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IMPACT OF TRAUMA ON CHILDREN AND BEST PRACTICES FOR INTERVENTION

Exposure to violence and other life-threatening events is unfortunately a part of daily life for many children in South Africa. For example, in a national prevalence study of South African adolescents aged 15-17 years, 20% reported being sexually abused and 30% reported being beaten by a caregiver during their lifetime. Outside the home, many South African children regularly witness or directly experience community violence. Accidental traumas within the home (for example, burn injuries) and in the community (road accidents) also affect many South African children. However, just because such events are commonplace doesn't necessarily mean children are desensitised to them, or that their impact is benign. Trauma can affect children psychologically in different ways.

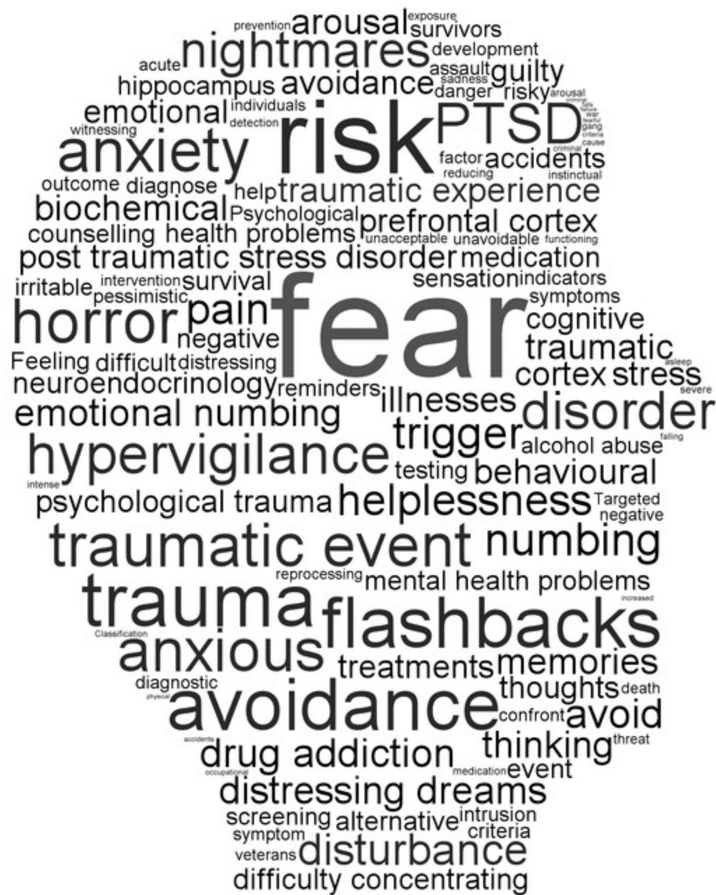
POSTTRAUMATIC STRESS

When children experience or witness an event that involves a threat to their own, or another person's, physical safety it can result in temporary symptoms of posttraumatic stress (PTS) that alleviate within a few days or weeks or, in some cases, a more protracted, full-blown posttraumatic stress disorder (PTSD) that requires formal intervention.

PTS can be expressed in four symptom clusters. First, the child may re-experience a past traumatic event in unwanted, intrusive ways. This includes memories, images or flashbacks. Flashbacks are a kind of sensory re-living of the event, where the child hears the same sounds as they heard during the traumatic event, smells the same odours etc. Second, the child may start to avoid reminders of the trauma, such as places or people that were part of the traumatic event or that the child associates with the traumatic event. For example, children who have been bullied at school may refuse to go back to school, even if those who bullied them are no longer there, because they associate school with threat. Third, the child may be in a constant state of vigilance and preparedness for danger, even if the actual threat has been removed. For example, they may always be scanning the environment for

possible threats, may struggle to fall asleep or concentrate on daily tasks due to feeling constantly unsafe, or may react with aggression to interactions that are not actually threatening. Finally, PTS can also include feelings of fear, guilt or shame, and negative beliefs about oneself, others and the world, resulting from the traumatic experience. For example, feelings of shame and self-blaming beliefs are common amongst children who have experienced sexual abuse.

When a child who has experienced a traumatic event continues to experience *all* the above symptom clusters for longer than four weeks, resulting in difficulties with school and social functioning or significant distress, a diagnosis of PTSD can be made. While PTS is a typical human response to trauma and often resolves spontaneously, a diagnosis of PTSD indicates that the natural processes of recovery from trauma have become impeded. After isolated traumatic events, only a minority of children will develop PTSD: international epidemiological studies indicate that about 5% of adolescents have met criteria for PTSD in their lifetime (there are no comparable studies in South Africa as yet). However, children who experience repeated trauma (such as prolonged abuse), continuous trauma exposure (such as daily gang violence in their neighbourhood) or a combination of several different forms of trauma are at higher risk of developing PTSD. PTSD in children is often accompanied by symptoms of depression (including low mood, low self-esteem, loss of interest in usual activities, feelings of hopelessness and sometimes suicidal feelings) and at times depression may develop in the absence of PTSD after a traumatic experience.



