain (or most) emotions. This may be a "freeze" response to being overwhelmed or it may be a special kind of avoidance. Some kids will say, for example, "I can't let myself feel anything or I'll feel everything; it'll all come back. And that's too much," or, "I'm afraid that if I start crying, I'll never stop." The numbness solution is to block it all out.

Substance Abuse and Other Avoidance Strategies

Many traumatized kids are unable to effect that numbness and so seek activities that will help them "forget about" the memory or related affect. For example, some kids become thrill seekers, troublemakers, or workaholics to stay busy and distracted with attention-compelling activities. Many youth turn to substance abuse to keep the trauma memories away, if only for a while. One nineteen-year-old boy who had been brutally assaulted by peers said, "I think about it every night. It keeps me awake for hours. I have to catch a buzz [smoke marijuana] to get myself to sleep."

Affect Dysregulation

The technical term for sore-spot reactivity is *affect dysregulation.* We should not use this term in front of our clients, but it's important to understand it. Breaking it down, *affect* is emotion, and *dysregulation* means unregulated, out of control, or volatile. Emotions may become out of control when traumatized kids react very strongly to minor stressors because they are already sensitized. This in-the-moment reaction, perhaps of anger, fear, sadness, shame, or helplessness, can



be very intense and uncomfortable, even intolerable. The fear of these reactions drives many of the avoidance behaviors.

Also, kids who react very strongly to minor stressors are at a high risk of impulsive acting out behavior (van der Kolk et al., 1996). The impulsive acting out provides quick relief from the intolerable feeling, but often leads to other problems. It is likely that unprocessed trauma plays a significant role in the acting-out problems of many kids with oppositional/defiant and conduct disorders (Ford, 2002; Greenwald, 2002b).

Posttraumatic Symptoms over Time

Unfortunately, kids don't just "get over" their traumatization. The memory (and associated symptoms) doesn't just fade away with time. It stays fresh as long as it's behind the wall. It stays fresh until it's digested. But what does it take for digestion to be possible? What needs to happen?

Going back to the food analogy. Suppose you've just had a nice lunch and you're back at work. Someone bursts into your office and announces that there's a bomb scare in the building, so you have to rush out and go somewhere else. Meanwhile, your nervous system is shifting from parasympathetic to sympathetic, and the blood is going away from the stomach to supply the brain, arms, and legs. This allows you to escape and survive. Twenty minutes later you hear an announcement that the whole thing was a hoax—there's no bomb. You go back to work and gradually your nervous system shifts back to parasympathetic. The blood goes back to your stomach, and you can proceed with digestion.

This return to relaxation does not happen with posttraumatic stress symptoms because they are self-perpetuating. The need for survival mode is repeatedly reinforced, with no shift to safety and relaxation, no opportunity for digestion:

- A young girl who had been assaulted on a certain street walks the long way home from school to avoid going down that street. She may say to herself every day that she does this, "Phew! I escaped another assault."
- A girl who was raped by the babysitter—who is now in jail—is bullied by her big brother in minor ways on a daily basis. She learns, over and over again, that males who are bigger and more powerful than she is can have their way with her. Her "psychological truth" is that she is in constant danger.
- A previously victimized teenaged boy believes that he is being stared at by a peer and interprets this as a hostile affront. If he
  —quickly leaves the situation, he may say to himself, "Phew! I got away! I'm glad I've stayed so alert."
  —challenges the peer, who then backs down, he may say to himself, "I defended myself well."
  —challenges the peer, who responds by fighting, he may say to himself, "I was right: he was hostile."

Regardless of specific outcome, these posttraumatic symptoms serve to reinforce the perception that the world is still dangerous. Every avoidant behavior—such as walking the long way around—only provides relief from fear, and reinforces the perceived need for avoidance. The defensive-intent aggressive behaviors also are self-reinforcing: by forcing the other's withdrawal or hostility, the need for the defensiveness is confirmed. Since traumatized kids tend to be hypervigilant and to overinterpret neutral cues, these types of situations may occur frequently. As long as kids remain in survival mode, they do not feel safe and are not prepared to relax or to digest their trauma memories.

Posttraumatic stress symptoms can also make it more difficult for kids to handle new challenges in a healthy way. A new upsetting experience may be hard enough to manage already. However, when this new experience triggers trauma-related reactivity from something that's already behind the wall, the reaction to the new experience can be much stronger than is apparently warranted. This extra-strong reaction can make it even more difficult to manage the new experience effectively, and the child is more likely to push the memory behind the wall rather than attempt to digest it. Thus, previously traumatized kids are at a higher risk for being overwhelmed, and traumatized, by new upsetting experiences.

