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Helping A Child After A Traumatic Event

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Our Vision

Our foundation is one of respect for all with a commitment to listen fully and learn from the diverse viewpoints of our team and those we service in our community.

At the heart of our work is the importance we place on insight, compassion, trust and warmth. We want to foster lasting change in the lives of families and transform our community. We believe that everyone should have access to affordable mental health resources.

We believe strongly in dismantling the stigma around mental health and in empowering caregivers and professionals to help children to reach their full potential. We continually identify important questions, seek out the answers, and evaluate and document what we learn.

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CTV Global CBC Canadian Counselling and Psychotherapy Association / L'Association canadienne de counseling et de psychothérapie

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A Self-Care Kit

for Kids and Teens

- Share my feelings or thoughts with an adult I trust
- Exercise (i.e., ride my bike, swim, walk, run, jump on the trampoline)
- Spend time with friends
- Listen to my favourite happy/uplifting song
- Cuddle up to one of my favorite adults who I trust or a pet
- Create art that expresses my feelings (i.e., drawing, painting, colouring)
- Have a warm bath, cuddle up in the blanket, or drink something warm (i.e., hot chocolate)
- Write in my diary or journal
- Write positive affirmations (explanation below)
- Relax my muscles (explanation below)
- Deep Breathing (explanation below)

Working with Negative Self-Talk with Positive Affirmations

Many children who have experienced trauma are prone to negative self-talk derived from feelings of shame (i.e., feeling something is wrong with them, or they're broken) and grief. It's important to normalize these feelings and reassure them that they did not do anything to deserve what happened to them, nor is anything wrong with them.

Ask your child or teen what the voice in their mind says that makes them feel bad inside.

It might go like this:

"I deserve that to happen to me"

"My mom and dad probably hate me now"

"What if he/she finds out I told and something bad will happen"

Let them know that:

> ***Sometimes our minds whisper things that aren't true. The bad thing that happened can change our brains to say negative/bad things, because it thinks by doing that it will keep up safe—but it really it just makes us feel more scared or confused. Your brain is like a muscle, and you can help re-train your brain by making the part of it that speaks true things stronger.***

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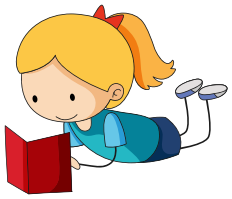
Here are some ways to practice positive thinking/affirmations:



With the help of an adult, write down 5 positive thoughts for every negative thought that comes up.

1. _____
2. _____
3. _____
4. _____
5. _____

Say or write down 10 things your grateful for each day.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

If your best friend was here what would they say if you said that negative thing?

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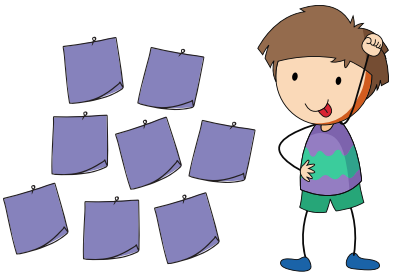

Write things you would rather think on post-it notes, and cover your bedroom walls or bathroom mirror with it

~~I'm not good enough~~

Write down the negative thought and scribble it out with a pencil, pen, crayon or marker.

Record the positive things you want your brain to say, and listen to them over and over again when you are feeling down.

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Progressive Muscle Relaxation

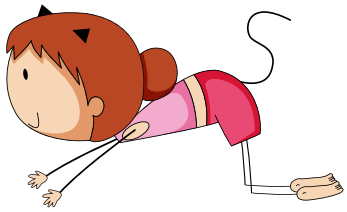
When a child's body is feeling angry or anxious it can be calmed by engaging the major muscle groups in the body sequentially. We are going to give you two versions: one for children and one for teens.

For these exercises, each muscle group is done 2x, holding each muscle group for 10 seconds each:

Children

Pretend you have a very hard gumball in your mouth—clench down to break the gum ball as hard as you can!

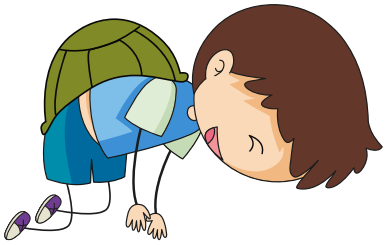
Imagine you have a lemon in each of your hands—squeeze them really hard!!!



Pretend you are a cat who just woke up from a nap. Stretch your claws and paws out in front of you for a big stretch!

Imagine you are playing tag, and a friend is chasing you. You see a way to get away from them . . . a hole in a fence (a board is missing). Make yourself a hard and rigid as a board to get through the hole in the fence!

