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Childhood Trauma: An overview of fractured family statistics, the implications of childhood stress and effective treatment options within the South-African context.

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Course outcomes:

Once you have completed this course you will have an understanding of:

- Childhood trauma within the South-African context;
- A statistical overview of research studies on orphaned, abandoned and vulnerable children and the implications of fractured families;
- An overview of the implications of childhood stress and how this stress affects health across the entire lifespan. This is discussed in connection with the Adverse Childhood Experience (ACE) study;
- A brief look at treatment options available for traumatised children. Treatments include Cognitive Behavioural Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), Psychodynamic psychotherapy, Systemic Interventions, School Based Interventions and Creative Expressive Art Therapies (CEAT).

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Childhood Trauma: An overview of fractured family statistics, the implications of childhood stress and effective treatment options within the South-African context.

1. Introduction

Children's exposure to trauma is one of our country's foremost social and public health challenges, with devastating and costly effects on individual children, families and communities. The implications of childhood trauma, especially a child's repeated exposure to traumatic events, are often widespread and persistent. Children's minds, bodies and brains are not yet fully developed and are extremely vulnerable to trauma. They need their psychological resources to successfully master developmental tasks, but traumatic stress impedes on these resources and seriously alters their physical health as well as their cognitive and psychosocial functioning (Kaminer & Eagle, 2010).

Children are often both direct and indirect victims of trauma as they often witness violence between adults in their environment (Kaminer & Eagle, 2010).It has long been recognised that children who are the victims of one form of abuse are more likely to experience multiple forms of abuse or trauma (Edwards, Holden, Felitti, & Anda, 2003; Mullen, Martin, Anderson, Romans, & Herbison, 1996, cited in Friedman, Keane & Resick, 2007). Exposure to a single traumatic event, for example a car accident or house robbery, is described as "Simple Trauma" whereas children's exposure to multiple or prolonged traumatic events refers to "Complex Trauma" (Spinazzola, Ford, Zucker, Van der Kolk, Silva, Smith, 2005 cited in Friedman, Keane & Resick, 2007).

Although simple trauma can cause impaired functioning, it presents less risk to a child than complex trauma. Complex trauma in children often occurs in cases of abuse and neglect and can include the witnessing of domestic violence, war, or natural disasters (Cook, Spinazzola, Ford, Lanktree, Blaustein, Sprague, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson, van der Kolk, 2007). A study of 6 year olds indicated that child abuse is related to delayed language and cognitive development, low IQ and poor school performance (Delaney-Black, Covington, Ondersma, Nordstrom-KleeTemplin, Ager et al, 2002 cited in Friedman, Keane & Resick, 2007). Research also found that children who are struggling with intense fears and concerns about their primary care givers, fall behind in their emotional, social and cognitive development and have poor physical health (Osofsky, 1999, cited in Friedman, Keane & Resick, 2007).

The exact number of children affected by trauma is difficult to determine, but research studies confirm that a significant number of children are exposed to highly challenging and dramatic life events. Although children do not always show difficulties that can be categorised within the framework of PTSD, the following studies highlight the occurrence of childhood trauma and PTSD:

- A ten year longitudinal study of 1,420 children and adolescents in the United States found that by age 16, more than two thirds of youths had been exposed to at least one traumatic event (Copeland, Keeler, Angold and Costello, 2007).
- A study that looked at the impact of ongoing war on Palestinian children from age six to sixteen, showed 54% of children to be suffering from PTSD (Ehlers & Clark, 2000 cited in Kaminer & Eagle, 2010).
- In 1997 a study conducted in Kayelitsha, Cape Town, showed 21.7% of children met the criteria for PTSD (Davidson, Connor & Lee, 2005 cited in Kaminer & Eagle, 2010).
- In a Youth Stress Clinic in South-Africa, 53% of its 97 children were sexually abused and 64% of them presented PTSD (Eagle, 2005a cited in Kaminer & Eagle, 2010).

On 19 October 2011 the Green Paper on Families was published in the Government Gazette. Faced with social ills like poverty, unemployment, domestic violence, crime, absent fathers, HIV/Aids and moral decay, the Green Paper places the family at the center of national policy development. The main aim of the Green Paper is to promote family life and strengthen families in South-Africa. It aims for government and society interventions to stem family disintegration and to promote and strengthen family life in South-Africa.

This course will take a statistical view on children most at risk for complex trauma by highlighting the impact of fractured families on childhood distress. The implications of childhood stress will be discussed in terms of the Adverse Childhood Experience study (ACE) www.cdc.gov/nccdphp/ace/index.htm. It will conclude with a brief overview of effective treatment options of childhood trauma, with relation to South-Africa's diverse context.

2. Fractured Families: Research Statistics on orphaned, abandoned and vulnerable children

Statistical data obtained from research papers by the South-African Institute of Race Relations and reprinted with permission from the South-African Institute of Race Relations (Holborn & Eddy, 2011).

