THE EFFECTS OF TRAUMATIC STRESS
IMPLICATIONS FOR FAMILY COURT COUNSELLING

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In everyday usage 'trauma' is used to denote an extraordinary event that is highly impactful. In the Greek derivation 'trauma' means a "wound" or "lesion". Both current usage and meaning intimate that a trauma is an unwanted, unexpected and damaging hurt. This implies that trauma leaves the individual scarred, and that first-aid and long-term healing is required.

Whilst everyday nuances have some applicability to the understanding of psychological trauma, the use of the term trauma will be confined to a clinical context in this presentation.

The basic definition of psychic trauma was provided by Freud (1920) who described it as:-

> "the injury to the personality which happens as a result of anxiety so sudden, intense and unexpected that it overwhelms ordinary coping mechanisms".

Early diagnostic classifications of the symptoms of psychic trauma described the reactions as "traumatic neuroses" or "gross stress reactions". These classifications reflected the difficulties in clinically separating responses to the traumatic event from those responses already developed as part of the individual's model of the self and the world (Horowitz et al: 1980).

With the advent of DSM-111 (APA, 1980), a precise diagnosis of these responses became available under the classification of PTSD. PTSD implies that an individual with 'normal' pre-trauma functioning may develop the disorder, given a sufficiently traumatic experience (Creamer: 1990).

The objectives of this presentation are to raise awareness of psychological trauma; to discuss the experience of psychological trauma amongst FC clients; and to relate the implications of these discussions to counselling frameworks.

This presentation incorporates two approaches: one based on clinical observations and PTSD diagnostic criteria, with special reference to the experience of children as witnesses of traumatic events; the second based on a comparison of PTSD with the other models used in FCC.

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PART 1

PTSD - CLINICAL CRITERIA AND DESCRIPTION

We believe that an understanding of trauma in a clinical sense will assist in articulating a syndrome which could be a valuable tool for recognition, identification, understanding, and treating particular issues and families as they present to the Family Court.

PTSD is a recently formulated diagnostic entity. PTSD was first formalised as a classification in the DSM-III (1980). This provided a precise diagnosis of symptoms of psychic trauma and has resulted in research, diagnosis and understanding of stressful life events within the framework of the PTSD model. With this, specific treatment models have evolved. We are interested to address the experience of psychological and physical trauma amongst Family Court clients in the context of the PTSD research and thinking.

The DSM-III-R provides examples of what constitutes a traumatic event (traumatic stress) including:

- threats to life or physical integrity of oneself, one's children, spouse, close relatives or friends;

- seeing another person seriously injured or killed as a result of accident or violence;

- sudden destruction of one's home or community.

Symptoms are now categorised into 3 main areas:

- re-experiencing of the trauma
- avoidance or numbing
- increased arousal

N.B. Appendix DSM-III-R Diagnostic Criteria

PRESENTING TRAUMA IN THE FAMILY COURT CONTEXT

In this project we are addressing human induced trauma (as against natural disasters) focussing on stress situations that most commonly present in the Family Court context.

The literature addresses the two primary categories of experience. People who WITNESS and people who are VICTIM to, or experience traumatic events.

Research findings indicate that there are differences in the experiences of witnesses and victims in their early and long-term responses and their potential for trauma resolution which has implications for trauma mastery strategies.

Our focus at this point, is on children's experience. This system has a primary responsibility in this mandate to see to "the best interests of the child". Along with the family and schools the Family Court has a most significant influence on the lives of children in this society as approximately 40% of our children are affected by separation and divorce.

It is also our premise that adults who are in abusive, violent, or socially dysfunctional or chaotic situations may well have been witnesses or victims of violence themselves as children. (N.B. Anthony and Cohler - the notion of a preceding disorder in the individual exacerbating the original disorder.)

It is important for diagnosis and assessment in our work as Family Court Counsellors, to be able to identify such patterns, and essential to have appropriate understanding for effective therapeutic intervention with these clients. Understanding and awareness of these issues has implications for Court Response and for recommendations we make to the Court, particularly decisions affecting child arrangements.