Pretend your feet is in a puddle of squishy mud. Squeeze the mud as hard as you can between your toes and hold it!



Imagine you are a turtle! Something frightens you, so you go into your shell to hide! Tuck into a ball and squeeze your whole body as hard as you can to stay safe inside!

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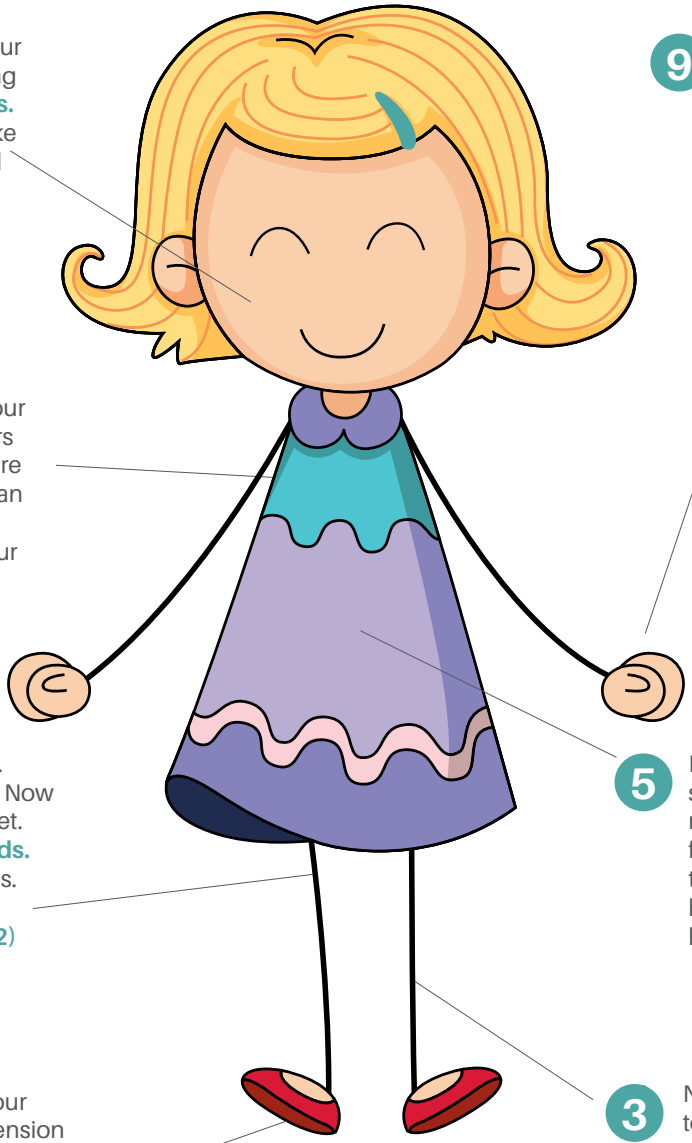
Teens

1. Sit back or lie down so you're comfortable and close your eyes. Take **5** big deep breathes and notice what it feels like for the air to move in and out of your body. In and out.



8. Next, clench the muscles in your jaw by biting down and holding a clenched jaw for **10 seconds.** Release and notice what it's like to have your mouth be relaxed **(x2)**

9. Last, tighten the muscles in your entire body. Feet, legs, stomach, chest, arms, shoulders, hands, and jaw. Tense hard, but without straining. Hold this for **10 seconds. (x2)**

6. Next, tighten the muscles in your back by moving your shoulders behind you and hold them there with as much tension as you can for **10 seconds.** Release and notice what it's like to have your shoulders be relaxed **(x2)**

7. Now move your attention to your arms. Make a fist with both hands and squeeze each as hard as you can for **10 seconds.** Release the tension in your hands, and notice what it's like to have your hands and arms relax **(x2)**

4. Now focus on your upper legs. Squeeze your thighs together. Now move your attention to your feet. Hold the tension for **10 seconds.** Notice how that tightness feels. Release and allow your legs to become heavy and relaxed **(x2)**

5. Now move your attention to your stomach. Tighten your abdomen making it hard as a board. Hold the feeling for **10 seconds**. Release the tension and breathe out a big breathe, and notice what it's like to have your stomach relax **(x2)**

2. Now move your attention to your feet. Curl your toes. Hold the tension in your feet for **10 seconds**. Notice how that feels. Release the tension, and notice what it's like to have your feet relax **(x2)**

3. Now move your attention to your legs. Tense the muscles in your calves. Hold the tension for **10 seconds.** Notice how that feels. Release the tension, and notice what it's like to have your legs relax **(x2)**

End this exercise by shaking out your entire body and taking 10 deep breathes, in and out.

