Eileen Wilson

ESSAY 3

Post Qualifying Diploma
In Counselling Children & Young People

Edinburgh: 2007/2008

Unit 3 - Essay 3:
Specialist areas of work in Counselling Children and Young People
Describe one specialist area of work with young people and evaluate the use of a variety of creative interventions in your work practice.

Word Count: 3228

Introduction:

According to Levine (2005: 7):

> *"Trauma is the most avoided, ignored, denied, misunderstood,*
>
> *and untreated cause of human suffering."*

For this reason I should like to focus on trauma as my specialist area of therapeutic work with young people. In this essay I intend to describe the current neurological research underpinning the development of trauma in young people. From a number of sources I wish identify the main issues, affects and concerns relating to this client group, coupled with the child's developmental stage and cognitive ability.

I aim to illustrate through a series of client case studies the circumstances where creative interventions may be more effective or appropriate for use with traumatised children, in preference to 'straightforward counselling'. It is however, important that I note and evaluate both the benefits *and* contraindications of the particular therapeutic interventions I use.

These client case studies originate from my work as a volunteer counsellor within a city-based primary school, counselling P2 to P7 pupils, however names have been changed to protect the client's identities.

"The first three years of seeking and affectively engaging the world are critical for the future success of every boy and girl. It is important for them to get off on the right track both emotionally and intellectually." as *".....healthy minds emerge from emotionally well-fertilised brains"*

I feel, Jaak Panksepp, Ph.D. (2006: foreword 7), illustrates very clearly how the quality of care a child receives, even from their earliest days, can have lifelong consequences for their developing mental health.

Margot Sunderland (2006: 8) continues to uphold this view by stating;

"Both excessive stress and tender loving care leave lasting marks on the emotional circuits, mentalities......and long-term chemical balance in children's brains."

In addition, Erikson believed that for a child to become 'securely attached' with a sound sense of self, they must evolve through a three step process of development (1963). He described the child's 'first step' on the road to personality development as being through their interaction with others. As a consequence trust is formed within the child through repeated interactions experienced with the 'predictable reliability' of the people closest to them. Hence, through this 'good enough parenting' (Winnicott, 2005), personal autonomy and their ability to regulate impulses becomes the 'second step' which as a

consequence creates opportunities, not only of making the *right*

choices but in the belief *their* trust will be reciprocated.

It is believed by Erikson and Sunderland (1963, 2007), this process

creates a foundation of stability, resilience and self-worth in the

child's developing psyche. As a result these attribute help carry the

child through life's inevitable tough experiences. As Perry

corroborates; children are not born resilient, they are *made* it;

> "*…by virtue of having opportunities in early childhood to have*
>
> *elements of safety, predictability and nurturing.*" (2000)

And finally to the third and 'last step'; out of these predictable

exchanges a reflective, personal and shared narrative evolves.

> "*What is safe and comfortable becomes so through experience;*
>
> *something in the present moment matches the associated, stored*
>
> *'memories' of previous safe, pleasing or rewarding experiences.*"
>
> (www.ChildTrauma.org)

However, when the child experiences a life filled with fearful,

traumatic, unregulated stresses such as inconsistent and unpredictable

care-giving, violence, abuse or neglect for example, the infant

perceives their world as dangerous. This perceived threat; one that

"*…matches with stored neuronal patterns* [memories] *associated with a*

previous threatening experience…", causes the release of high levels of

cortisol and adrenaline; the 'stress hormones' within the brain.

The body's immediate response to threat is termed by Perry as *"hyperarousal"* (2002). Hyperarousal activates many physiological systems required for survival; increased heart-rate and blood flow, sweating, dry mouth and creates tension in the muscles; detected as feeling 'alert' or hyper-vigilant to further signs of danger. These feelings require 'action' and prepare the child to 'fight' with, or 'flight' run away from the potential threat. Children reacting to hyperarousal may appear constantly on guard, aggressive, violent or confrontational (www.ChildTrauma.org).