DEVELOPMENTAL IMPACTS

While many children who experience traumatic events will not develop full-blown PTSD, trauma can impact on children's development in other ways that are important to recognise. Even babies can be impacted by a traumatic experience (such as abuse or a burn injury), despite not being able to fully cognitively comprehend what has happened. Children younger than two years tend to express their distress primarily through physical symptoms such as sleeping or eating difficulties, crying or unusually clingy behaviour. Children between the ages of three and six years may display regressive behaviours, such as losing skills they have recently acquired (like the ability to feed or dress themselves). They may also have a re-activation of old fears (for example, of strangers or of animals) and a resurgence of separation anxiety that can manifest as psychosomatic complaints (like headaches or stomach aches). In children of primary school age, the effects of a traumatic event may be evident in marked changes in classroom and playground behaviour, ranging from social withdrawal to signs of hyperactivity, impulsivity and distractibility. Children may also start to act out traumatic themes in their play.

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Children with PTS are constantly attuned to signs of possible threat and danger, and focused on how to keep themselves safe, even if there are no objective threats in the classroom or school environment. As a result, their brain is not able to concentrate on learning, remembering and thinking about school tasks. Marked changes in a child's school performance in the aftermath of a traumatic event can therefore be a signal of distress, of a brain that has shifted into survival mode rather than learning mode. Amongst adolescents who have experienced trauma, defiant, aggressive and reckless behaviours can sometimes develop as a defensive response

to feeling scared and vulnerable. This can be mistakenly attributed to 'typical' teenage acting-out behaviour, rather than being recognised as a sign of trauma-related distress.

Whenever children or adolescents present with sudden, marked changes in behaviour or regressions in their development, such as those described above, it's important to explore whether the child or a close caregiver has experienced any recent traumatic experiences.

HOW TO HELP TRAUMATISED CHILDREN

While many parents may be extremely concerned if their child develops signs of PTS immediately after a traumatic event, a wait-and-see approach is generally recommended. As noted above, after an isolated traumatic event most children will experience only temporary PTS and naturally return to their usual functioning over a few days or even several weeks. In such cases no formal intervention is required. However, the family and school systems may benefit from having PTS symptoms explained and normalised, and from guidance on how to support the child's recovery by:

1. Providing emotional support and comfort as needed to make the child feel safe and secure.
2. Not punishing the child for difficult or disruptive 'acting out' behaviours after a trauma (rather, clear communication, setting of boundaries, and use of non-physical consequences will provide a sense of structure and security).
3. Returning as soon as possible to normal routines which provide containment and security.
4. Ensuring the source of threat or danger is removed or, if this isn't possible (for example, in a context of ongoing gang violence in the neighbourhood), that clear safety plans are set up within the family.

The risk of a child with PTS going on to develop full-blown PTSD is heightened when a parent or caregiver is extremely distressed or fearful for a prolonged period following a traumatic event. It may therefore assist the child's recovery if the parent or caregiver is able to receive support or treatment.

If, despite the above strategies, a child's PTS symptoms don't remit after four weeks and continue to impair their functioning or cause the child significant distress, a diagnosis of PTSD may be appropriate. A psychotherapeutic intervention is then indicated. The first-line treatment for PTSD in children is trauma-focused cognitive behaviour therapy (TF-CBT). A therapist, trained in TF-CBT will help the child to explore and re-process their traumatic memories within the safety of a supportive therapeutic relationship. Trauma re-processing enables the child to safely express, and then gradually master, their fear and anxiety about the trauma. At the same time, the therapist will help the child to develop emotional and cognitive coping strategies to deal with both the traumatic memories and other stressors they may be experiencing. The therapist may also work with the parents or caregivers to enable them to support the child's recovery. In numerous international studies, and in recent South African research, TF-CBT has been shown to be effective in addressing the symptoms of PTSD for many children. The evidence to support use of medication for paediatric PTSD is still limited and medication isn't recommended as a stand-alone treatment. Where the child's PTSD symptoms are severe enough to prevent them from engaging with psychotherapy, medication may be considered as an adjunctive treatment to enable the child to benefit more from psychotherapy.

CONCLUSION

Although exposure to trauma is common amongst South African children, in many cases the psychological impact of the trauma will resolve itself so long as adequate natural support systems and a safe recovery environment are in place. However, some children will go on to develop PTSD and/or disruptions to different aspects of their development. Fortunately, PTSD in children appears to be amenable to intervention. Referral to a mental health professional with training and experience in trauma-focused therapy can resolve the PTSD and place the child back on a healthy developmental path. MHM

References available upon request