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Deep Breathing

The breathe should come in through the nose **(4-5 seconds)** and out through the mouth (pursed lips; **5 -7 seconds**). The breathe should enter the stomach, and not just to the chest. You should be able to see the stomach rise and fall with each breathe.

For deep breathing to be affective it should be done for **5-20 minutes (not simply 10 breathes)**

Ideas to get children and teens doing deep breathing:

- Buy a guided meditation app
- Put on soothing music and breathe for the duration of 1-3 songs
- Go outside and breathe in nature
- Put a cup on your stomach and breathe in and out so you can watch the cup move up and down.
- Use bubbles and haven children breathe in through their nose and blow bubbles out on the out breath very slowly
- Have your child or teen sit in a chair, and with their arms behind their back do their deep breathing (this opens up the chest cavity **10x** to allow the air in more readily)

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ChildTrauma academy

Helping Traumatized Children

A Brief Overview for Caregivers

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

CAREGIVER SERIES

www.ChildTrauma.org

This booklet is one in a series developed by the ChildTrauma Academy to assist parents, caregivers, teachers and various professionals working with maltreated and traumatized children.

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Introduction

Each year in the United States approximately five million children experience some form of traumatic event. More than two million of these are victims of physical or sexual abuse. Millions more are living in the terrorizing atmosphere of domestic violence. Natural disasters, car accidents, life-threatening medical conditions, painful procedures, or exposure to community violence – all can have traumatic impact on the child. By the time a child reaches the age of eighteen, the probability that any child will have been touched directly by interpersonal or community violence is approximately one in three. Traumatic experiences can have a devastating impact on the child, altering their physical, emotional, cognitive and social development. In turn, the impact on the child has profound implications for their family, community and, ultimately, us all.

Traumatic events in childhood increase risk for a host of social (e.g., teenage pregnancy, adolescent drug abuse, school failure, victimization, anti-social behavior), neuropsychiatric (e.g., post-traumatic stress disorder, dissociative disorders, conduct disorders) and physical health problems (e.g., heart disease, asthma). The deterioration of public education, urban violence and the alarming social disintegration seen in some of our communities can be linked to the escalating cycles of abuse and neglect of our children.

For most children, thankfully, a traumatic event is a new experience. And like all new experiences, the unknown will add to the confusing and frightening circumstances surrounding this overwhelming experience. The trauma may significantly challenge the child's sense of the world. A flood, tornado, car accident, shooting or abuse by a caregiver - all challenge the child's beliefs about the stability and safety of their world. Very young children may not understand what happened and will be confused or even frightened by the reactions of their siblings or caregivers.

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The acute post-traumatic period is characterized by an attempt by the child to reorganize, reevaluate and restore their pre-traumatic world. Many of the emotional, behavioral and cognitive signs and symptoms of the acute post-traumatic period are due to these efforts. Unfortunately, children often do not have the same capacity to understanding or explaining most traumatic experiences. Young children may make many false assumptions about the event – "the tornado came because God was mad."

As with most situations, children seek answers and comfort from adults around them, yet we often feel helpless in this role. Indeed, most traumatic experiences challenge the most mature and experienced adult. While adults do not have all the answers, they can help children better understand the traumatic event and the ways we respond following trauma.

This booklet addresses some of the key issues related to the child's complex set of reactions that often follow traumatic events. While focused on caregivers, this information may be helpful to caseworkers, teachers, other family and other adults working and living with traumatized children.

This simple guide is intended to inform and provide general principles -- it is not intended to be comprehensive or to exclude other observations or approaches to helping traumatized children. The more we understand these children and the impact of traumatic experiences, the more compassionate and wise we can be as we try to help these children.

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Frequently Asked Questions

1. **Should I talk about the traumatic event?**

Do not be afraid to talk about the traumatic event. Children do not benefit from 'not thinking about it' or 'putting it out of their minds.' If a child senses that her caregivers are upset about the event, she will not bring it up. In the long run, this only makes the child's recovery more difficult. A good rule of thumb is to let the child guide when you talk about it. If the child doesn't ask about or mention it, don't bring it up on your own, but when the child brings it up or seems to be thinking about it (see below), don't avoid discussion. Listen to the child, answer questions, and provide comfort and support. We often have no adequate explanations about senseless death or traumatic events. It is just fine to tell children that you do not know why something happened or that you get confused and upset by it, too. In the end, listening and comforting a child without avoiding or over-reacting will have long-lasting positive effects on the child's ability to cope with trauma.