However, if the child is unable to escape through being too young, vulnerable or overpowered for instance, an avoidant psychological survival-mechanism is activated; *"dissociation"* ('freezing' or submitting). Females and young children are more likely to use dissociation and may present this state as robotic, 'tuned-out', detached or over-compliant behaviour. Adolescents may describe themselves as feeling 'unreal', or observing themselves in an 'out-of-body' experience. In extreme cases, young children may withdraw into an elaborate fantasy world where they assume special powers or strengths.

Humans are hard-wired to seek attachment, especially when danger is present, both hyper-arousal and dissociative tendencies have evolved adaptively to help people survive trauma. However problems arise when

the individual experiences *prolonged*, high levels of pervasive and ever present trauma. In this circumstance, these survival techniques become maladaptive and internalized as 'normal'; thus forming a new but less functionally flexible state of equilibrium.

The brains of young children are malleable, being designed to absorb and be shaped by vast amounts of experiences in a very short time. There is growing recognition that children are, if anything, more vulnerable to traumatic experiences than adults. As Perry states; this can in fact work against the child living through trauma;

> *"...unfortunately, this highly adaptive capacity is at the core of the emotional, behavioural and long-lasting physiological symptoms that develop following a traumatic experience".* (2002)

The structure of the brain:

Seigal (1999) and Wilcox (2006) provide some insight into how the brain structure processes and stores experiential-information and also how it is shaped or altered by traumatic experiences.

> *"Research suggests that emotion operates as a central organising process within the brain - a product in part of earlier attachment relationships".* Sensitive attunement enables the mind *"...to integrate experience and to adapt to future stressors"* Seigal (1999:4)

Wilcox (2006) describes the human brain as being split into two hemispheres; the creative, right hemisphere is concerned with non-verbal, somatic, visual storage and initial impressions. It also contains the amygdala which screens for threats and activates the stress hormones; cortisol and adrenaline and as a consequence, controls and manages the response emotions such as anger and anxiety. The amygdala is fully mature at the time of birth however, further traumatic damage to this area results in poor impulse control.

The left analytical hemisphere contains the hippocampus; this part of the brain develops over the first two or three years after birth. Its function is involved with the retrieval of verbal and emotional memory, details and analysis and holds 'positive' emotions. However because language is unavailable to the young child, pre-verbal sensory memories are stored 'unexplained' in the right brain. The hippocampus also deals with the 'time-line' of memory and help place memories into the individual's history. Often trauma sufferers describe the traumatic event in the 'here-and-now' rather than in the past.

Therapy can help the client place traumatic memories into their rightful, historical setting. Generally the left brain is the larger of the two; however in children with traumatic histories the stress hormones activated by the amygdala during trauma, 'stunts' its development. Consequently the right brain becomes enlarged.

The corpus collosum connects the two hemispheres and holds the necessary functions of integrative and generalised learning; putting

meaning and words to the felt sense. Interestingly enough it is also smaller in trauma sufferers. This integrative 'split' can be observed through the client's inability to verbally express their feelings experienced during a panic attack for instance (Wilcox 2006).

Therapy helps the client acknowledge, describe and express their trauma, through this process the event becomes integrated into the psyche internalized and made 'whole'. However, it is vitally important the child is allowed to move forward slowly and carefully as 'pushing' a client before they are psychologically ready could easily lead to re-traumatisation.

Unresolved trauma:

According to Perry (2002) and Levine's (2005) findings, unresolved childhood trauma results in a variety of debilitating after-affects; the detrimental effects of which may become further traumatic 'triggers' or not surface until many years after the event. The individual may have survived the experience but at what cost to their future mental health? As Levine clearly states;

> "*The effects of unresolved trauma can be devastating. It can affect our habits and outlook on life, leading to addictions and poor decision-making. It can take a toll on our family life and interpersonal relationships. It can trigger real pain, symptoms and disease. And it can lead to a range of self-destructive behaviours.*" (Levine: 2005: 3)

Levine feels the word trauma has become a 'buzzword' misrepresented to describe everyday stress. However, he believes the correct interpretation of trauma, refers to the *"debilitating symptoms"* suffered by people recovering from the after-affects of a variety of *perceived* life-threatening or overwhelming experiences. Children suffer not only as you might expect from large, highly-documented disasters, but from everyday incidents such as falling off a bicycle, a pet dying or even from suffering the loss of treasured toy. Hence Levin (2005) proposes that the incidence of trauma related dysfunction is therefore higher than first believed.