The number of orphaned, abandoned and vulnerable children continues to increase in South-Africa. There are over 20 million children and youth in South-Africa, but in 2010, 3.6 million of these children had lost one or both parents, and more than 10.3 million children are receiving benefits from the child support grant. The 2010 statistics paint a disturbing picture:

- Only 34% of children live with both biological parents
- 39% live with mothers only
- 3% live with fathers only and are cared for by their fathers only 18% of the time
- 23.9% live with neither parent
- 7.6% live in 'skip-generation' households (households where children live with their paternal or maternal grandchildren)
- 92 000 (0.5%) live in child-headed households of which 49.3% do not have employed members
- By age 22 years, 56.6% youth are not learning, nor are they working

According to the SAIRR these vulnerable children are at a higher risk of:

- Missing out on schooling
- Lower food security
- Anxiety and depression
- Exposure to HIV infection

2.1. Absent fathers have a detrimental effect on a child's overall wellbeing. A father's presence contributes to the cognitive development, intellectual functioning and school achievement of a child. Children growing up without a father are:

- More likely to experience emotional disturbance and depression.
- Girls growing up without their fathers are more likely to have lower self-esteem, higher levels of risky sexual behaviour and more difficulty in romantic relationships.
- They are also more likely to have early pregnancy, bearing children outside marriage, marrying early or getting divorce.
- Boys growing up without fathers are more likely to display 'hyper-masculine' behaviour, including aggression (Richter & Morrell, 2006 cited in Holborn & Eddy, 2011).

2.2. Children not brought up by both parents are affected in the following ways:

2.2.1 Education

- 80% are more likely to experience educational failure,
- 40% are more likely to be unemployed (Social Policy Justice Group, 2006 cited in Holborn & Eddy, 2011).

2.2.2 Youth unemployment

- 52% of 15 – 24 year-olds are unemployed
- 68% of 18 – 35 year-olds have never had a job
- 34% of 15 – 24 year-olds have nothing to do (no education, training or employment)
- Only around 50% of surveyed youth received career guidance at school (Umsobomvu Youth Fund & HSRC, 2005 cited in Holborn & Eddy, 2011).

2.2.3 Youth sexual behaviour

- 39% of 12 -22 year olds have sex and 55% of these had sex before age 15
- 32% of sexually active youth have had 4+ sexual partners
- 77% of young men and 80% of young women believe that people should wait until they are married to have sex, although this does not play out in their lives, possibly due to a lack of role models whose example they can follow (Centre for Justice and Crime Prevention, 2009/2010 cited in Holborn & Eddy, 2011).

2.2.4. Teenage pregnancy

- 50 000 girls fell pregnant while at school in 2008, a 150% increase since 2003 (Department of basic Education, 2010 cited in Holborn & Eddy, 2011).
- Falling pregnant was the most common reason for dropping out of school (Umsobomvu Youth Fund & HSRC, 2003 cited in Holborn & Eddy, 2011).
- 93% of pregnancies occurred with girls between age 15 – 19 years (Harrison, 2008 cited in Holborn & Eddy, 2011).

2.2.5 HIV/AIDS

- 13% of girls and 4% of boys between the age of 15 – 24 years old are HIV+,
- Youth HIV aids prevalence has decreased in the last decade,
- Today 61% HIV+ youth receive ARV's compared to only 2% in 2002/3 (Unicef cited in Holborn & Eddy, 2011).

- 27% of 18-35 year olds have been tested,
- 42% of 15 – 24 year olds have correct knowledge of HIV/AIDS, down from 66% in 2005 (HSRC, 2008 cited in Holborn & Eddy, 2011).

2.2.6 Youth violence and crime

- A third of schoolgirls have experienced sexual harassment
- In 2011 there were 28 000 reported sexual offences against children
- 40% of rape victims were children
- Youth victimisation rate is double that of adults
- More than 75% of youth victims of assault received no support or counselling
- 51% of youth witness violence within their community
- One in six youths have family members who have been in jail

2.2.7 Youth drug and alcohol use

- Over half of incidents of domestic violence witnessed by young people were preceded by the consumption of alcohol or drugs
- 20% of young people drink to relieve boredom
- 36% have easy access to marijuana

2.2.8 Youth mental health

- 26% of young people have felt so depressed in the last year that they stopped their normal activities
- One in 20 depressed young people have considered suicide.
- Boys who don't know their parents' identities are more likely to suffer from anxiety and depression (Nduna & Jewkes, 2010 cited in Holborn & Eddy, 2011).

3. Implications: The effect of childhood stress on health across the lifespan

Stress is an inevitable part of our daily life. Stress is largely beneficial in that it helps us to develop new skills, or to cope and adapt to new, possibly threatening situations. However, the beneficial aspects of stress diminish when it is severe enough to overwhelm our ability to cope effectively. Intensive and prolonged stress can lead to a variety of short and long term negative health effects. It can disrupt early brain development and compromise functioning of the nervous and immune systems. Studies have acknowledged childhood trauma and adversity as a major risk factor for many serious adult mental and physical health problems including PTSD, substance abuse, depression and poor health outcomes (Edwards, Holden, Felitti & Anda, 2003; Felitti, Anda, Nordenberg, Williamson, 1998 cited in Friedman, Keane & Resick, 2007).