2. **How should I talk about the event?**

Use age-appropriate language and explanations. The timing and language used are important. Immediately following the trauma, the child will not be very capable of processing complex or abstract information (see Table). As the child gets further away from the event, she will be able to focus longer, digest more and make more sense of what has happened. Sometimes young children act as if they have not 'heard' anything you have said. It takes many individual many moments of sad clarity or the reality of the trauma to actually sink in for young children. Between these moments of harsh reality, children use a variety of coping techniques – some of which can be confusing or upsetting for adults.

During this long process, the child continues to 're-experience' the traumatic event. In play, drawing and words, the child may repeat, re-enact and re-live some elements of the traumatic loss. Surviving adults will hear children ask the same questions again and again. They may be asked to describe 'what happened' again and again. The child may develop profound 'empathic' concerns for others experiencing trauma, including cartoon characters and

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animals. “Is Mickey Mouse scared?” Or as they put their stuffed animals under the bed, they may explain “They have to go hide because the bad guy is coming with a gun.” The child will experience and process the very same material differently at different times following the trauma. In the long run, the opportunity to process and re-process many times will facilitate healthy coping. This re-processing may take place throughout the development of a given child. Even years after the original trauma, a child may ‘revisit’ the loss and struggle to understand it from their current developmental perspective. An intensity of emotional feelings will often be seen on various anniversary dates following the trauma (e.g., one week, one month and one year). Children may develop unusual fears of specific days – “Bad things happen on Fridays.”

One of the most important elements in this process is that children of different ages have different styles of adapting and different abilities to understand abstract concepts often associated with trauma such as death, hate or the randomness of a tornado’s path or a drunk driver hitting their car.

3. Should I talk to others about the traumatic event?

Yes. Inform adults and children in the child's world what has happened. Let teachers, counselors, parents of the child's friends and, if appropriate, the child's peers know some of the pain that this child is living with. Sometimes this can allow the people in the child's life to give them the small amount of tolerance, understanding or nurturing that will smooth the way. People can often be intolerant or insensitive when dealing with the traumatized child "Isn't it about time they got over this?” When you see that this is occurring don't be shy about taking this person aside and educating them about the long-lasting effects of traumatic events and the long process of recovery.

4. How long to these reactions last?

An acute post-traumatic change in feeling, thinking and behaving is normal – persistence or extreme symptoms are not. Many clinicians working with traumatized have noted that the persistence of symptoms beyond three months is associated with increased risk for problems. If symptoms of re-experiencing, avoidance, fearfulness, sleep problems, nightmares, sadness or poor school or social functioning persist beyond three months, they need to be addressed. If they persist for six months or if the symptoms interfere with any aspect of

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functioning, you should have the child see a professional. If the child is in therapy, communicate this with the therapist. Find out if school performance has been affected. Watch for changes in patterns of play and loss of interest in activities. Be observant. Be patient. Be tolerant. Be sympathetic. These children have been terrified and hurt.

In many cases, some form of post-traumatic symptom can last for many years. Indeed, more than thirty percent of children living through traumatic stress develop some form of post-traumatic stress disorder (PTSD) . This is a chronic disorder requiring the attention of mental health professionals.

5. Do children understand events accurately?

Young children often make false assumptions about the causes of major events. Unfortunately these assumptions may include some sense that they were at fault for the event -- including the death of a loved one. Adults often assume that causality is clear -- dying in a car accident, being shot in a drive-by shooting, dying in a fire. The child may very easily distort an event and make the wrong conclusions about causality. Mom died in the car accident because she was coming to get me at school. The other driver was mad at her. My brother is dead because he was helping me with my homework. The person that shot my brother was shooting at me and hit my brother because he was in my room. The tornado was God's way of punishing my family. In many of these distorted explanations, children assume some degree of responsibility for the traumatic event. This can lead to very destructive and inappropriate feelings of guilt.

Be clear. Explore the child's evolving sense of causality. Correct and clarify as you see false reasoning develop. Over time, the ability of the child to cope is related to the ability of the child to understand. While some elements of trauma seem beyond understanding, this can be explained to a child -- some things we don't know. Don't let the child develop a sense that there is a secret about the event -- this can be very destructive. Let the child know that adults can not and will not understand some things either.