According to the Diagnostic and Statistical Manual [DSM I V] (1994), there are two components to traumatic experience.

> *"First there must be an external event, either an actual or perceived threat to life……..of self or others. Then there must be a response to the event which includes fear, helplessness or horror. Thus trauma is by definition a combination of an external event and an internal experience."* (Cairns, 2002)

A multitude of factors may affect an individual's response to threat, such as:

- Genetic make-up,
- Age and gender,

- Nature, duration and pattern of trauma,

- The individual's history of trauma,

- The family dynamics: not only their family of origin but also adoptive or foster families

- Presence (if any) of supportive caregivers.

Hence, when it comes to trauma no two people are likely to react in exactly the same way. Falling off a bicycle may not cause a teenager much concern for example, but the same incident can feel totally overwhelming to a very small child. Consequently, how a parent or other adult reacts to a child following the event can help them recover more quickly and completely. Being dismissive or telling the child they are being silly for crying or "over-reacting" can hinder the child's recovery and distort their perception of the incident.

The affects of trauma on children and adolescents:
How children react towards traumatic incidents will differ depending not only on their chronological age but also on their cognitive and developmental stage.

Birth to 2 years:

Without the ability to verbalise, children of this age cannot either describe the event or the resultant feelings. However, sensory memories *are* retained; sights, sounds or smells for instance and may re-emerge in their play when older. They will respond to caring offered by an adult.

Pre-school:

Very young children can feel insecure, helpless, powerless and unable to protect themselves. The concept of permanent loss at this age is not understood; consequences are therefore reversible. Play will involve repeatedly re-creating the disaster in an attempt for resolution. Children may appear 'clingy' and seeking constant re-assurance they *will* be cared for and not 'abandoned'. During this and the earlier age-group, use-dependant dissociation is highly probable.

School age (7 to 11 Years):

At this age, children have the ability to understand permanent loss resulting from trauma. Regressive type behaviours can arise, i.e. bedwetting, sleep problems and thumb-sucking for instance. Concentration may be an issue at school as may their 'acting-out' reactions such as guilt, feelings of failure and anger. The containment of a secure adult at this time is of great importance as the child may become pre-occupied with traumatic details and want to talk about it endlessly.

Pre-adolescence and adolescence (12 to 18 years):

In this age group, appearing knowledgeable or 'cool' about such events becomes important especially with family and friends. Peer support is used to contain anxieties and fears. If they have 'survived', feelings of immortality may arise as will their need to act recklessly or take risks. Often adolescents can display a mixture of reactions from the earlier

age-groups detailed above to much more mature, adult reactions.

Teenagers are naturally moving out into the world at this stage; although the experience of trauma can knock their confidence and trust in safety. However, discussing these intense or overwhelming feelings with their family may prove just too difficult.

Keeping to normal routines encourages stability and can help children of all ages recover after a traumatic event. Consequently, carrying the basic tenants of normalization, consistency and containment forward into an attuned and connected therapeutic relationship would also seem beneficial.

This view is supported by Miller who proposes;

> *"…children can only experience their feelings fully when there is a caregiver available to accept and support the expression of those feelings.* (1981)

Kohut (1977) believed it was only through a supportive, reflexive relationship; could children reach catharsis and express abreacted feelings.

The foundations of safe trauma therapy:

Rothschild (2000, 99) outlines a series of ten foundations for safe trauma therapy:

1. Establish safety for the client within and outside therapy (however for adults this might prove easier than the situation with children as it may be impossible for a child's family circumstances to be altered)

2. Build a good therapeutic relationship with the client before addressing traumatic memories.

3. Both client and therapist must be confident in applying the "brake" to emotional overload. With very young clients the therapist must introduce any interventions with the utmost care.

4. Identify and build on the client's internal and external resources.

5. Regard defences as resources. They have evolved for a reason; therefore, encourage the creation of *more* choices.

6. View the trauma system as a "pressure cooker". Always work to reduce; never to increase the pressure.

7. Adapt the therapy to the individual client.

8. The therapist should possess a solid foundation of psychological and physiological theory of trauma. This helps reduce therapist errors and allows the creation of techniques tailored to the client's needs.