Of the traumatic events discussed in the literature many have relevance to the Family Court population.

In the Witness category we have children presenting who have witnessed intense unremitting conflict between their parents, spouse violence, homicide or attempted homicide, attempted suicide, or rape/sexual assault of their mother.

There are also many children presenting to this system who are victims of child abuse, - physical and sexual; emotional abuse through prolonged intense conflict; are secondary participants in domestic violence situations; are victims of loss of a parent through abduction/kidnapping; or through access refusal caused by unresolved parental conflict.

There are adults presenting to this system who have witnessed/experienced these events as children or have experienced such events as adults.

CHILDREN'S EXPERIENCE

Child stress is defined as any intrusion into children's normal physical or psycho-social life experiences, that acutely or chronically imbalances physiological or psychological equilibrium, threatens security or safety or distorts physical or psychological growth/development and the psycho-physiological consequences of such intrusion (Arnold).

On reviewing the literature it would seem that the appearance of PTSD in children has only recently gained recognition.

Benedek in speaking of "clinical denial", states that until recently, the subject of trauma, disaster and psychological sequelae has only been examined cursorily. However children are no strangers to traumatic stress and its

sequelae. The importance of loss, grief, mourning and psychic trauma and the interconnections have only surfaced recently. With the recognition that there are precursors that dispose some children to the devastating effects of trauma there has been marked intensification of systematic research effort to study separation experiences, deprivation and psychic trauma in a more organised fashion. (PTSD in Children pages 4 - 15).

In their study of “Catastrophic Situations”, the authors look at the development of PTSD in children in a variety of calamitous events including natural and human induced disasters, hostage taking, child molestation and physical assault. They found that common psychological and behavioural symptoms manifest in children across all disastrous events: phobic reactions, sleep difficulties and anxieties about symbolic events. (PTSD in Children, p.77).

Victims of violently intrusive events are particularly prone to experience PTSD with long term psychological problems. Among some 300 cases of child molestation there was not one case beyond the age of 6 where PTSD was not in evidence.

The effects of trauma are attributed to 3 main factors in children:

- developmental level at time of trauma
- children’s perceptions of reactions in the family to the catastrophic event
- direct exposure of the children to the trauma

More specific short term responses include:

- sleep disorders (bad dreams)
- persistent thoughts of the trauma
- belief that another traumatic event will occur
- conduct disturbances
- hyper-alertness
- avoidance of any stimulus or situation symbolic of the event
- psycho-physiological disturbances

and in younger children:

- nightmares
- regression to enuresis (bed wetting)
- thumbsucking
- increased dependent behaviour

Young children can develop dramatic forms of separation anxiety manifested by clinging to parent, hiding under beds, refusing to go to school (or on access).

Longer Term Responses:

- unusual fantasies
- vulnerability to future stress
- altered sense of power over the self
- early awareness of fragmentation and death

Overt psychic numbing is a response commonly seen in adults. Among children and adolescents it often takes the form of withdrawal into uncustomary behavioural patterns.

If unresolved these factors can lead to subsequent trauma later in life when effective adaptation is not made through appropriate treatment.
(PTSD in Children, p. 87-87)

Interrelationship to Parents

Children are particularly responsive to stress suffered by their parents and will exhibit psychological or physical side effects to stressors affecting their parents. This phenomenon has particular relevance to children in separating families.

When parents are not seen to be coping, i.e. formerly stalwart figures being perceived to be unstable, children can become exceptionally upset.
(PTSD in Children pages 77-81).

THE TRAUMA OF CHILD WITNESS COMPARED WITH CHILD VICTIM

This Section on the child witness is adapted from the work of Pynoos and Eth.
(PTSD in Children, p. 23-27)

"Psychic trauma occurs when an individual is exposed to an overwhelming event and is rendered helpless in the face of intolerable danger, anxiety or instinctual arousal."

There are a number of unique features that define traumatic witnessing and distinguish it from the trauma of direct victimisation.