The type of stress which has severe negative influences on a child's wellbeing is typically child maltreatment, which includes abuse or neglect. Children are unable to manage this type of stress by themselves. The stress response system gets activated for a prolonged period of time, which in return can permanently change the development of the brain (http://www.developingchild). This leads to a decreased capacity for emotional regulation, a telling sign of the adverse effects of a child's significant early exposure to severe interpersonal violence and other forms of trauma (Allan & Tarnowski, 1989; Cheasty, Clare & Collins, 2002; Levitan, Parikh, Lesage, Hegadoren, et al., 1998; Schwartz & Proctor, 2000, cited in Friedman, Keane & Resick, 2007).The impact of these stressors can be overcome, however, when a child receives care from a supporting adult. This support can help change the stress response system back to its normal baseline (Middlebrooks & Audage, 2008).

3.1. The Adverse Childhood Experience (ACE) study was a retrospective study, conducted in 2006 in collaboration with the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Health Appraisal Clinic in San Diego, on childhood stressors and adult health. More than 17 000 adults participated, making it one of the largest studies of its kind. This study is particularly noteworthy as it demonstrates a link between:

- violence related stressors like child abuse and neglect and repeated exposure to intimate partner violence (IPV) and
- risky behaviours and health problems in adulthood

The ACE study assessed participant's exposure to the following ten adverse childhood experiences:

Abuse

- Emotional
- Physical
- Sexual

Neglect

- Emotional
- Physical

Household Dysfunction

- Mother treated violently
- Household substance abuse
- Household mental illness

- Parental separation and divorce
- Incarcerated household member

It is scored as follows: A participant who was exposed to emotional abuse had an ACE score of one. A participant who was exposed to emotional abuse and physical neglect had an ACE score of two. The general findings of the ACE study found that:

- Childhood abuse, neglect and exposure to adverse experiences are common.
- Almost two thirds of the participants reported to have been exposed to at least one ACE.
- One in every five reported exposure to more than three ACE's.
- It further confirms that too many children are exposed to violence and traumatic stress.
- It also revealed that when a child is exposed to abuse or neglect or witnessing intimate partner violence, it can lead to a wide array of negative behaviours and poor health outcomes.
- The study also established an association between experiencing ACE and two violent outcomes in adulthood: Suicide attempts and the risk of perpetrating or experiencing IPV.

The next are highlights of the findings:

Child maltreatment

- 25% of women and 16% of men reported being sexually abused.
- Participants who were sexually abused as children were more likely to experience multiple ACE.
- Women and men who experienced child sexual abuse were more than twice as likely to report suicide attempts.
- A strong relationship was found between frequent physical abuse, sexual abuse and witnessing IPV and a male's risk of involvement in a teenage pregnancy.
- Women who reported experiencing four or more types of abuse during their childhood were 1.5 times more like to have an unintended pregnancy at or before the age of 21.
- Men and women who reported being sexually abused were more at risk of marrying an alcoholic and having current marital problems.

Witnessing IPV

- Those who witnessed IPV were two to six times more likely to experience another ACE.

- Exposure to physical, sexual abuse and IPV in childhood resulted in women being 3.5 times more likely to report IPV victimisation.
- Exposure to physical, sexual abuse and IPV in childhood resulted in men being 3.8 times more likely to report IPV perpetration.

Link between ACE and suicide

- Experiencing one ACE increased the risk of attempted suicide two to five times.
- As the ACE scores of participants increased, so did the likelihood of attempting suicide.
- The relationship between ACE and the risk of attempted suicide appears to be influenced by alcoholism, drugs and depression.

The number of ACE's a person experienced, increased the risk for the following health outcomes:

- The higher the ACE score the higher the chance for alcoholism, alcohol abuse or marrying an alcoholic
- Depression (the higher the ACE score the higher the risk of lifetime and recent depressive disorders)
- Higher risk of illicit drug use and higher experience of addiction
- Liver disease
- Risk of IPV
- Multiple sexual partners (those with higher ACE scores were more likely to have 30 or more sexual partners, engage earlier in sexual intercourse and reported to feel more at risk to contract AIDS)
- Smoking
- Suicide attempts
- Unintended pregnancies

The findings of the ACE study emphasize the importance of preventing the maltreatment of children as it has severe consequences over the entire lifespan of the individual. Unfortunately the impact of violence and trauma on the developmental growth of very young children is often overlooked; many professionals do not recognize the far reaching impact of these experiences, particular for children in foster care and child welfare systems. Consequently, many children are misdiagnosed and receive the wrong treatment or no treatment at all (Burns, Phillips, Wagner, Barth, Kolko et al., 2004 cited in Friedman, Keane & Resick, 2007).

