NUMBER: 1.; DECEMBER, 2018.; RECIEVED: OCT 1, 2018.; ACCEPTED: OCT 1, 2018.; 51-59

Overview of trauma treatment in the framework of integrative child psychotherapy

Belma Žiga
Psychologist, CBT Therapist, Child and Adolescent Integrative Psychotherapist
Foundation for Support to Victims of War "Wings of Hope", Sarajevo
061 510 968
ziga.belma@gmail.com

Summary

Childhood trauma undermines the feeling of safety and takes a heavy toll on the formation of self-image and the perception of the surrounding world.

This case study describes psychotherapeutic work with a nine-year old girl, who experienced traumatic event caused by her father. Following the critical event, the father was hospitalised. Upon completion of his clinical treatment, he became withdrawn, which changed the family dynamics. During the course of the critical event, the girl experienced overwhelming fear. Early on in the course of the treatment, she complained of being irritable, feeling anxious about most of her school activities and having nightmares.

Psychotherapeutic treatment extended over a period of one year and was divided into three stages. The initial phase focused on the establishment of the therapeutic alliance and development of the sense of safety. During the central stage of the treatment, the focus was on creating the trauma narrative and processing the experience. Final stage of the treatment focused on building patient's personal resources and improvement of her overall functionality.

This paper illustrates the integration of trauma-focused Cognitive-Behavioural Therapy (CBT) with elements of play therapy and use of drawing, used in this case to facilitate processing of the trauma.

***Key words**: traumatic event, childhood trauma, trauma treatment*

Sažetak

Doživljena traumatska iskustva u djetinjstvu narušavaju osjećaj sigurnosti i utiču na oblikovanje slike o sebi i svijeta oko sebe.

Ova studija slučaja opisuje psihoterapijski rad s djevojčicom (9) koja je doživjela traumatski događaj koji je izazvao njen otac. Otac, nakon kritičnog događaja, biva hospitaliziran a nakon toga se povlači u sebe i od tada se mijenja obiteljska dinamika. U toku kritičnog događaja, djevojčica je doživjela intenzivan strah. Na početku tretmana djevojčica se žali na pojačanu razdražljivost, anksioznost vezanu za većinu školskih aktivnosti i noćne more.

Psihoterapijski tretman je trajao godinu dana i odvijao se u tri faze. Početni cilj je bio izgradnja terapijskog odnosa i razvijanje osjećaja sigurnosti. U središnjem dijelu tretmana radilo se na kreiranju traumatskog narativa i preradi traume. Završna faza je rezultirala jačanjem resursa i poboljšanjem funkcionalnosti.

U radu je prikazana integracija kognitivno biheviоralne terapije fokusirane na traumu sa elementima terapije igrom i korištenjem crteža tokom prerade traume.

***Ključne riječi**: traumatski događaj, trauma u djetinjstvu, tretman traume*

Introduction

Many children experience significant stressors during childhood. These events may vary in intensity, quality and the impact they have on a particular child. The range of potentially traumatic childhood events encompasses sexual or physical abuse, exposure to domestic violence, traumatic loss of a close person, war and experience of exile, serious traffic accidents, fire and medical trauma. (Cohen, Mannarino & Deblinger, 2012).

According to the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-V, 2013), to be able to diagnose Posttraumatic Stress Disorder, it is required that a child over six year of age experienced a life-threatening situation, serious injury or sexual violence (Criterion A). The second requirement, (Criterion B) is the presence of intrusive symptoms resulting from the traumatic experience, such as recurring flashbacks or dreams (in children, the content of dreams does not necessarily need to suggest recognisable traumatic experience), dissociative responses which cause the person to feel as if traumatic event was recurring, intense psychological distress related to trauma reminders and significant response to those reminders. In addition to symptoms specified above, other symptoms (Criterion C) include notable avoidance of disturbing memories as well as avoidance of external reminders of trauma. The fourth diagnostic requirement (Criterion D) includes negative change in mood or cognition such as the emergence of negative notions of self, others or the surrounding world and distorted notions of the cause or the consequence of the event that gives rise to the feeling of guilt. Negative notions are often combined with negative feelings of fear, anger and guilt and/or loss of interest in important activities. Finally, significant changes in emotional response and reactivity are commonly manifested in temper tantrums, self-destructive behaviour, hyperactivity and attention deficit issues.

