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#10016 UNDERSTANDING CHILDHOOD TRAUMA: IDENTIFYING AND RESPONDING TO TRAUMA—AGES 0 TO 5 YEARS OLD

MAGNA SYSTEMS, INC.., 2002
Grade Level: Adult
29 Minutes
1 Instructional Graphic Included

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CHILDHOOD TRAUMA

- **What is Childhood Trauma?**
- **Significant Event Childhood Trauma**
- **The Brain: Effects of Childhood Trauma**
- **Identifying and Responding to Trauma in Children Up to 5 Years of Age**
- **Identifying and Responding to Trauma in Ages Six to Adolescence**
- **Domestic Violence and Childhood Trauma**
- **Trauma and Healing**
- **A Parents Guide to Identifying and Responding to Childhood Trauma**

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CHILDHOOD TRAUMA

A Guide to Study

Each section of the individual module in this workbook contains the following: Overview, Questions To Consider, Vocabulary, Instructional Objectives, and Self-Test.

The OVERVIEW establishes the framework for the total module.

The QUESTIONS TO CONSIDER can help focus the student's attention while viewing the video.

The VOCBULARY contains words used in each module.

The INSTRUCTIONAL OBJECTIVES set forth what the student will be able to accomplish upon completion of the module.

The SELF-TEST is a check to progress. The answers are found in the self test answer key.

The Video Modules of Understanding Childhood Trauma: Strategies and Solutions and the Workbook Chapters which are an integral part of the series, were produced by Linkletter Films.

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Biography

Bruce D. Perry, M.D., Ph.D.

Dr. Perry is the Medical Director, Provincial Programs in Children's Mental Health for the Alberta Mental Health Board. In addition he continues to lead the ChildTrauma Academy, a training and research institute he founded in 1990. From 1992 to 2001, Dr. Perry served as the Trammell Research Professor of Child Psychiatry and Chief of Psychiatry for Texas Children's Hospital at Baylor College of Medicine in Houston, Texas.

Dr. Perry, a native of Bismarck, North Dakota, was an undergraduate at Stanford University and Amherst College. He attended medical and graduate school at Northwestern University, receiving both M.D. and Ph.D. degrees. Dr. Perry completed a residency in general psychiatry at Yale University School of Medicine and a fellowship in Child and Adolescent Psychiatry at The University of Chicago.

Dr. Perry has conducted both basic neuroscience and clinical research. His neuroscience research has examined the effects of prenatal drug exposure on brain development, the neurobiology of human neuropsychiatric disorders, the neurophysiology of traumatic life events and basic mechanisms related to the development of neurotransmitter receptors in the brain. His clinical research and practice has focused on high-risk children - examining long-term cognitive, behavioral, emotional, social, and physiological effects of neglect and trauma in children, adolescents and adults. This work has been instrumental in describing how childhood experiences, including neglect and traumatic stress, change the biology of the brain - and, thereby, the health of the child.

A focus of his work over the last five years has been the development of innovative clinical and systemic programs and practices based upon emerging concepts regarding child development and neurodevelopment. These programs are in partnership with multiple sectors of the community and in context of public-private partnerships which help catalyze systemic change within the primary institutions that work with high risk children such as child protective services, mental health, public education and juvenile justice.

Dr. Perry is the author of over 180 journal articles, book chapters and scientific proceedings and is the recipient of numerous professional awards and honors, recently including the T. Berry Brazelton Infant Mental Health Advocacy Award and the 2000 Award for Leadership in Public Child Welfare from the National Association of Public Child Welfare Administrators

Coping with Traumatic Events: Terrorist Attacks in the United States
Special Comments for Teachers and School Personnel

Bruce D. Perry, M.D., Ph.D.