9. Regard the client as a unique individual; do not judge them for non-compliance or 'failed' techniques.

10.   The therapist must be prepared at times to put aside any or all techniques – and just 'be' with the client.

Creativity encourages integration:

In my role as a primary school counsellor I work with many young people, although not diagnosed as traumatised, but referred for exhibiting trauma-type behaviours either in the classroom or playground. Anger, hyper-activity, general anxiety and attention seeking behaviour could be viewed as stemming from periods of traumatic hyper-arousal for example. Although at the opposite end of the spectrum, i.e. dissociative tendencies; children can appear to withdraw from their peers and teachers, seemingly depressed, uncommunicatively "tuned-out", lacking in self-esteem and difficult to reach. Interestingly, Perry's research suggests that undiagnosed trauma might indeed underlie the vast majority of client cases (1998).

Work with either angry or uncommunicative clients can appear daunting; however, as Schore proposes, it is important not to overlook the fundamental, essential restorative properties forged within the therapeutic relationship;

> "*The patient – therapist relationship acts as a growth promoting environment that supports the experience-dependant maturation of the right brain, especially those areas that have connections with the subcordial limbic structures that mediate emotional arousal*" (1994: 473)

The brain's creative right hemisphere, as previously discussed in this essay, stores somatic memories; touch, sounds, smells, visual images,

etc. However, if the damage has been experienced early enough; the memories will have been stored 'pre-verbally' i.e. *without* the necessary language from the left hemisphere to make sense of them (Wilcox 2006)

As Edwards (1993) states: *"Creativity opens the door to the right brain",* therefore in addition to using straightforward talking in therapy - a left brain activity, it would to be more appropriate to access the right hemisphere with more creative interventions.

Art, clay, imaginary play, sand-tray work, metaphor, puppets, music and movement are just some of the therapeutic techniques I have used to good affect. However once the work has been created the left-brain can help with full reintegration by naming and placing the image in the client's history.

> *"Image-making, story-telling, therapy……are each concerned with joining together actions, intentions, emotions, perceptions and events into meaningful narratives."* (Edwards D. 1999:7)

Therapeutic interventions:

Film Animation, Clay and Letter-writing:

David a boy of 11 years, referred himself for counselling because he found it difficult to make friends, felt different because he couldn't speak out and thought that nobody liked him. He presented as quiet, hesitant, lacking in self esteem and found it difficult to look at me

directly. David's case history described a chaotic background, several house moves, a distant nervous mother and violent, highly critical father. He was disappointed in David wanting him to be a 'real' boy; able to stand up for himself.

David brought an array of different aspects of self expression to the play room in the form of a series of animated films with modelled clay figures. He wanted to be a film-maker when he grew up but felt he would be laughed at. To begin with his films were silent, the modelled figures small, jumpy and 'shadowy', like them David didn't like to be seen or heard. Clay was an ideal creative medium as he was able to form the *"split off"* (Klein, 1987) parts of himself whilst still staying in control of his feelings. I feel David expressed through these silent shadowy characters his dissociated *"speechless terror"* still trapped and imprinted in his right-brain when witnessing his father's violence (Wilcox 2006).

Often the two hemispheres lack integration, meaning the client describes thoughts and feelings as being separate or 'split off' from each other or may have feelings-reaction without understanding.

Over the course of therapy his figures changed, they became bigger, stronger and found words to express their hurt and rejection. Story lines alternated between caring and obliterating. David was beginning to verbalise feelings of love and hate felt for his father; therefore integrating both the left and right hemispheres of his brain.

"When verbal language of social interaction and communication,

which is also a language between parts of the self, becomes so

enmeshed in symtomatology, analytic work with art materials and

play may offer a combined pathway to the outside world, for the

child trapped inside." (Case: 2005,207)

Eventually David's demeanour changed, he walked more confidently and approached people with his head held high; he had found his voice in several remarkable ways. David wanted to tell his class members who he was and what he did. I suggested writing down what he needed in a letter, this he agreed to do then to my surprise (and delight), announce he would read it out in-front of his class. The effect was amazing; instead of being rejected as he feared, everyone wanted to see his films and in fact be a part of them.