The research shows that the high percentage of persons exposed to childhood trauma develop maladaptive emotional and behavioural responses that impede their psychosocial development and adjustment (Cohen, Mannarino & Deblinger, 2012). As noted by Profaca and Arambašić (2009), the impact of childhood trauma could be wide ranging and could impede academic achievement and cognitive development, causing a range of psychological issues.

Trauma represents an act of violence against the life philosophy or the worldview that made the world, as previously seen in the eyes of the person experiencing trauma, feel like a safe place. As a result, posttraumatic symptoms occur as the result of undermined or destroyed worldview (Subotić, 1996). In persons who experienced trauma, part of the brain that evolved to “scan” for threats, remains overactive and becomes stimulated upon exposure to the smallest signs of threat, regardless of whether the threat is real or misinterpreted, which often triggers acute reaction to stress, followed by very unpleasant emotions and overwhelming physical reactions (Van der Kolk, 2014).

In children who experienced trauma, problems occur in functioning of the hormonal system, specifically the hypothalamus area, which plays critical role in stressful situations. Autonomous nervous system becomes stimulated, which causes increased hyperactivity and irritability, often manifested in social and school situations (Harris, Putnam and Fairbank, 2006).

Pynoos, Steinberg and Goenjian (1996) note several areas of child development strongly affected by exposure to trauma, specifically: focus/cognition/learning, self-image, perception of self-efficacy, autonomous nervous system activation, specific concerns, impulse control, moral development, awareness/perception of continuity, representation of self and others, biological development, interpersonal and family relations and development of competencies.

Psychopathological phenomena, resulting from traumatic experience may occur in each of these areas. Therefore, traumatic experience may impede or otherwise adversely affect critical developmental areas. Arambašić (2005) explains this process by pointing to the interaction between traumatic events and loss experienced in everyday life, noting that despite differences between the two, they still share much in common. Differences include intrusive thoughts, anxiety and avoidance, all of which are distinct features of trauma. Similarities are much more common. They occur in the form of ***disorganisation or disruption*** of the previously established routine. ***Attachment*** is yet another common area. Arambašić notes that ***both events cause the sense of vulnerability.*** Other similarities include ***destruction or loss of self and feeling of helplessness and loss of control.***

Purpose of the Paper

The purpose of this paper is to showcase the specific nature of the treatment of Posttraumatic Stress Disorder of a nine-year old girl resulting from a single traumatic event, within the framework of integrative child and adolescent psychotherapy.

Anamnesis

Mother of the nine-year old girl came to see a psychologist and asked for help because the girl had repeatedly complained of anxiety, nightmares, irritability and overwhelming feeling of fear prior to being examined in school orally or in writing. The girl was third and youngest child in the family. The family lived together, in their own house.

A year prior to commencement of the treatment, the girl, together with older sister, mother and father, experienced a traffic accident. The accident caused by the father, occurred as the result of a psychotic episode. At the moment of the accident, the father believed that he and his family were pursued by dangerous individuals in another ve-

hicle, and that he had to get away from them. Immediately after the accident, the father was forcefully committed to psychiatric hospital. Immediately before being committed, as he was driving, he suddenly changed direction, drove at high speed, changed lanes, drove on the sidewalk, went to a location away from the planned destination, broke the metal chain, smashed into the metal door and drove the car into the underground garage. Other than some bruising and minor injuries, none of the persons in the car sustained any serious injuries. Similarly as with other traumatic experiences, this one too was complex in nature, tied to different stressful situations involving the girl and shaped by her great concern for her father and her mother. In addition to traumatic experience, father's subsequent withdrawal, feeling of guilt which was the only thing clearly verbalised and inability to make contact, all represented the loss for the girl. The girl too experienced guilt, resulting from her conclusion that she was responsible for father's withdrawal, because "she was the only one who experienced problems after the accident". Adjustment to new family situation was impeded because the girl was all alone in her grief – the subject of grief was not openly discussed within the family and the mother's resources were solely dedicated to providing care to the father.

Based on the information received from the mother, the teacher and the girl, the girl was irritable and high-strung, experiencing strong hand tremors, nightmares, high level of anxiety in the school environment and difficulties maintaining focus. These problems had adverse effect on her academic achievement.