THE EXPERIENCE OF THE CHILD WITNESS

A sense of helplessness predominates caused by the passivity imposed by having to watch or listen. Unprotected from the full emotional impact of the violence, the child witness may immediately suffer all symptoms of PTSD.

In contract, the injured child victim may immediately become self-absorbed with the pain of this objective experience of the physical hurt or danger and from that point the child's memories are involved with internal sensations and their first preoccupation may focus on physical recovery.

The different experiences of the uninjured and injured child may influence subsequent symptoms and their time course (i.e. responses and adaptations).

The direct victim is more vulnerable to later development of dissociative symptoms and even multiple personality disorders. In the uninjured child witness there is an absence of subsequent psychopathology. Child witnesses do not display traumatic amnesia or disavowal; they do not feel any disbelief about the reality of what they have witnessed (in line with adult witnesses). However they are unprotected from the full emotional impact of physiological response to watching the event which results in the immediate experience of PTSD symptoms.

The perceived danger to the child witness does not depend on fear of self harm. Focus is on the personal meaning of the threat to the victim. They feel emotionally overwhelmed by the danger to their parents.

Children (witnesses) experience an intense perceptual, effective and physiological experience. Two major examples of persistent physiological changes are: high frequency of sleep disturbance (including night terrors and somnambulism) and startle reactions to specific perceptual traumatic reminders.

In adults unresolved, intrusive imagery and autonomic physiological reactions are noted. These phenomena are common in children as well.

There is increasing awareness of the effects of witnessing or experiencing violence on developmental progression and learning capacity.

Intrusive imagery and associated affect may interfere with a child's capacity to learn. Gardiner 1971 reported experience of violence can chronically diminish precise learning in a child.

PSYCHOLOGICAL METHODS FOR MASTERING TRAUMA INDUCED ANXIETY:

Pynoos and Eth describe four common psychological methods employed by children for limiting traumatic anxiety in the immediate future or months after an occurrence:

1. Denial and fantasy.

The child tries to mitigate painful reality by imaginatively reversing the outcome.

2. Inhibition of spontaneous thought.

The child works to avoid reminders of the event.

3. Fixation to the trauma.

The child hopes to make the event more tolerable by means of reiteration - usually incomplete, unemotional journalistic recountings of the event.

4. Fantasies of future harm.

The child avoids directly addressing the actual trauma by supplanting the memories of the event with new fears.

Inner Plans of Action are a further strategy to mitigate the sense of helplessness.

These occur when activity has appeared ineffectual in a catastrophic situation. Fantasies of third party intervention either by the child or a third party dominate in the child witnesses' inner plans of action.

To offset traumatic helplessness, the child witness needs to consider, if only in fantasy, alternate actions that could have prevented the occurrence - they may be mentally involved with cognitive reappraisal of the action of all participants and witnesses.

Strategies of emotional coping may persist and remit only to reappear with traumatic reminders.

Developmental considerations are important determinants of these cognitive efforts at maturity of the trauma and subsequent developmental maturity may bring about revision. Important predisposing factors and specific psychodynamic issues may be especially at work. Child witnesses differ from victims in their set of observations, in that they can monitor simultaneously the assailant, the victim, or the third person intervening. Identification with any of the participants will result in modelling. (N.B. The modelling of aggression/victim behaviour). The choice may be influenced by being of the same sex as the parent, victim or assailant. Being seen as a special child of one parent can also be a predisposing factor.

(PTSD in Children, p. 24-27)

FACTORS INFLUENCING ADJUSTMENT

If the stress is of human design, this suggests a more prolonged course of PTSD.

Blame is more easily assigned if the assailant is a stranger. If a parent is held to be at fault this can cause intense conflict of loyalty.

Intervention fantasies may also serve as a continuing source of self-blame for the child witness therefore, post trauma guilt is connected with imagined failure to intervene.

Violent occurrences challenge the child's trust in adult restraint. It may prompt fantasies of revenge, of an identification with the aggressor that can seriously jeopardise the child's confidence in his/her own impulse control.