6. Do all children have problems after traumatic events?

The majority of children experiencing trauma will have some change in their behavior and emotional functioning. In addition to the symptoms listed above,

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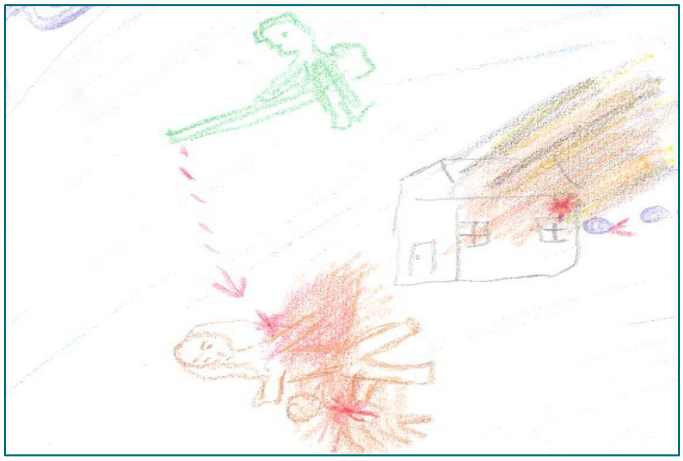
these children will often be more irritable, tired and regressed. Fortunately, however, for the majority of these children these symptoms are short-lived. Some children may exhibit no easily observable changes in their thinking, feeling or behaving. In general, the more threatened a child felt, the closer they were to injury or death, the more the event disrupted or traumatized their family or community, the more likely there will be symptoms. In some cases, children's symptoms do not show up for many weeks or even months after the traumatic event, confusing many caregivers. Indeed, in these cases, caregivers or teachers may not even make a connection between the symptoms and the traumatic event.



How Can I Help?

1. **Don't be afraid to talk about the traumatic event.** Children do not benefit from 'not thinking about it' or 'putting it out of their minds'. If a child senses that his/her caretakers are upset about the event, they will not bring it up. In the long run, this only makes the child's recovery more difficult. Don't bring it up on your own, but when the child brings it up, don't avoid discussion, listen to the child, answer questions, and provide comfort and support. We often have no good verbal explanations, but listening and not avoiding or over-reacting to the subject and then comforting the child will have a critical and long-lasting positive effect.

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2. **Provide a consistent, predictable pattern for the day.** Make sure the child has a structure to the day and knows the pattern. Try to have consistent times for meals, school, homework, quiet time, playtime, dinner and chores. When the day includes new or different activities, tell the child beforehand and explain why this day's pattern is different. Don't underestimate how important it is for children to know that their caretakers are 'in control.' It is frightening for traumatized children (who are sensitive to control) to sense that the people caring for them are, themselves, disorganized, confused and anxious. There is no expectation of perfection; caretakers themselves have often been affected by the trauma and may be overwhelmed, irritable or anxious. If you find yourself being this way, simply help the child understand why, and that these reactions are normal and will pass.

3. **Be nurturing, comforting and affectionate, but be sure that this is in an appropriate 'context.'** For children traumatized by physical or sexual abuse, intimacy is often associated with confusion, pain, fear and abandonment. Providing a hug, a kiss and other physical comfort to a young child can be very reassuring. A good working principle for this is to be physically affectionate when the child seeks it. When the child walks over and touches you, return in kind. The child will want to be held or rocked – feel free. On the other hand, try not to interrupt the child's play or other free activities by grabbing them and holding them. Further, be aware that many children from chronically distressed settings may have what we call attachment problems. They will have unusual and often inappropriate styles of interacting.

   Do not tell or command them to 'give me a kiss' or 'give me a hug.' Abused children often take commands very seriously. It reinforces a very malignant association linking intimacy/physical comfort with power (which is inherent in a caregiving adult's command to 'hug me').

4. **Discuss your expectations for behavior and your style of 'discipline' with the child.** Make sure that there are clear 'rules' and consequences for breaking the rules. Make sure that both you and the child understand beforehand the specific consequences for compliant and non-compliant behaviors. Be consistent when applying consequences. Use flexibility in

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consequences to illustrate reason and understanding. Utilize positive reinforcement and rewards. Avoid physical discipline.

5. **Talk with the child.** Give them age appropriate information. The more the child knows about who, what, where, why and how the adult world works, the easier it is to 'make sense' of it. Unpredictability and the unknown are two things which will make a traumatized child more anxious, fearful, and therefore, more symptomatic. They may be more hyperactive, impulsive, anxious, and aggressive and have more sleep and mood problems. Without factual information, children (and adults) 'speculate' and fill in the empty spaces to make a complete story or explanation. In most cases, the child's fears and fantasies are much more frightening and disturbing than the truth. Tell the child the truth, even when it is emotionally difficult. If you don't know the answer yourself, tell the child. Honesty and openness will help the child develop trust.