1. **Talk about these events in class in factual and focused ways.** It is appropriate to talk about these events in the classroom. But it is not appropriate to turn each class into an unstructured group therapy session. There should be open, honest, and accurate discussion in classes that is directed and contained by a teacher. Once this initial period of grief has subsided, try to keep discussions focused on aspects relevant to the content of your curriculum. You should not ignore it: children never benefit from 'not thinking about it' or 'putting it out of their minds.' But your students will be better served if they take an aspect of this and discuss it in focused, thoughtful and rational ways. In history talk about extremism in other key world events; in Social Studies talk about various cultural/religious views of death. Now, this does not mean you should ignore the emotional impact of this; just don't feel that you have to become an expert in trauma psychology to help your students.
2. **Find out what the children think and feel.** An important first step in talking about this event is to find out what the children think and feel. Many of the children will have distorted information. Young children, for example, often make false assumptions about the causes of major events. These distortions can magnify his sense of fear and make him more likely to have persisting emotional or behavioral problems. Correct misperceptions with accurate but age-appropriate explanations.
3. **Don't over focus on these events: resume normal patterns of activity at school as soon as possible.** In the immediate post-event period, children and adults often over-focus on traumatic events. The horror of this event, the pervasive media coverage and the many discussions can actually saturate a child's capacity to process and move forward in a healthy way. Make the classroom a safe place to get some structured relief from this emotional barrage. By focusing on school work, a child's over-worked stress-response system can get a little rest period.
4. **Take a child's lead on when, what and how much to say.** After you have some sense of what your students know, and you have clarified any distortions, let them take the lead during your informal discussions about this topic. Students may ask you many difficult questions, "How long can you live if you are trapped like that?" You do not need to be too detailed or comprehensive in your answers. If you let children direct unstructured discussions by their questions - you will find that you will have many, many short discussions and not one "big" talk. These little discussions make it easier for students to digest this huge emotional meal.
5. **Don't feel that you have to have all the answers.** Some aspects of this will forever remain beyond understanding. You can explain that you just don't know - and that sometimes we will never know why some things happen. Help teach your students that hate can lead to senseless cruelty. And that you, we all, learn to live with some unknowns. When you share your struggles

with the child, their own struggles become easier.

6. **Reassure the children about safety.** Many children - and many adults - are frightened. This event has shattered our sense of safety. Your students may have fears about personal safety but more likely will be worried about parents flying, going to work in public places or working in high-rise buildings. Reassure your students. Your home and community are safe. Steps are being taken to make things safer. Remind them that only a few hateful people did this.
7. **Inform parents and children about the risks of children watching too much media coverage.** Watching the images of this over and over not only won't help child. In fact, it may make this worse for them. Young children are very vulnerable to this. Children six and under may actually think that there have been hundreds of buildings collapsing. Tell children and parents to limit their viewing of the media coverage with explicit images. Ultimately, the goal is to decrease the traumatic power of these images and that is very difficult when the images permeate the media.
8. **Anticipate increased behavioral and emotional problems and decreased capacity to learn.** When children feel overwhelmed, confused, sad or fearful, they will often "regress." And so do adults. You may see a variety of symptoms in your students: these include anxiety (or fearfulness), sadness, difficulty concentrating, sleep problems, increased impulsivity or aggression. These symptoms are usually short-term (days or weeks) and tend to resolve with reassurance, patience and nurturing. When children feel safe, they will be most likely start to "act their age."
9. **Some children will be more vulnerable than others.** Not all children will react to these events in the same way. Some children may seem disinterested and no changes in their behaviours will be noticed. Other children may have profound symptoms that seem out of proportion to their real connection to these events. We can not predict how a given child will react but we do know that children with pre-existing mental health or behavioural problems are more likely to show symptoms. We also know that the closer a child is to the actual traumatic event (i.e., if a loved one was injured or killed) the more severe and persisting the symptoms will be. The high-risk children in your class are high risk for having increased problems following this event.
10. **Your reactions will influence children's reactions.** Children sense emotional intensity around them and will mirror the emotional responses and interpretations of important adults in their life. That includes their teachers. Younger children will try to please you - sometimes by avoiding emotional topics if they sense that it may upset you. Try to gauge your own reactions. If you find yourself crying or being very emotional, it is fine. Just make sure that you try to tell your students why you cried. It is reassuring to children to know they are not alone with their feelings. Make sure they hear, many times, that even though it may be upsetting it is still important to share feelings and thoughts with each other.
11. **Don't let anger be misdirected.** A major mistake following these events would be to let hate win. Don't let the frustration, anger and rage that this event produces to be misdirected. Only a small, hateful group of people did

this. No ethnic group or religion bear the brunt of these senseless destructive acts. Every religion and ethnicity has produced examples of extreme hateful and violent behaviours. Don't let the hate spread. Make sure your students understand that hurting more innocent people will only mean that terror wins.

