CLINICAL INTERVENTIONS

GENERAL PRINCIPLES: Interventions in the aftermath of trauma, including assessment and treatment, can be conceptualized as preventing and attenuating malignant memories, restructuring their configurations, or uncoupling links among reexperiencing, arousal, and avoidance. Clinicians intervening with traumatized youngsters must consider not only the presenting symptoms and the individual child's ability to cope, but also the biopsychosocial development and the impact of trauma on the youngster's maturational and developmental trajectories. Additionally, it is crucial to intervene with the child's community and network of caretakers, including parents, other family members, and teachers to enlist their assistance and provide them with support (20, 76). Clinicians who undertake work with traumatized youngsters and families should be adept at such interventions and familiar with changing developments in this rapidly evolving field. They must maintain a compassionate, empathic, professional attitude and remain alert to the common pitfalls of subtle biases, inclinations to identify with or condemn young survivors and parents, or tendencies to gratify voyeuristic wishes or rescue fantasies. Such work can be so demanding that even experienced clinicians should consider obtaining ongoing consultation from colleagues who specialize in working with traumatized children. In disaster, episodes of community violence, or complex clinical situations, interventions are often best coordinated among mutually supportive members of a specialized multidisciplinary team. Intervention modalities may include critical incident debriefing; individual, pharmaco-, family, and group assessments and therapies; and pragmatic consultative, administrative, political, or economic support and advocacy. Specialized techniques include art, storytelling, role playing, and free or directed play. Intervention sites may include the home, clinic, or school. Because PTSD may be preventable, professional activities should include public education aimed at preventing violence and children's exposure to it and identifying its effects on them, as well as advocacy for provision of services to traumatized youngsters. Especially for events such as war or natural disasters, but also for ongoing trauma such as abuse or neglect, the media can be used to educate caretakers about the special needs of children. The media should be encouraged and assisted to furnish children themselves

with carefully crafted comprehensible information to assist in their avoidance, active cognitive and behavioral coping, and interpretation and appraisal of traumatic events. Additionally, if exposure to violent events is inevitable but predictable, systematic training may prepare youngsters and attenuate the impact of the stressor.

Following disasters, large public health education and screening efforts can be undertaken. Case finding often includes educating caretakers and advocating for children's right to evaluation and treatment. However, caretakers' own response to the traumatic event and psychological mindedness determine access to and the nature of care they would allow. For example, family members, teachers, and even therapists, often deny youngsters' symptoms, enclosing them in a 'trauma membrane' (40) to shield the children -- and themselves -- from retraumatization. Intending to "put the event behind" them and fearing reexperiencing, caretakers can be quite hostile to interventions they perceive as reminders of the trauma. Because such resistance often results from displaced anger, hypervigilance, or avoidance symptomatology (75), educational efforts may have limited success.

Youngsters can develop post-traumatic reactions to a wide variety of events, and individual children exposed to the same event may react differently. Stressors are generally categorized as either single or repeated (93, 28). Single event traumas can include rape, dog bites, automobile or other accidents, violent crimes, disasters, and medical procedures such as bone marrow transplants (84). Chronic exposure can include sexual abuse (45, 98), burn injury (82), or witnessing domestic violence (30). However, the distinction between single event and chronic trauma is often more theoretical than real because a single event may produce a chronic course when retraumatization with each episode of reexperiencing and remembering repeatedly reactivates malignant memories. For example, symptoms may recur during anniversaries, medical procedures, other reminders, or legal proceedings. Often, as in the case of chronic abuse forgotten or kept secret, remembering or disclosing the abuse to others can become a significant acute stressor for the youngster and family. Moreover, symptoms are usually related to degree of exposure (61), but dose of exposure may not necessarily be limited by physical proximity (74). Exposure can be through direct experience, direct observation or

witnessing (60, 63), or merely hearing about an event (70). Therefore, children exposed to traumatized family members or schoolmates may suffer post-traumatic reactions themselves by contagion (85).

Once a survivor or witness is identified and becomes accessible to the clinician, responsible and ethical professionalism dictates protection of the youngster followed by initiation of rational treatment rooted in an adequate diagnostic assessment. If at all possible, intervention should begin during the course of the event itself (e.g. ongoing domestic violence, war or natural disaster), through preventive measures that include reduction of helplessness and arousal, promotion of a sense of safety, provision of emotional support, and encouragement of active coping, mastery and adaptation (99).

Because the course and clinical presentation of ensuing symptoms depend on exposure to a specific pattern, nature, and number of stressors, as well as distinct demographic, temperamental, developmental, and envirosocial factors, any generalizations about intervention must be interpreted cautiously. For example, while younger children have been reported to be less symptomatic after disasters (23), they reacted more to domestic violence (29, 30). Traumatized girls may become more passive, while boys turn to activity and aggression (18). Furthermore, single event traumas differ from chronic patterns of exposure, with children exposed to ongoing stress presenting as more disturbed (35). Man-made or repeated traumas are likely to cause more profound and long-lasting damage and require ongoing intervention.

Intervention with a youngster should include family and school functioning. Caretakers need ongoing support and interpretation of the youngster's experience. Pre-schoolers and toddlers can be assessed and treated through cooperative parents and teachers, with less individual contact with the child himself. Intervention with the family should include not only attention to family factors that may mediate the youngster's response to the traumatic event, such as capacity for nurturance and protection, but also to the impact of the event on the family itself. Trauma can dramatically change family members' roles, level of family conflict, and family process, functioning, and structure. For example, parents may become secondarily traumatized themselves, feel guilt about their failure to protect the youngster, and blame each other with resultant increase

in marital discord. Parents of survivors of low probability, high impact traumas may require help to avoid regressive over-protection of the child that can interfere with age-appropriate autonomy and development of a sense of competence. A family may face disintegration because it lacks resiliency sufficient to survive the distress, or the trauma may precipitate or exacerbate family violence. Such impact on the family can indirectly distort a child's development and become the principal determinant of a youngster's post-traumatic course. Family members and survivors are helped by focussing on their demonstrated competence to survive and heal. Family therapy is indicated if the trauma has affected family functioning or if the trauma has occurred in the family. Additionally, a parent may require individual attention for malignant memories or other psychopathology that may be triggered by the passage of a child through a particular developmental period, leading to complicated family problems and difficulties in accessing the parent or youngster.

Because the line between assessment and treatment is indistinct, the therapeutic value of the assessment should be maximized, while ongoing evaluation should continue throughout the therapeutic phase. Periodic intervention with of the youngster and family through adolescence is often indicated because development can add new capacities for coping, as well as a new experience of the trauma. The maturing youngster may need to reassess and work through grief and trauma repeatedly. Additionally, symptoms may become submerged or altered during development, only to reappear later. For example, a child traumatized when young may appear to make good progress until the onset of hypersexual behavior, school problems, aggression, depression, and anxiety in early adolescence. Furthermore, because childhood trauma may be hidden until adulthood when malignant memories again emerge in the form of PTSD or other psychiatric disorders, a presentation of sudden decompensation in an adolescent or adult should raise suspicion that malignant memories have been triggered. Dissociation, guilt, depression, disorganization, and suicidal behavior often accompany such presentations (78).

Other general principles that may apply to work with survivors of all ages include: establishing an ethical, non-exploitative, non-intrusive, and empathic professional psychotherapeutic

relationship; giving the survivor as much control as possible over the format of the therapy and pace of remembering, revealing, and reexperiencing while providing sufficient structure and protection from overstimulation and retraumatization; enabling reappraisal of affective and cognitive aspects of malignant memories and authenticating the experience; and encouragement of coping and restoration of individual, family, spiritual, group, and community competence.