Therapy and Discussion

Feeling of vulnerability is central issue resulting from traumatic event. Our autonomous nervous system, which regulates breathing and blood flow, functions without our control, maintaining balance between energy supply and demand of different systems. When the body requires higher level of energy due to a perceived threat, the brain prepares the body, putting the sympathetic nervous system in motion by triggering the fight-or-flight response, taking the energy away from the non-essential systems such as digestion, speech or long-term memory. Once the threat is no longer present, parasympathetic system restores normal bodily functions. In stress-free times, these two systems operate in balance. During traumatic experience, the balance is disrupted, and we either become highly alerted or we "freeze". To restore balance between these systems, trauma needs to be processed through relaxation, breathing exercises, physical activity, guided meditation or play. The purpose of relaxation is to enable the child to gain control over situations in which trauma reminders emerge. At the outset of the therapy, it was agreed that the goal would be for the girl to learn to relax by mastering relaxation and safe place techniques. The girl was highly anxious, very alert and highly emotionally responsive. She reported that the relaxation techniques had a calming effect on her. In addition to that, these techniques were highly valuable therapeutically. We focused our attention to

learning to breathe and to relax and we drew an image of the safe place. Relaxation techniques turned into a kind of a ritual and part of our each appointment was dedicated to breathing and physical activity. Along with the development of our therapeutic alliance and the sense of safety, part of our work focused on the ability to recognise different emotions. We acknowledged the fact that we should be familiar with the whole range of emotions to be able to better express ourselves. Upon commencement of the treatment, the mother was provided with training on the subject of responses to traumatic experience. This effort primarily focused on allowing "negative" emotions resulting from traumatic event to be expressed and acknowledging traumatic experience as such.

In the central phase of the treatment, we focused our efforts on the trauma narrative, often relying on drawings, sandbox games and guided meditation to adapt the therapy to the age of the girl.

At the moment of trauma, hippocampus, which deals with memory and spatial mapping and thalamus, which integrates the two, shut down. This causes persons who experienced trauma to recall traumatic experience in fragments. This also explains why persons with Posttraumatic Stress Disorder may experience extreme responses to specific sensory stimuli. Certain scent, image or sound may trigger traumatic memories. Traumatic memory is formed and stored in different way compared to explicit memory. That means that traumatic event is not remembered as a finished, linear storyline about something that happened at some point. Instead, it is activated by sensory stimuli which cause emotional states experienced during the traumatic event to emerge. It is as if there is no past – the feeling of vulnerability is real in the present moment. The approach to trauma processing needs to take into account the way in which traumatic memory is stored. When working with children, communication needs to be driven by play. To children, play comes as naturally as breathing and it represents the language they know and understand. Play is not only important catalyst of child development – it also has valuable therapeutic potential. Child's verbal abilities are often insufficient to allow for adequate self-expression, but play makes it possible. Having in mind the fact that trauma is stored in a non-verbal manner, different modes of play and drawing can help process trauma using different senses. Guided play, guided conversation, open and active approach are all necessary for the child to acknowledge and integrate traumatic events (feelings and experiences). Children are unable to initiate discussion on things that have overwhelming effect on them, things they hide from themselves or the things they cannot articulate.

The main aim of integrative psychotherapy is to harness the relationship between the therapist and the patient, the ability to establish full contact in the present moment – as a step toward establishing healthier relationship with others while also developing a stronger sense of self-satisfaction (Erskine, 2015). For the girl, the place of therapy was perceived as safe place to speak of her feelings and her experience, without the risk of further exacerbating her mother's anxiety or making her father even sadder due to

his feelings of guilt. The girl was protective of her parents, but found the place where her sense of safety was restored. She told the story of her trauma several times. She managed to tell it without crying or great distress. She drew how she felt and illustrated the worst moment of the accident. Her trauma narrative emerged in different ways, with new details added each time the story was told. We wrote a letter to children who shared similar experience. The most important principle of trauma-focused CBT is to ensure gradual exposure to traumatic experience. For that reason, the discussion on the subject of traumatic experience recurred in almost every session. It is also important to repeatedly present traumatic experience in different ways adding to the narrative the details of the experience, such as the scents or sounds. These techniques are designed to enable the therapist to prevent maladaptive avoidance of trauma triggers (Cohen, Mannarino & Deblinger, 2012).