The more trauma memories (and associated thoughts and feelings) are piled up behind the wall, the more likely this "trauma burden" (Greenwald, 1997) will affect the child's daily life. A single memory might be well contained, at least until the child is faced with a very closely related reminder. For example, after an initial period of adjustment, children of divorce tend to look and act like other kids, with no special problems—at least until they get old enough to attempt their own intimate/romantic relationships (Wallerstein, Corbin, & Lewis, 1988). Because kids can be good at containing or hiding their distress, many parents come to believe that the child has "gotten over" the trauma.

As unprocessed trauma accumulates behind the wall, two things happen. First, the strength of the reactivity to a current stressor is likely to be greater, so others are more likely to notice that the child is overreacting to things. Second, the child is more likely to overgeneralize and practice a wider avoidance. This is because humans are good at recognizing patterns and can use this ability to avoid repeating the same mistake. However, a traumatized child's interest in avoiding further trauma can be so powerful that she may take avoidance to an extreme.

Following is an example of how avoidance might be generalized from a specific identified high-risk situation to other less high-risk situations:

- I won't be alone in a room with Uncle Matt anymore. He messed with me last time.
- Uncle Matt has a beard—that must be it. I guess I can't trust men with beards.
- I can't trust men.
- I can't trust.

Pessimistic future can develop in a similar way:

- Wow—something bad happened. I didn't know that could happen.
- Something bad might happen again. I'd better be careful.
- I know bad things are going to happen.
- Only bad things will happen, and good things will turn bad, so why get my hopes up?

In summary, posttraumatic stress symptoms can persist indefinitely and can lead kids to react very strongly to minor stressors. In fact, sometimes others don't see any stressor at all, because we don't know what might be a trauma reminder to the child. When the triggers are not apparent to others, we are prone to forming opinions about the child's behavior that are not based on understanding. For example, we may be likely to assume that a child is gratuitously aggressive when, from his point of view, he is only defending himself.

A NOTE ON EXERCISES/ACTIVITIES IN THIS BOOK

The exercises and activities are included because they are likely to help you to learn the material. People tend to learn best when engaging personal experience is part of the lesson. Because this book is focused on trauma, the experiential component sometimes focuses on trauma as well. Participation in such experiences might hurt your feelings or at least bring up hurt feelings that were otherwise dormant. In live workshops, most people find that they can handle this and they are glad they participated. However, occasional exceptions do occur.

Although in general the value of the learning will outweigh the potential for discomfort, it will be up to you to make that determination for yourself at each instance. You will want to consider not only the value of the lesson but the possible impact of participation on your emotional status and functioning, in light of your current situation/surroundings and your plans for later in the day. You always have several options:

- Participate fully in the activity.
- Participate until you determine that your distress level is as high as you are willing to allow it to go; then stop.
- Participate but carefully select the content (e.g., which memory to focus on) to avoid an unwanted level of distress.
- Decline to participate.

Bear in mind that sometimes you get more than you bargained for. If you choose to participate and then find that it is too much for you, it is important to take care of yourself and make sure that you're okay. Here are some suggestions in this regard:

- Do the deep breathing or another of the calming exercises that are presented at various points in the book.
- Use any of your usual coping skills/methods as long as they are constructive (e.g., thinking of something else, taking a walk, listening to music, etc.).
- Discuss your concerns with the workshop leader if you are attending a workshop.

- Discuss your concerns with a trusted family member, friend, colleague, or supervisor.
- Discuss your concerns with a mental health professional.

EXERCISE: FLOAT-BACK

The main purpose of this exercise is to see how trauma-related triggers may be active in your own life. When you see how a principle applies to you, you can use your experience to better understand others. Another purpose of the exercise is to directly experience an activity that you might ask a client to do. For this exercise, you'll need a pencil or pen and paper.

Float-Back

1. Think of a situation that happened within the past couple of days in which you were somehow distressed: upset, mad, worried, hurt, sad, frustrated, etc. It doesn't have to be anything major. The first thing that pops into your head is probably the right one.
2. On a scale of 0–10, 0 is no bad feeling at all, 10 is the worst a feeling could possibly be. Concentrate on the worst part of the recent event. Notice the picture in your mind, what you are saying to yourself, and what you are feeling. On a scale of 0–10, how bad is the feeling *right now* as you are concentrating on it? (Not how bad it was then.) Write that number down.
3. Now as you are concentrating on this recent memory, again notice the image, what you are saying to yourself, what you are feeling, where you feel this in your body. Now try to make the feeling even more intense.
4. Let your mind float back in time, maybe a long way back, to when you first learned to feel this way. If something pops into your head, maybe that's it.
5. Now on a scale of 0–10, with 10 being the worst the feeling could be, how bad is the feeling from the old memory *right now* as you are concentrating on it? (Not how bad it was then.) Write that number down.