12. **Don't hesitate to get more advice and help.** If you feel overwhelmed or if you see persisting problems with your students, don't hesitate to reach out for help. In most communities there are professionals and organizations that can answer your questions and provide the services your students need.

About the ChildTrauma Academy

The ChildTrauma Academy is a unique collaborative of individuals and organizations working to improve the lives of high-risk children through direct service, research and education. These efforts are in partnership with the public and private systems that are mandated to protect, heal and educate children. For more information see: http://www.ChildTrauma.org

4 VIDEO #4
Identifying and Responding to Trauma: Ages 0 to 5 Years Old

Overview
Infants and very young children suffering from trauma are often difficult to recognize and treat because of limited verbal skills and the inability to report. Caregivers just beginning their interactions with traumatized children should try to find out as much as possible about a child's history to ascertain the presence and degree of a child's trauma. This history, and close observation of the child, will help a caregiver to determine the level of the child's present alarm state, and give the caregiver a starting baseline.

Various guidelines to assist caregiver interactions with children are given to assist them in building trust and helping to heal childhood trauma. A primary helping skill for caregivers is the understanding of the impact of non-verbal interactions. That is, actions will always speak louder than words to a very young child suffering from trauma. Caregivers will always be closely monitored by a traumatized child and should try to be calm, predictable, and attentive, to not escalate a child's emotions.

Additional information for caregivers include: significant loss, dissociating, being an example, and stopping self-pity. Through education and awareness, caregivers can offer tangible help for traumatized children through early identification, intervention, and caring treatment.

Questions To Consider

1. What should a caregiver look for in determining the possible presence of trauma in a very young child?
2. How can a caregiver best determine the level of threat a child has been previously experiencing?
3. What is the primary caution for a caregiver working with a traumatized child?
4. What are the specific guidelines a caregiver can use to help a traumatized child?
5. What happens to a traumatized child if he is raised in an unpredictable, chaotic, and violent environment?
6. What is dissociating?
7. How can a caregiver best be an example to a traumatized child?
8. What strengths can a traumatized child gain through healing and not succumbing to self-pity?

Vocabulary

The Alarm State The fight or flight reaction in a human being under threat.

Dissociation The attempt to withdraw attention from the outside world and go into a safer interior world in the attempt to avoid traumatic thoughts and feelings.

Baseline The consensus from observation of where a child is physically and emotionally after a significant traumatic event.

Significant event trauma An event that brings the feelings of overwhelming loss, fear, or danger to a child, and catches a child off guard.

Observation A caregiver's evaluation of a child's history, present alarm state, and behaviors.

Threat The emotional feelings from past incidences in a child's life that have caused traumatic reactions.

The Arousal Continuum The scale to determine the level of threat present in a traumatized child: calm, arousal, alarm, fear, terror.

Regressed The more primitive or primitive way a child thinks and behaves in relation to escalating threat.

Non-Verbal Cues The non-verbal behaviors a child perceives as threat in a caregiver, such as: tone of voice, body posture, and facial expressions.

Behavior Expectations Clear rules and predictable consequences for breaking the rules, consistently provide for the child by the caregiver.

Impulsivity A traumatized child's tendency to react without consideration of consequences.

Re-enactment Reminders of the original trauma, observable in play or drawing.

Avoidance Withdrawing for safety behaviors a traumatized child uses when under treat, including daydreaming and avoiding other children.

Hyper-reactivity A child's reaction to trauma manifested by anxiety, sleep problems, and behavioral impulsivity.

Framing A caregiver's predetermined activities; giving the impression that the child has some choices.

Instructional Objectives

1. Describe Dr. Perry's example of a positive non-verbal interaction.
2. Describe a child's natural reactions to the death of a loved one.
3. Describe why very young children naturally use dissociating to deal with trauma.
4. Describe how determining where a child is on the arousal continuum helps a caregiver to be the most effective.