The acting out/aggressive behaviour of little boys in particular who have been exposed to violent situations can be explained. Uncharacteristic, aggressive, reckless or self-destructive behaviour or prominent inhibitions may suddenly appear. Unconscious re-enactment behaviour in the child may lead to some repetition of violence in subsequent situations.

The child may need support to voice frighteningly violent revenge fantasies and may need assurance of safety against fantasies of retaliation.

Because these children are preoccupied with danger to the parent and with the need for intervention they may suppress or ignore any fear they have for their own safety. If their fear is not restored they may be vulnerable to trauma related dangerous situations.

Child witnesses are victim to viewing unexplained and frightening acts of adult individuals. Viewing such events can cause profound changes in the child's sense of safety and security of future intimate relationships. This change of future orientation may be one of the most significant markets of childhood trauma.

INTERVENTION STRATEGIES

Pynoo proposes an initial treatment response for children who have experienced trauma as a traumatic event which he describes as "psychological first aid".

He describes three stages of intervention:

1. Opening

2 Reliving the Experience
Coping with the Trauma

3. Closure

NOTES ON INTERVIEW FORMAT:

First Stage - Opening

Establish the focus
Free drawing or story telling
Traumatic reference

May go on for 1 1/2 - 2 hours depending on what is required - go in with the intent to take the child through recall of the total event.

Second Stage

A. Reliving the Experience:

Aim - emotional release through:
Reconstruction
Describe perceptual experience
Special detailing of violence, abuse, trauma witnessing
Reliving worst moment.

B. Coping with the Experience

Issues of accountability
Cognitive reappraisal - inner plans of action
Punishment or retaliation
Counter retaliation
Child's impulse control
Previous trauma
Traumatic dreams
Future orientation
Current stress

Third Stage - Closure

Recapitulation
Realistic fears
Expectable course
Child's courage
Child's critique
Leaving taking

"Recovering from trauma is the ability to think about it when we want to and to ignore it when we don't want it." (Horowitz)

IMPLICATIONS OF PTSD FOR COUNSELLORS IN THE FAMILY COURT CONTEXT

Recognition/Diagnosis

Recognising PTSD in child and adult clients has relevant in our work. The notion of a "trauma syndrome" would seem to have application to a significant number of clients presenting to our system.

Assessment

It is useful in determining appropriate case management; as an assessment tool in Family Reports; in clinical articulation of the effects of traumatic experiences for Reports; in providing solid clinical data to give weight to recommendations in Family Reports.

Intervention

Our contact with families primarily involves short term crisis intervention. In this context, I believe that we do have a role to play in therapeutic intervention with children who have experienced trauma.

Pynoo's proposed treatment concept of Psychological First Aid, which he describes as "a positive first step which is not treatment, but provides some kind of immediate relief". This mode of intervention could have relevance for our work in a variety of circumstances.

Children's Groups

The Children's Groups proposed in the Johnston Model could provide a realistic therapeutic alternative relevant to our Systems' needs.

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APPENDIX: DSM III

DIAGNOSTIC CATEGORIES

308.30 Post-traumatic Stress Disorder, Acute

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.

The characteristic symptoms involve re-experiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric, or cognitive symptoms.

The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). Some stressors frequently produce the disorder (e.g. torture) and others produce it only occasionally (e.g. car accidents). Frequently there is a concomitant physical component to the trauma which may even involve direct damage to the central nervous system (eg. malnutrition, head trauma). The disorder is apparently more severe and longer lasting when the stressor is of human design. The severity of the stressor should be recorded and the specific stressor may be noted on Axis IV (p. 26).

The traumatic event can be re-experienced in a variety of ways. Commonly the individual has recurrent painful, intrusive recollections of the event or recurrent dreams or nightmares during which the event is re-experienced. In rare instances there are dissociativelike states, lasting from a few minutes to several hours or even days, during which components of the event are relived and the individual behaves as though experiencing the event at that moment. Such states have been reported in combat veterans. Diminished responsiveness to the external world, referred to as “psychic numbing” or “emotional anaesthesia”, usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to become interested in previously enjoyed significant activities, or that the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and sexuality, is markedly decreased.