4. Treatment of childhood trauma

The prevalence of PTSD in children exposed to trauma ranges from 20 to 30% depending on the study or trauma type. Although impressive advances have been made in research regarding the treatment of children and adolescents, it is still commonly found that both professionals and community workers implement interventions with limited empirical support. Consequently, there is a great need to develop effective interventions for childhood trauma and PTSD symptoms (Saxe, MacDonald & Ellis, 2005 cited in Friedman, Keane & Resick, 2007).

Childhood trauma can be treated at a number of levels:

- Individual treatment for children with support to their parent or caretaker,
- Group psychotherapy and
- Community interventions.

Psychotherapy approaches used for treating children with PTSD include:

4.1. Cognitive Behavioural Therapy (CBT),

4.2. Eye Movement Desensitization and Reprocessing (EMDR),

4.3. Psychodynamic psychotherapy,

4.4. Systemic interventions,

4.5. School Based Interventions and

4.6. Creative Expressive Art Therapies (CEAT).

CBT is among the most widely investigated treatments for childhood traumatic stress and has been recommended as the first line treatment for childhood PTSD. It has the strongest empirical support for efficacy in treating children and adolescent PTSD to date (Cohen, Berliner & March, 2000a, cited in Kaminer & Eagle 2010).

4.1. Cognitive Behavioural Therapy (CBT)

Cognitive-behavioral therapies for PTSD are based on the idea that problems arise as a result of the way people interpret or evaluate situations, thoughts and feelings, as well as the problematic ways these evaluations cause people to act, for example, through avoidance of certain situations (Tull, 2012). Despite the fact that the reactions are considered normal, they become problematic when they overwhelm and threaten the wellbeing of a person.

There are several behaviorally based interventions that can be used to treat psychological trauma in children. They include, but are not limited to:

i. Trauma-Focused CBT (TF-CBT),
ii. Seeking Safety,
iii. KIDNET and
iv. Structured Psychotherapy for Adolescents Recovering from Chronic Stress (SPARCS).

Although several different trauma-specific CBT models are currently in use, they all share common components that can be summarised by the acronym **PRACTICE** (Cohen, Mannarino & Deblinger, 2006 cited in Foa, Keane, Friedman, Cohen 2009).

The PRACTICE acronym represents the following components:

- **Parental treatment component and psycho-education.** Parental components run parallel to the child components. Therefore both parent and child receive individual therapy simultaneously. The fundamental part of the parent/caregiver's therapy is to educate them on how to support their child as their child progresses through the different components. Psycho-education involves parenting skills, knowledge on how to process their child's trauma, helping the parent to normalise their child's responses and encouraging them to provide ongoing corrective responses to their children's cognitive distortion.

- **Relaxation and stress management.** These skills are taught in many different ways specific to the CBT model and include self-regulation skills like muscle relaxation, focused breathing, mindfulness exercises, dance and physical exercises. This enables children to become aware of their own fear, anxiety and tension and aids them in reducing these symptoms. Parents are continuously encouraged to practice these skills themselves and with their children.

- **Affective expression and modulation skills.** Other than relaxation skills, therapists also assist children through interactive games and activities to learn how to become aware and to be able to cope with distressing emotions like anxiety, anger, sadness and emptiness. The child is made aware of how to correctly describe the emotion and then how to deal with situations where the emotion can arise. The process differs from child to child. Some children may need to learn how to ask for help, some may learn how to activate their relaxation

skills and others may need to learn that it is better to leave an unsafe situation. Many children need to learn these coping strategies and when to apply them. As such, this module may take several sessions to master.

- **Cognitive coping skills** mean understanding the connection between thoughts, feelings and behaviours. Children are taught that uncomfortable feelings are caused by troubling or distorted thoughts. What the child feels influences his/her behaviour. A child who witnesses the stabbing of his mother can be aggravated when another child bumps into him on the playground. Feeling angry, he then chooses to push or hit the child back. In therapy the therapist explores the thoughts behind the angry feelings. The traumatised child can describe the thought as follows “when he bumped into me I thought he wanted to kill me.” The therapist can explore with the child if his thought was accurate, and if not, discuss alternatives. The therapist then helps the child explore how the new corrective thought makes him feel.

- **Trauma narrative and cognitive processing of the child’s trauma experience.** After the child gains the skills in the earlier mentioned components, the therapist can start to introduce trauma specific components. The child can be asked to tell his story. Again this is a slow process with the child leading. This can mean that several bits and pieces must be weaved together to make his story and it may take a few narratives before he can share the ‘worst moment’. Through telling his story the child is guided not to only tell it, but also to be aware of his feelings and thoughts and to discriminate between which thoughts are helpful and which aren’t. Caution is necessary and the therapist must go according to the child’s pace and work only with those experiences the child can cope with. A child must not feel overwhelmed or reach a point where he feels it necessary to implement avoidance strategies like “I don’t want to talk about it”.