Deep Breathing

Because I asked you to think about something that might be upsetting, now I will ask you to do a deep-breathing exercise that might help you to feel better, to relax again. You might not need this, but please do it anyway for the experience. You will be taking a very deep, slow breath in, to a count of three, then hold for three, then breathe out slowly to a count of three. Ready?

Breathe in 1, 2, 3; hold 1, 2, 3; out slow 1, 2, 3. Again, breathe in 1, 2, 3; hold 1, 2, 3; out slow 1, 2, 3.

This time, when you breathe out, look for any bad stuff—tension in your body, upsetting thoughts or pictures—and when you breathe out, imagine the air coming from that place and the bad stuff going out with the exhale. Ready?

Breathe in 1, 2, 3; hold 1, 2, 3; breathe out the bad stuff, 1, 2, 3. Once more, breathe in 1, 2, 3; hold 1, 2, 3; breathe out the bad, 1, 2, 3.

Discussion Questions

How many (in a group, raise hands) had a higher number—a worse feeling—for the old memory than for the recent one? (Normally about three-fourths of the group will raise hands here.) What might this mean?

- What was once significant may maintain its influence, even over a long time period.
- Do you think that, for you, your reaction to the current event was at least in part due to hitting the sore spot from the old one?

How many (in a group, raise hands) had a higher number—a worse feeling—for the recent memory than for the old one? (Normally about one-fourth of the group will raise hands here.) What might this mean?

- Perhaps the recent event was actually a major trauma, although the odds are against this.
- What's fresh may feel more relevant than something that happened a long time ago.
- Will kids believe you when you say that the recent event is not relevant?

The trick here is that both answers are the right answer, and with kids we must somehow address both the past and the present if we are going to be helpful.

A twelve-year-old boy had been doing pretty well until his mother died suddenly, when he was seven. Since then, he has done worse in school, had a short temper, and gotten into a lot of fights. You are absolutely sure that his problems are directly related to the death of his mother (and you're right). But when you bring this up, he storms at you, "Everybody wants to talk about my mother all the time! I'm sick of talking about my mother! That's not what's bothering me! My problem is that my teacher picks on me. I'm the one that gets in trouble even though the other kid started it!"

If you insist on talking with him about his mother, what will probably happen? He will feel disrespected. He is trying to tell you what is important to him and you are ignoring him. He will then discount you and become uncooperative. This is especially tempting for him because then he can avoid talking about his mother! And you lose your chance to be of service.

But if you do it his way and talk only about the problem of the day, what will probably happen? He will feel respected, he will work with you, and he might even learn a few problem-solving or other coping skills. But the core problem will remain because the source of his reactivity never gets addressed. He might go from one counselor to the next for years and never solve his problem.

So what do we do about this? How do we address the past as well as the present? I'll tell you later! This is the part of the book in which we try to understand what's going on with traumatized kids. Later on step-by-step guidance is available for what to do and how to help them. In the next chapter we take the first step, by learning how to analyze a presenting problem to take into account both past and present-day contributing factors.

Chapter 2

The Structure of Trauma Treatment

An understanding of traumatized kids' experience is a good first step. However, to know what to do about it, we must also understand exactly how the child's posttraumatic stress symptoms might relate to the current presenting problem. The next step will be to use that understanding to determine a course of action.

MEANING OF BEHAVIOR

Just about half of all child/adolescent mental health referrals are for problem behaviors (Kazdin, 1987), so problem behavior is a good example to use for the present focus on understanding the child's presenting problem. However, the same principles will apply to kids' presenting problems and symptoms more widely, whether or not problem behaviors are part of the picture. Based on this discussion, following is a summary of the possible role of trauma in problem behaviors:

- Kids learn from experience. Trauma can be an intense experience that teaches powerful, long-lasting lessons. These lessons—or negative beliefs about the self and the world—are protected behind the wall and may not be amenable to rational intervention.
- Unprocessed trauma creates a pileup of unprocessed feelings, possibly including shame, guilt, anger, fear, hurt, helplessness, and sadness.
- Thematically related reminders of the trauma may trigger a heightened response, or overreaction, to the present situation. This happens when the new stressor hits the sore spot; then the negative beliefs and the piled-up feelings kick in.
- When a child is experiencing an intense reaction which includes a distorted interpretation of what is happening and which feels intolerable, the child is at high risk of impulsively acting out.

In sum, problem behaviors may be set in motion by present-day minor stressors that trigger a trauma-related overreaction. How often are kids' problem behaviors related to their overreaction to a trauma-related trigger? How do we figure this out for a given child? What kind of information do we need?

Following are the suggested steps (again, details on how to accomplish these steps are provided later):

1. Get a good trauma/loss history.
2. What would someone learn from this (trauma/loss) experience? What negative beliefs might the child develop?
3. What kinds of feelings might be piled up behind the wall?
4. Learn details about the context in which the problem behavior occurs. What is the apparent precipitating event? In what way might that be a trauma-related trigger?