Self-Test

1. Why are traumatized children often confused with children who have Attention Deficit Disorder?

2. What does the presence of hyper-reactivity suggest to a caregiver?

3. What behaviors can a traumatized child induce by simply thinking about a past traumatic experience?

4. How does trauma-induced fear negatively affect a developing child?

5. According to Dr. Perry, why should child caregivers be aware of the needs of children?

6. How should a caregiver approach an aggressive child?

7. What element helps to determine that a child is suffering from trauma?

Self-Test (Continued)

8. Why is it important for a caregiver to plan each day?

9. Why shouldn't a caregiver insist on physical contact, such as hugs or kisses?

10. What are the benefits for a child when a caregiver offers some flexibility in discipline?

11. Why should a caregiver always tell the truth?

12. Why should a caregiver act quickly to stop activities that provoke a child's trauma?

13. Why should a traumatized child be given reasonable choices?

14. According to Dr. Perry, what do traumatized children often distort?

15. What is the benefit for traumatized children when a caregiver physically gets down on their level?

16. According to Dr. Perry, what has the most positive therapeutic effect on traumatized children?

17. What is a determining factor of how a child will react to the death of a significant loved one?

Self-Test (Continued)

18. How are music, movement, art, and play therapies helpful to a traumatized child?

19. Why do very young children often rock back and forth and bang their heads on objects?

20. According to Dr. Perry, why is childhood trauma often a gift for traumatized children?

21. Why should we, according to Dr. Perry, try to recapture a sense of community?

Identifying And Responding to Trauma in Children Up to 5 Years of Age
Self-Test Answer Key

Questions To Consider:

1. The known history of the child and trauma indicators such as: a recent significant traumatic event, death of a parent or sibling, a natural catastrophe, a serious accident, and any indications of abuse or neglect.
2. By evaluating where the child is on the alarm continuum scale: calm, arousal, alarm, fear, and terror.
3. To not escalate the alarm continuum.
4. Address the Trauma, Plan the Day, Intimacy, Behavior and Discipline, Tell the Truth, Observation, Protection, and Choices.
5. The child will become adaptive to that environment and over-interpret non-verbal cues.
6. A natural and primitive means to help avoid the pain and memories of overwhelming trauma, by withdrawing attention to the outside world, and going into a safer inside world.
7. By showing how respectful and loving human relationships can be possible.
8. Future resilience and wisdom.

Instructional Objectives:

Because Dr. Perry is tall he is often perceived as threatening to a traumatized child. Dr. Perry will get on the floor at the child's level to help reduce the child's perception of threat.

Children do not understand the permanence of death and will naturally seek answers and comfort from a primary caregiver.

Very young children do not yet have the verbal skills to discuss their feelings and will naturally dissociate in the attempt to cope.

Understanding where a child is on the arousal continuum will aid a caregiver in understanding the ways the child is processing information, reacting to the caregiver, and learning new skills.

Self-Test:

1. The outward behaviors can be very similar.
2. The child is chronically activating the alarm response.
3. Difficulty in concentrating, being more anxious, and paying more attention to the caretakers non-verbal cues.
4. The fear will influence how the child interacts with everyone and will diminish the capacity to form and maintain relationships.
5. A caregiver can try to meet the needs of a child independent of how the child got that way.
6. By calming down the child, showing the child that he is safe, showing the child he is valued, so the child is calm enough to be taught appropriate social boundaries.
7. Time. It takes longer to calm a traumatized child.
8. To show the child that someone is in control. It's very frightening for traumatized children when they feel that the people caring for them are themselves out of control.
9. The traumatized child might reinforce an association that links intimacy with power, causing upset.
10. Reason and understanding will be illustrated for the child.
11. Without the truth, a child will fantasize about what happened and become frightened.
12. This will help to protect the child and ease recovery.
13. Not having choices will cause the child to feel less in control and become more symptomatic.
14. Disapproving non-verbal cues by the caregiver.
15. It has a calming effect by diminishing the power differential.
16. Simply playing with children until they feel safe enough to bring up what is needed.
17. How powerfully the child was connected to the loved one.
18. They help to bring a child back from dissociation to here and now experiences, promoting healing.
19. These are very primitive self-soothing techniques to help cope with overwhelming threat.
20. Healing from trauma can be a route to wisdom, creating a better adult person.
21. All children are our children. The more isolative we are, the worse it is for society, and certainly the worse it is for these children who are already pretty isolated.

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