  The trauma narrative helps the child to contextualise the trauma within the larger framework of his life. This will show the child that a long time elapsed before the trauma occurred and that in time, a long time will elapse again during which he will play, have friends, go to school and do ‘normal kid things’. The therapist can help the child to reframe the experience/s as ‘an’ event rather than ‘the’ event in the child’s life.

- **In vivo desensitisation to trauma reminders.** A child may be taken to or be exposed to some of the trauma reminders. This can be done if the child is avoidant of inherently harmless cues. This can only be done with the full support

of the parent to help a child stop avoiding the feared but harmless situation. This might be the case where a child avoids riding in a car after a car accident.

- **Conjoint child-parent sessions.** Nearer to the end of the sessions the parent and child are seen together, where the child describes his trauma narrative to his parent. The parent would have already heard this in their individual sessions with the therapist and will be able to support the child when hearing this from the child. The aim is that the child will feel supported by his parents should traumatic concerns arise again in future.

- **Enhancing safety and future development.** Ensuring a child's safety is an important part of the treatment plan. It is important that a child feels safe after the occurrence of a traumatic event and that the child is protected from future trauma. To enhance a child's safety the child needs to know how to protect himself and how to ask for help. Treatment focuses on enhancing social skills, problem solving skills and anger management skills. It also involves the parent in the safety planning process. Parents and caregivers are encouraged to help their children practice safety skills between sessions and after treatment concludes.

4.1.1 Trauma-Focused CBT (TF-CBT) includes all of the PRACTICE components. It is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. The treatment model is based on the PRACTICE components that incorporate trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques. Each PRACTICE component is introduced incrementally by increasing discussion about the type of trauma(s) the child has experienced. The child and parent gradually become more tolerant to the trauma related triggers without feeling overwhelmed. They learn new skills to process trauma related thoughts and feelings and how to resolve them (http://academicdepartments.musc.edu/projectbest/tfcbt/tfcbt.htm).

TF-CBT is designed to be a relatively short-term treatment, lasting roughly 12 to 16 sessions. Treatment is provided in a flexible and developmentally appropriate manner and to sufficiently address the unique needs of each child and family. Cultural issues are included as part of the TF-CBT model. It has been evaluated with Caucasian and African American children, and it has been adapted for Latino and hearing-impaired/deaf populations. It is currently being adapted for Native American children and for children in many other countries (e.g., Zambia, Uganda, South Africa, Pakistan, the Netherlands, Norway, Sweden, Germany, and Cambodia),

(Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Cohen et al., 2004, Deblinger et al., 1996, Deblinger et al., 2001).

Multiple treatment outcome research studies and a large volume of clinical evidence indicates that TF-CBT is superior for improving a variety of child symptoms including posttraumatic stress disorder, depression, anxiety, externalising behaviors, sexualised behaviors, feelings of shame, and mistrust. The parental component increases the positive effects for children by reducing parents' own levels of depression and emotional distress about their children's abuse and improving parenting practices and support of their child (http://academicdepartments.musc.edu/projectbest/tfcbt/tfcbt.htm).

4.1.2 Seeking Safety is a treatment model used for comorbid PTSD and substance use disorders. It uses most of the PRACTICE components but usually excludes direct exposure techniques. It is verified to be used as a treatment model for adolescents with safety as its key goal. The model is divided into 25 treatment topics which include PTSD, Taking back your Power, Honesty, Asking help, Setting boundaries in relationships and Grounding (Najavits, 2002,cited in Foa, Keane, Friedman, Cohen 2009).

Although originally developed and tested for adults it has recently been studied in randomised controlled trials for adolescents. The adolescents in the Seeking Safety treatment programme had significantly better outcomes than adolescents that followed ‘treatment as usual’ in various areas including PTSD, trauma-related symptoms and various other areas of pathology (Najavits, Gallop, & Weiss, 2006, cited in Foa, Keane, Friedman, Cohen 2009).

4.1.3 KIDNET is a child friendly version of narrative exposure therapy (NET), which has recently been developed and evaluated (Ruf, Schauer, Neuner, Schauer, Catani, et al., 2007 cited in Foa, Keane, Friedman, Cohen 2009). A treatment programme begins with psycho-education where the importance of life narratives is explained. With help from the therapist the child is assisted in re-creating a narrative of his life which contains both positive and traumatic experiences. The therapist takes an empathetic approach and attention is given to human rights, which help the child to regain dignity and to acknowledge his experience.

4.1.4 Structured Psychotherapy for Adolescents Recovering from Chronic Stress (SPARCS). One of the problems we are facing in South-Africa is that traumatised children continue to live within their stressful environments. SPARCS is

a structured model that is divided into 22 sessions, specifically designed for chronically traumatised youth between the ages of 12 to 19 years. It focuses on abused children, children who witnessed intimate partner violence, community violence or chronic mental trauma. Treatment includes psycho-education, relaxation techniques, cognitive processing and enhancing of personal safety. It has successfully been implemented at schools and as outpatient treatment with diverse groups. Studies reported significant improvement in interpersonal relationships, functional impairment and behavioural symptoms (Habib& Ross, 2006, cited in Foa, Keane, Friedman, Cohen 2009).