David's last film was a commission from the head-teacher; depicting a day in the life of his school. It contained real characters and had a narrator in the form of himself! David had come full circle; he had emerged from the shadows to take his rightful place in front of the camera.

Obviously several interventions are described here; clay work, film-making and letter writing. However, I feel they possess a combined strength, which resides in the fact David was in control at all stages of the therapy. Not only with the approach itself but what he chose to do with it. David's understanding and cognitive level was sufficiently developed enough to cope with any possibility of rejection from his

class mates, we had spent many weeks discussing such an outcome.

However, with someone younger or less cognitively aware, encouraging a

traumatised child to speak about their deepest feelings in-front of

their class may in fact be totally inappropriate if not harmful.

> "*Therapists and patients need not be deterred from exploring*
>
> *trauma histories; however remembering for its own sake should*
>
> *not be a goal of therapy. Effective therapy for trauma helps*
>
> *patients resolve trauma-specific symptoms, leads to an accurate*
>
> *and meaningful interpretation of the traumatic event and allows*
>
> *the experience to be put in perspective.*" (Wilcox 2006)

Sand Tray Work:

Sand seems to be accepted by clients of any age, some appear to go

into a trance with just the feel of it running through their fingers. It

can be handled in a multitude of ways, gently as above, dug into

vigorously, 'drowned' with water and is a useful ally for hiding hated

family members. I have seen it used as 'food', either as poison or used

to nurture miniature animals brought back from the dead in

preparation for being killed and buried.

Traumatised children's emotions can often appear to 'pendulum' from

one extreme to another (Rothschild 2000); from appearing calm and

dissociated to hyper-aroused. Screaming and shaking in anger then

sinking back into appearing ashamed for their outburst. Sand can

accept all these emotions with ease.

Kohut proposed, early, fragmented identity-splits stemmed from the

caregivers inability to empathetically attune to their child.

> *"Shame is, of course, the affect that signals a loss of personal*
>
> *identity"* (1977)

One angry child used to write obscenities into the sands smooth

surface, screaming as he did so *"I hate you, I hate you.."* then

smoothing it over as if the words had never existed. In the next

instant he drew a smiling face. Occasionally he took away a few grains

of sand in his trouser pocket as a form of transitional object

(Winnicott; 2005)

My tolerance of both his 'faces' showed that he was indeed accepted;

if I could cope with both 'good and bad' parts, then maybe he could

accept them too?

> *"Sand tray work is powerful because it provides a visual structure*
>
> *in the form of a sand tray picture together with feedback from*
>
> *an observer (the counsellor). Hence, the child is able to gain an*
>
> *understanding of their world by directly viewing the scene they*
>
> *have created…and also through the feedback statements made to*
>
> *them by the counsellor."* (Geldard & Geldard; 2002, 152)

Conclusion:

The long-term costs of childhood trauma are only just coming to light.
A study carried out by Filliti, Anda, Norenberg, *et al.*; in 1998,
highlighted a relationship between the number of adverse events in
childhood and the resultant health and disease outcomes examined in
adulthood; i.e. heart disease, cancer, chronic lung disease for example.
With four or more traumatic childhood events, the risk for various
medical conditions increased 4 to 12-fold.

Citing David as an example; a study by Kilpatrick and Williams (1998),
has shown that 93% of children witnessing domestic violence develop
post traumatic stress disorder (PTSD). David's therapy has proven
successful - because he was supported in time; unfortunately the
outcome for others may not be as positive.

Many cases will remain hidden or be diagnosed as some other form of
neuropsychiatric syndrome. As Perry points out, hypervigilance is often
considered an attention problem; although there is evidence
traumatized children have actually been treated for attention deficit
hyperactivity disorder; ADHD instead. (2006).

Taking these findings into account, we as therapists might be working
with many more traumatised clients than we first envisaged, especially
when we consider these results are ten years old. Careful, creative

interventions are beneficial in allowing traumatized children to tell

their story in a variety of ways either directly or indirectly.

Horticulture is one such creative intervention not usually mentioned

although provides an array of opportunities for discovery as well as

laughter. I couldn't resist smiling when one client squealed with delight.

