Children and Trauma – What works?

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Children and Trauma – A specialised field?

- This is now being seen as a specialised field of work
- There is increasing evidence of the highly negative impact of trauma and abuse on children
- Larger numbers of children who have experienced trauma and/or abuse are being referred for therapy
- Internationally there is a lack of research on effective treatment programmes (Bonner 2008)

Children and Trauma – A specialised field?

- However in SA there are still many misunderstandings about the concept of therapy - (case)
- We also need to recognise, acknowledge the value of, and integrate the many cultural beliefs and practices that exist in our country into trauma management – particularly in the more rural provinces
- This is an area of research in itself.

Evidence-based practice

- In a country in which there is a huge need and scarce resources evidence based practice becomes critically important
- However few of us research our work systematically, document activities and responses in details
- Research in itself takes up resources – so there is the tension between time for work with children and time to gather and interpret evidence

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Evidence based practice

- We also need research that is longitudinal over a child's lifetime,
- taking into account that certain transitional stages in a child's life may require further interventions that sometimes indicate the success rather than the failure of previous therapy
- We also need to develop some common understandings of the indicators used to assess therapeutic interventions

How do we understand the concept of trauma in relation to children?

- How do children understand and process trauma?
- This may be related to the child's level of cognitive and socio-emotional development
- This understanding is often linked to the understanding and processing of that trauma by those who are closest to them
- Sometimes we focus all our efforts in the wrong space
- And sometimes we assume trauma without a proper assessment of the child because the parent is traumatised – or because we are horrified by the story. (Case History)
- Careful assessment of the child, the parents/caretakers and the "traumatic" events is critically important to determine who and what intervention – and research into effective intervention - should target.

Prevention – the best trauma management strategy

- Research into the brain development of children indicates that traumatic events (especially when repeated) may impact on the brain development and functioning
- These changes impact on every aspect of the child's development
- Repeated research over the past decade has confirmed these findings
- The younger the child, the more profound the impact
- Numerous researchers conclude that these changes are permanent

Prevention – the strategy that works

"The effects of early maltreatment on a child's development are profound and long lasting. It is the impact of maltreatment on a child's developing brain that causes effects seen in a wide variety of domains including social, psychological, and cognitive development. The ability to regulate emotions and become emotionally attuned with another depends on early experiences and the development of specific regions of the brain. Early maltreatment causes deficits in the development of these brain regions, primarily the orbito-frontal cortex and corpus callosum, because of the toxic effects of stress hormones on the developing brain." Arthur Becker-Weiderman (www.articlesbase.com) 2009

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Prevention

- Permanent damage cannot be changed, it can only be prevented. Recognizing that trauma may lead to such permanent changes demands early intervention to limit the actual damage that occurs.

Prevention – How?

- The importance of early intervention and attention to the chronicity of environmental adversity may indicate the need for permanent alternative caregivers, in order to preserve the development of the most vulnerable children. (Danya Glaser – Journal of Child Psychiatry and Psychology 2000)
- In South Africa children are often left in situations in which they are repeatedly exposed to continuous trauma/abuse in the home
- our law supports giving parents a second chance – and possibly a third, fourth……..

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Prevention – how?

- The younger the child, the more important the intervention – research indicates that all forms of bio-psycho-social interventions have diminishing returns the older the child becomes. (Doyle, Harmon, Heckman, and Tremblay)

Prevention - How

- Whose “best interests” do we act in?
- The law continuously emphasises that the best interests of children should be considered of paramount importance – and yet removal is seen as a last resort.
- How do we balance this imperative, knowing what we know about trauma/exposure to trauma and its impact on brain development, and ultimately a child’s holistic development?

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Prevention – How?

- Obviously many traumatic events experienced by children are difficult to anticipate and prevent but where children are exposed to repeated and potentially traumatic events in their home and community environment, protective intervention should occur as early as possible.

big mistakes in prevention?