4.2. Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a recently discovered treatment using bilateral stimulation when processing traumatic memories in patients with PTSD. Although EMDR originally focused on adults, clinical experience has also revealed encouraging effects on childhood PTSD. In 2002, Chemtob and colleagues reported that EMDR considerably reduced PTSD symptoms in 69% of the 32 children treated. This was significant as the children's symptoms had not improved during the 3.5 years that they received counselling administered treatment. Yet, after 3 session of EMDR the children reported reduced symptoms of PTSD, depression and anxiety (Chemtob, Nakashima, & Carlson, 2002 cited in Friedman, Keane & Resick, 2007).

Briefly explained, EDMR sessions take place where the therapist guides the client through the traumatic memory, while the client follows the therapist's hand movements from left to right. The client reports any images, thoughts or feelings that arise during this process. Contrary to the normal memories, which are under the person's control to recall or conceal, the traumatic memories have control over the person through recurrent and distressing recollection of the traumatic event through flashbacks, re-enactment and nightmares. EMDR neutralises the traumatic memories by reprocessing the information to a normal resolution which facilitates the healing process and enables the person to regain control.

EMDR, when used with children, can be adapted in the following ways:

- Firstly, a safe space must be established prior to treatment, to evoke positive emotions for the child.
- The EMDR treatment protocol must be followed as closely as possible but with age appropriate adjustments, based on the child's developmental stage.
- The eye movements can be replaced with other forms of bilateral stimulation like patting a child on his knees, alternating between the left and right knee.

- The Subjective Units of Distress (SUD) scale, used to determine a client's level of distress about the traumatic memory, can be replaced with a visual or physical means of indicating distress. A child can, for example, point to a picture that symbolizes his emotions, like a sad face, a scared face or a terrified face.
- The EMDR sessions are shorter for younger children. The actual time spent on EMDR for a five year old can be only ten minutes of the session, while up to 50 to 60 minutes is appropriate for older children and adolescents (Tinker and Wilson, 1999).

Studies and literature on the treatment of children with EDMR is still lacking. More research also needs to be done to compare the effects of EDMR with CBT in the treatment of traumatised children. This being said, EDMR remains a treatment avenue worth exploring in the treatment of PTSD symptoms in children (Saxe, MacDonald & Ellis, 2005 cited in Friedman, Keane & Resick, 2007).

4.3. Psychodynamic Approaches

Psychodynamic approaches place the emphasis on the unconscious mind, where we store upsetting feelings, urges and thoughts that are too painful for us to look at directly. Even though these painful feelings, urges and thoughts are outside of our awareness, they still influence our behavior. For example, a child may refuse to ride in a car after a car accident as this action could bring up overwhelming emotions about the traumatic event (Tull, 2012).

Psychodynamic treatment addressing childhood PTSD aims to help a child to become aware of and to experience those overwhelming feelings which have been pushed out of conscious awareness. The treatment is based upon the therapist's understanding of the child's inner life in the context of the child's daily life and history (Foa, Keane, Friedman, & Cohen, 2009). Emphasis is placed on the therapeutic relationship, which is essential in understanding these unconscious trauma-related emotions. Therapists also engage parents/caregivers in the treatment process to re-establish routine and safety in the child's world. The core aspect of the psychodynamic approach is to promote personality coherence and healthy development, rather than to alleviate the traumatic symptoms alone.

4.3.1. Child-Parent Psychotherapy (CPP) is an example of a psychodynamic based intervention. It typically involves 50 weekly sessions with both parent and child. While the parent and child are guided to create a joint narrative about the traumatic event, the therapist focuses on strengthening the parent-child relationship

and on fostering healthy childhood development. Therapy involves focusing on both the parent and child's trauma experience and their maladaptive behaviours. Its goal is to place the traumatic experience in perspective and to alleviate trauma triggers that deregulated their behaviours. Through the emphasis on the relationship between parent and child, symptoms are reduced and the child's development is promoted.

This approach highlights the importance of relationship-based treatment and the effectiveness of involving both parent and child when treating PTSD in children. Focus is not only on symptoms but also on developmental tasks that are disrupted by the trauma experience. Empirical studies continue to support the use of psychodynamic treatment, especially in treating trauma in young children. Data are convincing for cross-cultural validity and also indicate a reduction of trauma related symptoms and healthier childhood development (Lieberman & Horn, 2005 cited in Foa, Keane, Friedman, Cohen 2009).

