

Web-Based Radio Show


How to Help Infants, Children, and Adults Deal with Trauma

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Good morning everyone and welcome. Thank you for joining us today on our web-based radio show. Today's topic is one that we've touched on before, but requires a more in-depth discussion, and that's the subject of how to help infants, young children and older children, as well as adults, deal with trauma. Trauma takes many forms and in the broadest sense we can define it as a very frightening, upsetting, and emotionally overwhelming experience. It may involve loss of a loved one – a child losing a parent or a 70-year old gentleman losing his beloved wife or vice versa. It can involve a hurricane and the medical and catastrophic events that follow it. It can involve a mass shooting, similar to the one that recently happened at Virginia Tech. It can involve war injuries and dealing with one's own loss or infirmities. It can involve the aging process where one loses capacities and skills. In other words, trauma takes many forms. The common denominator, however, is overwhelming emotional feelings and the various reactions to these feelings. There are some common features that we can do to help others, whether they're babies or young children or elderly adults, cope with these overwhelming experiences.


First and foremost we have to recognize that the signs of trauma, like the traumas themselves, can take many forms. We each have different ways – starting from early infancy and on upward – of demonstrating that we're feeling overwhelmed or maybe hopeless and helpless, or maybe very frightened, or maybe very angry. We all have different emotional reactions, sometimes including a combination of all the above. In response to trauma, some withdraw. It's not unusual for a 14-month old toddler who's lost caregivers to become more withdrawn and self-absorbed. All parents have the experience, if they've been away for a couple of days, of getting the "cold shoulder" from their toddlers or preschoolers for a few hours or a day or so until they warm up again. Spouses are not immune from this, either, when they've been away on a trip and they come home to have their spouse gives them a relative cold shoulder, who may talk to the spouse, but the warmth isn't there and doesn't get rekindled for a few hours or a couple of days. The response to trauma can involve anxiety and frightening dreams. It can involve multiple fears. It can involve depression and sadness. It can involve anger and



agitation. We see this in older children, often, in response to a frightening experience or set of experiences – they become aggressive and they want to hurt others. It can involve impulsive behavior, like setting fires or the like. It can involve doing the same thing to others that was done to them that frightened them. So victims of sexual abuse, often, become abusers, themselves, repeating the traumatic event to others who are helpless. It can take many, many forms and each person, based on his own unique history and his physical dispositions, will have different reactions. Even toddlers, for example, will differ in their reactions. One toddler who's more sensory craving and active may become more agitated, more aggressive, and more active with loss or frightening experiences. Another toddler, who's more laid-back and less physically active and tends to sleep a lot and be very easygoing, may pull away and withdraw and become more self-absorbed. One preschooler may pull away into his own fantasy life, whereas another preschooler may intrude into the lives of others and become more demanding or more negative.

So, again, we have many different reactions in younger people, just like we do with adults – anxiety, depression, impulsivity, alcoholism, gambling problems, delinquent behavior and the like, can all be responses to traumatic events. In fact, in recent studies it's been shown that individuals exposed to a number of traumatic events early in their childhood – four or more – were thousands-fold (one- to four-thousand-fold) more likely to have physical illnesses as adults, including obesity, alcoholism, and pulmonary problems. The mediating events, often, were poor health behavioral patterns, so overeating, drinking, and smoking were often mediators to many of these physical problems. But there was not just a hundred or two hundred percent increase in problems, but there was a one- to four-thousand greater likelihood of severe medical problems in individuals exposed to multiple traumas, like the divorce of parents or having an alcoholic parent during their childhood years. So we know that traumatic events have profound effects on anyone at any time.


The big question is what can be done to help individuals? First, it's important to see the particular form the person's response to trauma is taking with the individual, whether it results in more anxiety or depression or more in behavior control problems and the like. Two, we have to determine to what degree it seems to be disrupting healthy development or healthy functioning. In other words, some individuals may experience nightmares and anxiety, but they continue to work and, if they're adults, they continue to be loving parents, but they're anxious and frightened and have nightmares when they sleep or maybe they're prone to getting panicked periodically. With others, however, the event and the overwhelming feelings may be more pervasive, so we may see depression, which interrupts work and family interactions because the individual sleeps all day or



becomes overwhelmed by feelings of lack of self-worth and wonders whether he should be alive and this individual requires more comprehensive care. So, to what degree does it disrupt our ability to think and use judgment and plan? To what degree does it disrupt relationships at work and at home and with family members? To what degree does it disrupt our basic ability to interact or regulate our moods? To what degree does it disrupt our basic ability to just focus and attend and think? These are all questions we need to ask to get a picture of just how pervasive the effects of the trauma are.