After experiencing the stressor, many develop symptoms of excessive autonomic arousal, such as hyperalertness, exaggerated startle response, and difficulty falling asleep. Recurrent nightmares during which the traumatic event is relived and which are sometimes accompanied by middle or terminal

sleep disturbance may be present. Some complain of impaired memory or difficulty in concentrating or completing tasks. In the case of a life-threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when many did not, or about the things they had to do in order to survive. Activities or situations that may arouse recollections of the traumatic event are often avoided. Symptoms characteristic of Post-traumatic Stress Disorder are often intensified when the individual is exposed to situations or activities that resemble or symbolise the original trauma (eg. cold snowy weather or uniformed guards for death-camp survivors, hot, humid weather for veterans of the South Pacific).

Associated features. Symptoms of depression and anxiety are common, and in some instances may be sufficiently severe to be diagnosed as an Anxiety or Depressive Disorder. Increased irritability may be associated with sporadic and unpredictable explosions of aggressive behaviour, upon even minimal or no provocation. The latter symptom has been reported to be particularly characteristic of war veterans with this disorder. Impulsive behaviour can occur, such as sudden trips, unexplained absences, or changes in lifestyle or residence. Survivors of death camps sometimes have symptoms of an Organic Mental Disorder, such as failing memory, difficulty in concentrating, emotional lability, autonomic lability, headache, and vertigo.

Age at onset. The disorder can occur at any age, including during childhood.

Course and subtypes. Symptoms may begin immediately or soon after the trauma. It is not unusual, however, for the symptoms to emerge after a latency period of months or years following the trauma.

When the symptoms begin within six months of the trauma and have not lasted more than six months, the acute subtype is diagnosed, and the prognosis for remission is good. If the symptoms either develop more than six months after the trauma or last six moths or more, the chronic or delayed subtype is diagnosed.

Impairment and complications. Impairment may either be milk or affect nearly every aspect of life. Phobic avoidance of situations or activities resembling or symbolising the original trauma may result in occupational or recreational impairment. “Psychic numbing” may interfere with interpersonal relationships, such as marriage or family life. Emotional lability, depression, and guilt may result in self-defeating behaviour or suicidal actions. Substance Use Disorders may develop.

Predisposing factors. Pre-existing psychopathology apparently predisposes to the development of the disorder.

Prevalence. No information.

Sex ration and familial pattern. No information

Differential diagnosis. If an **Anxiety, Depressive, or Organic Mental Disorder** develops following the trauma, these diagnoses should also be made.

In **Adjustment Disorder**, the stressor is usually less severe and within the range of common experience; and the characteristic symptoms of Post-traumatic Stress Disorder, such as re-experiencing the trauma, are absent.

Diagnostic criteria for Post-traumatic Stress Disorder

A. Existence of a recognisable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma as evidenced by at least one of the following:

(1) recurrent and intrusive recollections of the event
(2) recurrent dreams of the event
(3) sudden acting or feeling as if the traumatic event were reoccurring,
because of an association with an environmental or ideational stimulus.

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:

(1) markedly diminished interest in one or more significant activities
(2) feeling of detachment or estrangement from others
(3) constricted affect

D. At least two of the following symptoms that were not present before the trauma.
(1) hyperalertness of exaggerated startle response
(2) sleep disturbance
(3) guilt about surviving when other have not, or about behaviour required for survival
(4) memory impairment or trouble concentrating
(5) avoidance of activities that arouse recollection of the traumatic event
(6) intensification of symptoms by exposure to events that symbolise or
resemble the traumatic event

SUBTYPES

Post-traumatic Stress Disorder, Acute

A. Onset of symptoms within six months of the trauma.

B. Duration of symptoms less than six months.

Post-traumatic Stress Disorder, Chronic or Delayed
Either of the following, or both:

(1) duration of symptoms six months or more (chronic)
(2) onset of symptoms at least six months after the trauma (delayed)