6. **Watch closely for signs of re-enactment** (e.g., in play, drawing, behaviors), **avoidance** (e.g., being withdrawn, daydreaming, avoiding other children) **and physiological hyper-reactivity** (e.g., anxiety, sleep problems, behavioral impulsivity). All traumatized children exhibit some combination of these symptoms in the acute post-traumatic period. Many exhibit these symptoms for years after the traumatic event. When you see these symptoms, it is likely that the child has had some reminder of the event, either through thoughts or experiences. Try to comfort and be tolerant of the child's emotional and behavioral problems. These symptoms will wax and wane - sometimes for no apparent reason. The best thing you can do is to keep some record of the behaviors and emotions you observe (keep a diary) and try to observe patterns in the behavior.

7. **Protect the child.** Do not hesitate to cut short or stop activities that are upsetting or re-traumatizing for the child. If you observe increased symptoms in a child that occur in a certain situation or following exposure to certain movies, activities and so forth, avoid these activities. Try to restructure or limit activities that cause escalation of symptoms in the traumatized child.

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8. **Give the child 'choices' and some sense of control.** When a child, particularly a traumatized child, feels that they do not have control of a situation, they will predictably get more symptomatic. If a child is given some choice or some element of control in an activity or in an interaction with an adult, they will feel safer, comfortable and will be able to feel, think and act in a more 'mature' fashion. When a child is having difficulty with compliance, frame the 'consequence' as a choice for them - "You have a choice- you can choose to do what I have asked or you can choose….." Again, this simple framing of the interaction with the child gives them some sense of control and can help defuse situations where the child feels out of control and therefore, anxious.

9. **If you have questions, ask for help.** These brief guidelines can only give you a broad framework for working with a traumatized child. Knowledge is power; the more informed you are, the more you understand the child, the better you can provide them with the support, nurturing and guidance they need. Take advantage of resources in your community. Each community has agencies, organizations and individuals coping with the same issues. They often have the support you may need to help you.

Special Considerations for Traumatized Infants

1. Can infants recall a traumatic experience later in life? The key word in this question is "recall." Unfortunately, for most, the concept of memory is limited to the storage and recall of cognitive, narrative memory. In this conceptualization, a preverbal infant would not be capable of "remembering" and "recalling" any event. Furthermore, we are all familiar with the developmental amnesia that occurs at approximately age three. In this normal developmental phase, there appears to be a reorganization of cognitive and memory functions such that narrative memory for events prior to age three or four are difficult to access later in life. These two points have led to the pervasive, inaccurate and destructive view that infants do not recall traumatic experience, including sexual abuse. Nothing could be further from the truth.

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The human brain has multiple ways to "recall" experience. Indeed, the brain is designed to store and recall information of all sorts – motor, vestibular, emotional, social and cognitive. When you walk, play the piano, feel your heart race in an empty parking lot at night, feel calmed by the touch of a loved one or create a "first impression" after meeting someone for first time, you are using memory. All incoming sensory information creates neuronal patterns of activity that are compared against previously experienced and stored patterns. New patterns can create new memories. Yet the majority of these stored memory templates are based upon experiences that took place in early childhood – the time in life when these patterns of neuronal activity were first experienced and stored. And the majority of our 'memories' are non-cognitive and pre-verbal. It is the experiences of early childhood that create the foundational organization of neural systems that will be used for a lifetime.

This is why, contrary to popular perception, infants and young children are more vulnerable to traumatic stress – including sexual abuse. If the original experiences of the infant with primary caregiving adults involve fear, unpredictability, pain and abnormal genital sensations, neural organization in many key areas will be altered. For example, abnormal associations may be created between genital touch and fear, thereby laying the foundation for future problems in psychosexual development. Depending upon the specific nature of the abuse, the duration, the frequency and the time during development, a host of problems can result. In many ways, the long-term adverse effects of sexual abuse in infancy are the result of memories – physiological state memories, motor-vestibular memories and emotional memories, which in later years can be triggered by a host of cues that are pervasive. Incestuous abuse in infancy is most destructive in this regard. It will result in the association of fear, pain and unpredictability into the very core of future human functioning – the primary relational templates. If these original 'templates' for all future relationships are corrupted by sexual exploitation and abuse, the child will have a lifetime of difficulties with intimacy, trust, touch and bonding – indeed the core elements of healthy development and functioning throughout the lifecycle will be altered.

Furthermore, if the child is maltreated or abused during early childhood, they may not have any cognitive "memory" and be completely unaware that the source of their fears, difficulties with intimacy and relationships has its roots in this betrayal in infancy. This can lead to problems with self-esteem and, will make any therapeutic efforts more difficult.