When traumatic experience cannot be expressed verbally, it remains captured at a symbolic level. To reach it, it needs to be externalised in a symbolic form, through an image or a drawing. Given the fact that children experience drawing as a sensory exercise, they have the ability to recall memories of the traumatic experience by drawing "what happened". Drawing initiates the process of healing and the actual drawing gives us an accurate symbolic representation of the traumatic experience. Drawing also makes it easier for the child to verbalise and organise traumatic narrative in a meaningful way, while helping reduce reactivity due to exposure. Drawing also shows us what happened to the child. Adults often deprive children of information, leaving them in the state of confusion. There was no discussion in the girl's home about the accident. After the first shock subsided, although they were all shaken, they never discussed what happened. In this case, we had what is often referred to as "the double wall of silence", where adults protect the children by keeping quiet, while the children also protect the adults and no one is talking about what's on their mind. Through support and training, the family was allowed to discuss the accident and the way it made them feel. One of the interventions in the central phase of the therapy focused on the feeling of guilt. The girl developed the feeling of guilt, because the trauma was never discussed and she believed that she was the only one who experienced fear and therefore concluded that father's grief was her fault. Through therapy, the girl learned to better understand the event and its impact on all members of the family, which encouraged her to approach the father more freely and initiate contact.

During the final phase, the emphasis was put on her right to have a happy childhood and her acceptance of the fact that her father was different than before. Despite that, life must go on and the girl is now capable of successfully overcoming developmental challenges that come her way.

Conclusion

Childhood traumatic experience is real and it has real consequences to the overall functioning of the child. Depending on the age when the critical event occurred and parental reaction to it, the consequences may vary and may be observed in family, school and social interactions.

Children experience trauma as an implicit experience which encompasses a range of sensory perceptions resulting from visual, auditory, palpatory, olfactory and gustatory stimuli. Given physical symptoms and undermined sense of safety, the first priority was to establish safety and ensure physical relaxation. In later phases, emphasis was put on the creation of trauma narrative, taking into account gradual exposure to traumatic experience through the use of different senses.

Child integrative psychotherapy, combined with trauma-focused CBT, requires more work to be done with family members while the interventions during the course of the treatment are tailored to child's age. It is a supportive and flexible method of work with children rooted in the relationship with the therapist, which recognises and responds to the child's age, both at the moment traumatic event occurred and at the moment the therapy commenced. Particular strength of this approach is reflected in the use of play as an important form of communication for children. Techniques used include the use of therapeutic dolls, sandbox, clay, movement and role play. Processing of the traumatic experience is initiated and encouraged through the use of drawing. In addition to drawing, efforts were made to create trauma narrative which included all senses and resolve the feeling of guilt, which often goes hand in hand with the traumatic experience.

References:

1. American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed). Washington DC: APA.
2. Arambašić, L. (2005). Gubitak, tugovanje, podrška. Jastrebarsko: Naklada Slap.
3. Cohen, J. A., Mannarino, A. P., & Deblinger, E. (Eds.). (2012). Trauma-focused CBT for children and adolescents: Treatment applications. New York, NY, US: Guilford Press.
4. Erskine, R.G. (2015). Relational Patterns, Therapeutic Presence: Concepts and Practice of Integrative Psychotherapy. London: Karnac.
5. Harris, W.W., Putnam, F.W., Fairbank, J.A. (2006). Mobilizing trauma resources for children, U: A.F. Lieberman, R. DeMartino (ur.), Intervention for children exposed to violence. Johnson and Johnson Pediatric Institute, 311-339. L.L.C., www.JJPI.com.
6. Profaca, B. i Arambašić, L. (2009). Traumatski događaji i trauma kod djece i mladih. Klinička psihologija, 2 (1-2), 53-73.
7. Pynoos, R.S., Steinberg, A.M., Goenjian, A. (1996). Traumatic stress in childhood and adolescence – Recent developments and current controversies, U: B.A. van der Kolk, A.C. McFarlane, L. Weisaeth (ur.), Traumatic stress – The effects of overwhelming experience on mind, body and society, 331-358. New York: The Guilford Press.
8. Subotić, Z. (1996). Tretman traume. U: J.Pregrad (ur) Stres, trauma, oporavak, udžbenik programa “Osnove psihosocijalne traume i oporavka”; Društvo za psihološku pomoć, Zagreb
9. Van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. New York, NY, US: Viking.