4.4. Systemic Interventions

With a systemic approach, problems are understood within a contextual framework. The therapist looks at problems and solutions by focusing on understanding and shifting the system in which they occur. If a teen, for example, was suffering from depression, the therapist would investigate all contributing factors which are affecting the symptom of depression. Factors will include the teen's relationship with his family, the marital satisfaction of the teen's parents, the structure of the family system, family dynamics such as communication patterns, the teen's relationship with friends, his access to activities and so forth (Margolies, 2012). Unlike individual therapy where the problem is viewed solely in relation to an individual and the intervention aims to rid the individual of the symptom, systems theory suggests that we look at problems collectively, not blaming an individual, but seeing the problem as a symptom of a dysfunctional system.

Systems theory acknowledges that often, the environment that places a child at risk to trauma is the same environment that hampers a child's recovery. Traumatised children often come from an environment caught up in violence, abuse, substance abuse, mental illness and neglect, and children remain in these systems for prolonged periods of time. The mental health interventions we apply when working with traumatized children need to not only address trauma symptoms within the child, but also the ongoing stressors within their environment which severely impede a traumatised child's development (Cohen, Mannarino, & Rogal, 2001 cited in Foa, Keane, Friedman, Cohen 2009).

4.4.1 Trauma Systems Therapy (TST) is a systemic intervention that recognizes both the individual symptoms and the supportive environment. Briefly, it acknowledges that a child's traumatic stress often points towards two factors:

- the child is unable to control his emotional or behavioral state,
- The child is not receiving sufficient support from his surrounding environment to help him regulate these feelings.

The goal of TST is to address some of the 'real world' problems of children who are facing considerable adversity and to help children and families where there is ongoing stress in the social environment. It is designed to address typical barriers to treatment engagement and/or implementation. For instance, this treatment provides a specific module on treatment engagement that addresses practical barriers and cultural barriers. In addition, it specifically addresses social environmental issues that are contributing to traumatic stress symptoms, such as poor living conditions, poverty and immigration status.

TST has been developed for children aged between 6 to 19 years, it is not restrictive to a specific form of trauma and has been adapted for use with several populations, including refugee and immigrant groups, substance abusing adolescents, medical trauma and pediatric settings, school based treatments, and residential settings (http://www.nctsnet.org/sites/default/files/assets/pdfs/tst_general.pdf).The TST model involves a multi-disciplinary team organising a series of interventions which correspond to the fit between the traumatized child's own emotional regulation capacities and the ability of the child's social environment to help him or her manage emotions or to protect him or her from threat of further traumatisation. It uses a phase-orientated approach by beginning to provide children in desperate cases of traumatic stress with coping skills and by removing ongoing threats in their social environment. These environments include family, school and neighbourhood.

The programme has up to five phases: Surviving, Stabilising, Enduring, Understanding, Transcending. The phase is chosen depending on the degree to which the child can regulate emotional behavioral responses and whether the social environment is stable, distressed, or threatening. Within each phase there are prescribed treatment modules, many of which have their own demonstrated efficacy.

These treatment modules include:

- Home and Community Based Services
- Services Advocacy
- Emotional Regulation Skills Training
- Cognitive Processing
- Psychopharmacology

An open trial study of 110 families produced a reduction of traumatic stress symptoms and decreases in family and school related problems over 3 months, suggesting that TST may be an effective intervention in engaging families in treatment (Casey, Saxe, Ellis, Rubin, & Allee, 2005).

4.5. School Based Interventions

South-Africa is a country where the exposure to traumatic stress is almost a given. Professional intervention is often needed to ensure that at risk youth do not develop full blown PTSD. Unfortunately the majority of our country's children come from socioeconomically disadvantaged circumstances and are often medically uninsured and have great difficulty in receiving speciality mental health services. This places them at a high risk not to receive any medical intervention after trauma exposure.

Schools can offer children the opportunity to receive professional intervention to address unmet mental health needs following trauma. School based interventions hold many benefits:

- Firstly, schools are often the first point of entry after a community-wide disaster or after a critical incident that happened at school. This means that a professional team can offer crisis interventions, which provide emotional support and psycho-education about the traumatic incident, followed by psychological first aid which helps to restore calmness and bring reassurance to learners once the situation is stabilized (Dorn & Dorn, 2005; Duda, Shepherd, Dorn, Wong, & Thomas, 2004a, 2004b, cited in Foa, Keane, Friedman, Cohen 2009).
- Secondly, due to schools' familiarity and easy access to children it also provides children with a safe and secure environment where they can begin to review their own trauma.
- A third benefit is that therapy occurs where children do their day-to-day work and it is within this 'natural' environment where children can easily integrate work done in treatment, like they integrate other school based learning activities.
- A fourth benefit is group work. At schools it is easier to facilitate group work due to the number of children of the same age or gender that are present.

A recently published review on school-based intervention programmes has identified cognitive behavioural therapy as the most common treatment approach to reduce serious trauma reactions, such as PTSD, anxiety and behavioural problems in treating children and adolescents. They also found empirical verification for Cognitive Behavioural interventions for Trauma in Schools (CBTIS) and Trauma Focused Cognitive Behavioural Therapy (TF CBT) as effective interventions for reducing PTSD symptoms of learners (Rolfsnes and Idsoe, 2011).