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2. Can trauma during infancy arrest cognitive, emotional or behavioral development? The abuse of an infant is often accompanied by extreme disruptions of normal caregiving behaviors and by extreme and prolonged stress responses. Altered caregiving and a prolonged stress response will alter the development of the infant. The major mediators of emotional, cognitive and social environment and, therefore, learning during infancy are the primary caregivers. Development in all domains can be disrupted if these primary relationships are compromised. As mentioned above, it is almost inevitable that emotional, behavioral and cognitive development will be arrested by early traumatic experience.

3. Are there physiological changes in the brain resulting from a traumatic event? As mentioned above, the brain is designed to change in response to experience. Indeed, all experience changes the brain. With traumatic experiences, the changes are in those parts of the brain involved in the stress and fear responses. Many studies with adults and, now with children, have demonstrated a host of neurophysiological changes that are related to traumatic stress. While many more well-controlled studies are needed, it is likely that certain brainstem catecholamine systems (e.g., locus coeruleus noradrengergic), limbic areas (e.g., amygdala), neuroendocrine (e.g., hypothalamic-pituitary-adrenal axis) and cortical systems involved in regulating stress and arousal may all be altered in traumatized children.

4. Do infants display problems similar to older children who are traumatized or abused? The long-term problems that result from maltreatment will vary as a function of several keys factors: what is the nature of the abuse, the duration, frequency, intensity, time during development and the presence of attenuating factors such as other caring, attentive caregivers in the child's life. In general, however, with all traumatic experiences, the earlier in life, the less "specific" and more pervasive the resulting problems appear to be. For example, when traumatized as an adult, there is a specific increase in sympathetic nervous system reactivity when exposed to cues associated with the traumatic event. With young children, following traumatic stress, there appears to be a generalized increase in autonomic nervous system reactivity in addition to the cue-specific reactivity. Due to the sequential and functionally interdependent nature of development, traumatic disruption of the organization and functioning of neural system can result in a cascade of related disrupted

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development and dysfunction. Examples of this include the motor and language delays in traumatized children under age six. The "causes" of these delays are likely due to the primary, trauma-induced alterations in other domains (e.g., the stress response systems, thereby influencing physiological reactivity, hypervigilance, concentration), which, in turn, impair the young child's willingness to explore, capacity to process new information and ability to focus long enough on new information to learn.

Key Points: Helping Traumatized Infants

• Anything that can decrease the intensity and duration of the acute fear response (alarm or dissociative) will decrease the probability of that the infant or young child will have long term emotional, behavioral, social or cognitive problems. The longer an infant stays in a fear state, the more likely it will be that she will have problems.

• In general, structure, predictability and nurturing are key elements to a successful early intervention with a traumatized infant.

• The primary source of these key elements is the primary caregiver. Therefore, it is critical to help the caregivers understand as much about post-traumatic responses as possible. Further it is crucial to be sensitive to the needs of the caregiver.

• If the primary caregivers are impacted by the same trauma, it is imperative that they get treatment that compliments the work with the child. Indeed, the best intervention for infants and young children is treating the primary caregiving adults. As they become less anxious, fearful and impaired, the more available they are to the infant and toddler.

• Early assessment and intervention can be prophylactic -- helping prevent a prolonged acute neurophysiologic, neuroendocrine and neuropsychological trauma response. If an infant or young child has been in a traumatic event, or if the primary caregiver of young children has been traumatized, early aggressive intervention can be crucial.

• Contrary to popular belief, even infants and very young children experiencing traumatic events can be affected. Indeed, there is increasing evidence to suggest that the younger a child, the more pervasive are the post-traumatic problems. These are a few simple points to keep in mind. The infant's world is defined by his or her caregivers. If the caregivers are pre-occupied, depressed, anxious, exhausted or absent due to post-traumatic symptoms, this will adversely impact the infant and toddler.

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About the drawings:

The Weeping Sun: from a drawing by a 12 yo Kosovar girl living in an Albanian refugee camp following displacement in 1999.*
The Firing Squad: from a drawing by an 11 yo Kosovar boy after witnessing the murders of members of his village in 1999.*
Mother and Child: from a drawing of the experiences of a 10 yo Kosovar boy.*

* Drawings from the collection of Dr. Shoaib (A trainee at the ChildTrauma program in 1998) obtained during clinical work at Kosovar refugee camps in Albania in 1999.