She described the emergence of a new shoot after forgetting to water

her seeds for several days as *"hopeful"* as it proved that 'life' (like

herself) could still 'flourish' after adversity. To see such hope after

the traumatic experiences she had endured was indeed encouraging.

"There is a cost to traumatic stress in childhood.

With changes in public policy and professional practices, however,

which address prevention and effective early intervention,

we can decrease this cost

and help children meet their potential in emotional,

cognitive, social and physical domains" (Perry, 2006)

Bibliography:

Case C. (1986): ***Hide–and–Seek a Struggle for Meaning*** – Art and play
    therapy with bereaved children: Inscape, Winter.

Cairns K. (2002): ***Attachment Trauma and Resilience,*** Therapeutic
    caring for children BAAF, London

Diagnostic and Statistical Manual of Mental Disorders: *Fourth
    Edition (DSM IV):* (1994). American Psychiatric Association,
    Washington, DC.

Edwards D. (1999): ***Endings:*** Inscape, Winter

Geldard & Geldard (2002): ***Counselling Children***, *A practical
    Introduction 2nd Edition*: Sage, London

Kilpatrick K.L. & Williams L.M. (1998)*: Potential mediators of post
    traumatic stress disorder in children witnesses to domestic
    violence.* ***Child Abuse and Neglect***

Klein M. (1987): ***Our Need for Others and its Roots in Infancy:***
    Routledge, London

Kohut H. (1977) ***Narcissism and Childhood Recollections:*** A
    Quantitative Test of Psychoanalytic Predictions: Otway and
    Vignoles, *Personal Social Psychology Bulletin*

Levine, Peter E. (2005): ***Healing Trauma:*** *A Pioneering Program for
    Restoring the Wisdom of Your Body:* Sounds True, Korea

Mabey, Sorensen, B., 1995, ***Counselling For Young People***, Open
    University Press, Buckingham.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as
    disorganized/disoriented during the Ainsworth Strange Situation.
    In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.),
    Attachment in the preschool years ; Chicago: University of
    Chicago Press.

Panksepp, J. (2000): ***The Cradle of Consciousness:*** A Peri-conscious
  Emotional Homunculus?: Neuro-Psychoanalysis

Perry, Bruce D. (2000): The ChildTrauma Academy; **Trauma and Terror**
  in Childhood: *The Neuropsychiatric Impact of Childhood*
  Trauma: ᵣwww.ChildTrauma.org
(Prefinal Draft <u>For:</u> ***"Handbook of Psychological Injuries: Evaluation,***
Treatment and Compensable Damages" (Ed., I. Schulz, S. Carella &
D.O. Brady): American Bar Association Publishing: August 20, 2000)

Perry, Bruce D. (2002): The ChildTrauma Academy; **Brain Structure**
  and Function I: *Basics of Organization* ₌www.ChildTrauma.org

Rothschild B. (2000): ***The Body Remembers;*** *The Psychophysiology of*
  Trauma and Trauma Treatment: Norton, USA

Schore A. (1994): ***Affect Regulation and the Origin of the Self***; *The*
  neurobiology of emotional development: Erlbaum, New Jersey

Scott, E. (Updated December 22ⁿᵈ 2007): ***Cortisol:*** About.com Health's
  Disease and Condition
  http://stress.about.com/od/stressmanagement/g/Chronicstress
  htm

Seigal M. & Hartl D. (1999): Ovi-position-site preference in Drosophila
  following inter-specific gene transfer of the Alcohol
  dehydrogenase locus**:** ***Behavior Genetics***

Sunderland M.(2006): **The Science of Parenting:** Dorling Kindersley,
  London

Filliti V.J., Anda R.F., Norenberg D, *et al.* (1998); Relationship of
  childhood abuse and household dysfunction to many of the leading
  causes of death in adults: the Adverse Childhood Experiences
  (ACE) Study; ***American Journal of Preventative Medicine,*** USA

Winnicott D. (2005): ***Playing and Reality***: Routledge, London

Wilcox P. (2006): ***Trauma Treatment for Children:***
      www.traumatreatment.blogspot.com