4.5.1 Cognitive Behavioural Therapy for Trauma in Schools (CBTIS). The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) programme is a school-based, group and individual intervention. It is designed to reduce symptoms of PTSD, depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills. Children learn skills in relaxation, challenging upsetting thoughts, and social problem solving, and work on processing traumatic memories and grief. These skills are accomplished by the use

of drawings and through talking in both individual and group settings. CBITS also includes parent and teacher education sessions.

CBITS has been used with students from 5th grade through 12th grade who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters. It has now been effectively implemented with a wide range of racially and ethnically diverse children.

The programmed consists of 10 group sessions, with six to eight children per group. A session is approximately an hour in length and is usually conducted once a week in the school setting. CBITS uses cognitive-behavioral techniques such as education about trauma reactions, relaxation, social problem solving, cognitive restructuring, and exposure.

In a randomised controlled study at 2 middle schools in East Los Angeles, a socioeconomically disadvantaged area, children in the CBITS intervention group had significantly greater improvement in PTSD and depressive symptoms compared to those on the waiting list at a three-month follow-up. Parents of children in the CBITS intervention group also reported significantly improved child functioning compared with children in the waiting list group. The improvements in symptoms and functioning in the CBITS group continued to be seen at a subsequent follow-up six months later (Stein, Jaycox, Kataoka, Wong, Tu, Eliot & Fink, 2003).

4.6. Creative Expressive Art Therapies for Children

Creative expressive arts therapies (CEAT) are an intervention method that traditionally has drawn from psychoanalytic theory for its framework and procedures but are currently based in diverse theoretical orientations. It includes modalities such as art, dance/movement, drama, music, and poetry (Eaton, Dorothy & Widrick, 2007).CEAT is an experience that takes place within the context of a therapeutic relationship between a qualified therapist and client and provides clients with ways to express themselves that may not be possible through more traditional therapies (McNiff, 2004).

> The neurobiological premise is that trauma is stored in the right hemisphere of the brain, which is associated with visual-motor functioning and emotions (Schiffer, Teicher, & Papanicolaou, 1995; Schore cited in Hontz, 2006; Siegel, 1999; Van der Kolk, 1996 cited in Foa, Keane, Friedman, Cohen 2009). During the traumatic experience, the left hemisphere, associated with language and cognitive problem solving is turned off. Therefore no verbal information about the

traumatic incident is stored (Perry, Pollard, Blakely, Baeker, & Vigilante, 1995 cited in Foa, Keane, Friedman, Cohen 2009). To be effective, therapy has to access the right hemisphere to gain access to the nonverbal chaotic fragments of the traumatic experience (Score, cited in Hontz, 2006 cited in Foa, Keane, Friedman, Cohen 2009). The modalities of CEAT help by giving expression to the trauma that the child cannot express verbally.

Currently CEAT are used by two streams of professional work:

- It is used by professionals that construct their treatment around the CEAT and implement any of the CEAT modalities such as music, dance or art for example.
- Or it is used by professionals that implement CEAT modalities to support interventions with a non-CEAT theoretical foundation, for example therapists that use dance or music with CBT.

During the first stream of professional work, the creative activity, for example dancing, is the therapy in itself. The creative output is rarely, if ever, interpreted. Empirically verified studies have yet to prove whether this approach is enough to bring about neurological change in the processing of the traumatic event. In the second stream, the CEAT only forms part of the treatment. In CBT a therapist can use CEAT to help a child to construct a life narrative or to give expression to emotions (Goodman, 2004; TF-CBT Web, 2006 cited in Foa, Keane, Friedman, Cohen 2009).

4.6.1. Music Therapy is an innovative and creative form of CEAT that involves exploration of various instruments, including guitars, drums, pianos, and others. Music therapy is non-directive and the child does not need to have any musical interest. Instead, he is encouraged to experiment and express himself through the music in any way that he feels inclined.

Music therapists are trained to be able to identify and recognise various emotional issues based on how the client creates the music. As client and therapist build their therapeutic alliance, both participate in the music making as a method to strengthen their bond and access deeper tools of communication. For children more prone to anxiety or fear, the music can provide a soothing and necessary backdrop, or element of release, during difficult therapeutic sessions. Empirical studies are still needed to validate this form of intervention (http://www.goodtherapy.org/Psychodynamic.html).

5. Conclusion

Disturbing statics have set the scene of the fractured family in South-Africa. These statistics are hopefully the first step we take towards healing the South-African family. Discussions of the findings of the Adverse Childhood Experience study raised awareness of the research done on childhood toxic stress and how it influences health across the lifespan. Both the statistics on fractured families and research findings on childhood stress emphasise the need for professional intervention. This course highlighted the most common interventions available to treat childhood trauma but it also emphasized areas of interventions where empirical data are still lacking.

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