The Traumatized Child and Threat

Adaptive	REST	VIGILANCE	FREEZE	FLIGHT	FIGHT
Hyperarousal	REST	VIGILANCE	RESISTANCE	DEFIANCE	AGGRESSION
Dissociative	REST	AVOIDANCE	COMPLIANCE	DISSOCIATION	FAINTING
Regulating	**NEOCORTEX**	**CORTEX**	**LIMBIC**	**MIDBRAIN**	**BRAINSTEM**
Cognition	ABSTRACT	CONCRETE	EMOTIONAL	REACTIVE	REFLEXIVE
AROUSAL	**CALM**	**ALERT**	**ALARM**	**FEAR**	**TERROR**

When we are under threat, our minds and bodies will respond in an adaptive fashion, making changes in our state of arousal (mental state), our style of thinking (cognition) and in our body's physiology (e.g., increase heart rate, muscle tone, rate of respiration). To understand how we respond to threat it is important to appreciate that as we move along the arousal continuum - from calm to arousal to alarm, fear and terror - different areas of our brain control and orchestrate our mental and physical functioning. The more threatened we become, the more 'primitive' (or regressed) our style of thinking and behaving becomes. When a traumatized child is in a state of alarm (because they are thinking about the trauma, for example) they will be less capable of

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concentrating, they will be more anxious and they will pay more attention to 'non-verbal' cues such as tone of voice, body posture and facial expressions. This has important implications for understanding the way the child is processing, learning and reacting in a given situation.

The key to understanding traumatized children is to remember that they will often, at baseline, be in a state of low-level fear -- responding by using either a hyperarousal or a dissociative adaptation -- and that their emotional, behavioral and cognitive functioning will reflect this (often regressed) state. The key points outlined in this booklet help a caregiver provide the structure, predictability and sense of safety that can help keep traumatized children from staying in a state of fear too long. And help them understand how the behaviors of the child can regress (move to the right on the Arousal Continuum).

Glossary

Trauma: A psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror and helplessness.

Post-traumatic Stress Disorder (PTSD): A neuropsychiatric disorder that may develop following a traumatic event that includes changes in emotional, behavioral and physiological functioning.

These resources will be periodically updated and posted in a special section of the ChildTrauma Academy web site www.ChildTrauma.org. Visit this site for updates and for other resource materials about traumatic events and children.

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About the Author

Dr. Perry is the Senior Fellow of The ChildTrauma Academy, a not-for-profit organization based in Houston, TX (www.ChildTrauma.org), and adjunct Professor in the Department of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine at Northwestern University in Chicago. He serves as the inaugural Senior Fellow of the Berry Street Childhood Institute, an Australian based center of excellence focusing on the translation of theory into practice to improve the lives of children.

Dr. Perry is the author, with Maia Szalavitz, of The Boy Who Was Raised As A Dog, a bestselling book based on his work with maltreated children and Born For Love: Why Empathy is Essential and Endangered. His most recent multimedia books, BRIEF: Reflections on Childhood, Trauma, and Society and RESILIENT: Six Core Strenths for Healthy Development were released in 2013. Over the last thirty years, Dr. Perry has been an active teacher, clinician and researcher in children's mental health and the neurosciences holding a variety of academic positions.

Dr. Perry has conducted both basic neuroscience and clinical research. His experience as a clinician and a researcher with traumatized children has led many community and governmental agencies to consult Dr. Perry following high-profile incidents involving traumatized children such as the Branch Davidian siege in Waco, the Oklahoma City bombing, the Columbine school shootings, the September 11th terrorist attacks, Katrina hurricane, the FLDS polygamist sect and most recently, the earthquake in Haiti, the tsunami in Tohoku Japan, and the recent Sandy Hook Elementary school shootings.

Dr. Perry is the author of over 500 journal articles, book chapters and scientific proceedings and is the recipient of numerous professional awards and honors. He has presented about child maltreatment, children's mental health, neurodevelopment and youth violence in a variety of venues including policy-making bodies such as the White House Summit on Violence, the California Assembly and U.S. House Committee on Education. Dr. Perry has been featured in a wide range of media including National Public Radio, The Today Show, Good Morning America, Nightline, CNN, MSNBC, NBC, ABC and CBS News and the Oprah Winfrey Show.

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About The ChildTrauma Academy

The ChildTrauma Academy (CTA) is a not-for-profit organization based in Houston, Texas working to improve the lives of high-risk children through direct service, research and education. A major activity of the CTA is to translate emerging findings about the human brain and child development into practical implications for the ways we nurture, protect, enrich, educate and heal children. The "translational neuroscience" work of the CTA has resulted in a range of innovative programs in therapeutic, child protection and educational systems.

The mission of the ChildTrauma Academy is to help improve the lives of traumatized and maltreated children — by improving the systems that educate, nurture, protect and enrich these children. We focus our efforts on education, service delivery, program consultation, research and innovations in clinical assessment/treatment.

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Our mission is to empower parents, teachers, therapists, social workers and psychologists by giving them pertinent insights, skills, and tools necessary to help children thrive.

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