- Teaching children to say “no”
- Teaching children self defence
- Assuming that teaching children their rights gives THEM the power to enforce these
- Teaching children that sexual touching is BAD touching

Does placing the responsibility for avoiding abuse and trauma on children themselves compound the impact of a traumatic event when it happens?

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Evidence based Prevention Strategies

- Little good research in this area
- Most of it relates to classroom teaching of "protective" skills and behaviours to children
- Good results in the classroom
- Effective outside the classroom in the real situation?

Minimise secondary traumatisation

- Wherever possible track the child's progress through the Criminal Justice system and mediate contacts and processes to ensure competent management
- A dilemma is the imperative to report to this system – all helping professionals including psychologists and social workers are all "mandated reporters" in terms of the

- Children's Act as Amended no 38 of 2005
- Criminal Law (Sexual Offences and Related Matters) Amendment Act no 32 of 2007
- Films and Publications Act as Amended

Preparing children to enter the CJS system

- There is broad recognition of the negative impact of children moving through the system without assistance and preparation
- There are numerous court preparation programmes internationally and in South Africa.
- Most have not been rigorously tested
- Some are of dubious quality
- There is an enormous need for research in this area and for evidence based programme development where successful outcome does not focus on convictions but rather on the experience of and outcomes for the child and the child's family

Therapy – The limited resources

- Few families/caregivers can afford open-ended continuous therapy for their children
- Our focus therefore needs to be on effective but time limited interventions
- The “Dibs in Search of Self” scenario might sound very inviting – but how possible is this for our average child and family?
- Yesterday we heard that for certain forms of attachment disorder children need to be seen 3 times per week
- Given the number of traumatised children in SA and the shortage of therapists – this is not realistic.

Where time and resources are limited

- Assess the situation and condition of the child and caretaker and
- Where possible invest in the child's caretaker
- Deal with their sense of trauma
- Enhance their ability to care for the child and provide some healing experiences
- A therapist may spend an hour a week with a child – the caretaker – numerous hours
- Help them restore routine for the child – routines bring a sense of security and predictability into a child's life

- For example – if one looks at some of the impacts of traumatic experiences for children (and adults), caretakers of children can use numerous activities and interactions with children to reduce these – eg dealing with

- Powerlessness
- High levels of arousal
- Re-experiencing symptoms

Evidence Based Treatment Approaches

- Once again there is a lack of good research in this area especially in SA.
- Studies are based on small samples
- Studies are often time limited – longitudinal studies are scarce
- Intervening variables are sometimes unpredictable and difficult to control
- Therapist variables are difficult to assess and control – different therapists may use theory and practice in different ways

Evidence Based Therapy

- Bonner (2008) reviewed research into outcomes of various trauma/abused focussed therapies
- Conclusions –

- The therapeutic approaches that showed most promise were

1. Trauma Focussed Cognitive Behaviour Therapy
2. Parent-Child Interaction Therapy

Trauma Focussed Cognitive Behaviour Therapy

- Is most effective when it acknowledges the diversity of symptoms in children
- Specifically focusses on the trauma itself
- Focusses on improvements in post traumatic Stress symptoms in both children and their parents

Parent Child Interaction Therapies

- Were most effective when the focus
- included a focus on parent symptoms of trauma and stress
- Included a focus on the child's symptoms
- included a focus on pre-existing issues/challenges experienced by the child or caretaker or both or the interaction between child(ren) and caretaker

Bonner noted that home visitation contributed to the success of PCIT.

Further notes from Bonner's review of research

- Parental beliefs and support to the child is significantly related to positive outcomes for the child.
- There should be a clear focus on parent/child relationships, health care and home safety in the management of trauma
- There is some evidence to support the use exposure based therapies and cognitive therapy particularly when these are linked to specific needs

Some thought provoking questions

- Is therapy an art form?
- How important is relationship versus theory, skill and technique?
- Match between child and therapist?
- When should therapy stop – what are the disabling consequences of continuing therapy when a child is "well"? A specific issue for children seen in private practice?
- How do we measure "Wellness"?

THANK YOU

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