Then we must plan our intervention accordingly. Some individuals may require hospitalization or more comprehensive care; others, less comprehensive care. But here are some common principles that help the individual who's been exposed to trauma begin the pathway to overcoming the trauma and regaining healthy functioning. If we follow these principles, regardless of the extent and degree of the trauma, we can help all individuals – from infants on up through elderly individuals – cope more effectively with trauma. We'll also point out some of the common mistakes we make when trying to help individuals overcome trauma. Again, before sharing these principles with you I want to emphasize an important overarching concept, which is the quicker we institute a program in relationship to the traumatic event, the more effective this type of a program is likely to be, but it's never too late. It's always possible to regroup and to help an individual towards the path of recovery, but the quicker and the earlier, the better. When we talk about services in universities when we see a frightening and almost incomprehensible event, like a mass shooting that happened at Virginia Tech recently, or earlier in some high schools, we really need to have training and people available on the spot to help, but often we talk about it and then don't institute a national or local policy to be ready for such events, whether it's 9-11 or a mass shooting or a hurricane. Often we're playing catch-up after giving good lip service to the need for improved capacities to respond quickly. Obviously, there are two levels to the response. One, like with a hurricane, is to reestablish vital services but also we have to deal with the emotional and social consequences of the trauma.

Having that in mind – that the earlier, the better, in terms of being ready, here are the principles we want to pay attention to. Number one, the first and most important principle is to reestablish a sense of security and safety for the individual. So whether it's a wartime situation or a response from an illness or loss, individuals feel unsafe and insecure and they feel very, very frightened. This is fundamental, regardless of whether it shows up with anxiety, depression, or behavior problems or the like. It's vital, therefore, to reestablish a sense of safety and security. When it's a large, traumatic event, like a hurricane or a war situation, as quickly as possible we want to establish vital services –




food, shelter, housing, medical care – and provide a sense of security and safety that there are those who can help. So rushing in with supplies and with food and with housing, as we have done all over the world in recent years, to catastrophic events, is very, very important. The world community tends to do that reasonably well and local communities tend to do it reasonably well, although on occasion we see we get “caught with our pants down” – we’re not properly ready and we don’t coordinate services well and we don’t reestablish that sense of safety and security quickly; when we’re not ready this continues the traumatic experience for many individuals for much longer than it really need be. So we have to improve our ability to establish safety and security. For a young child, for example, a toddler who’s just lost a parent or who has a parent who’s become ill, that means establishing other adults who can provide safety and security in a regular way so that that person feels safe. For a victim of sexual abuse it means, again, to have that sense of safety and security established. I’ve been enlightened, for example, about some practices for individuals who have been sexually abused – children – they may be interviewed by law enforcement officials too quickly to “get information” and in a way that the officials feel is supportive but doesn’t reestablish a sense of safety and security and in retelling the event with a stranger and without allowing the parent or the guardian or the trusted adult to be in the room with the child during the time of the interview with the verbal child, and this only frightens the child more. They were exposed, let’s say, to a sexual assault by a stranger and now there’s another stranger asking them about it. That’s hardly establishing a sense of safety and security. It may be important to get information so that the culprit doesn’t abuse or hurt others, but there’s no reason not to do it in the presence of a safe, secure adult who can be there with the child and then they get the information for the law enforcement officials that will help identify the person. So, in addition to having a skillful mental health professional there as part of the group that helps the youngster identify what happened and who did it, there really needs to be a very trusted adult present. That’s just a little thing, but the overall goal is safety and security first.

The second principle is reestablishing engagement or relationship with the most trusted individual that will be part of the child’s life or the adult’s life or the elderly person’s life for a long time. In other words, we have to reestablish not only safety and security in the physical sense – protection from the elements or protection from an abuser or protection from the bombs or the guns – but we have to reestablish a nurturing relationship with somebody, if possible. In some situations – in a war torn country where there’s been a genocide – there may not be anyone available short term, but in certain camps, such as Red Cross run camps or in others there may be adults who can play that role for children or for other adults, at least temporarily. We should be doing the best we



can for a child whose parents are ill – the grandparents or other relatives need to come in or a neighbor or other helpers who will be part of that child’s life for a long time and establish a trusting, nurturing relationship. The mistake we make here is we often feel it’s important, particularly for children, to re-tell the event, to “unburden” themselves of the trauma, to play it out, to talk it out and sometimes we have them do that too quickly. If we do that too quickly, the reliving of the event only re-frightens the person. We shouldn’t shut off the person talking about it or playing it out – they may want to and need to do that – so we should certainly create the availability and opportunity with the young child with symbolic toys, dolls, and the like, so they can play it out with an adult and give them opportunities to talk it out, but let them do it at their own pace. Don’t probe, don’t intrude – they’ve already been overwhelmed and we don’t want to overwhelm them again. The first goal is to reestablish safety and security and that nurturing relationship, which also provides a protective sense of warmth and security in an ongoing way. This begins helping the individual regain trust in the world – that the world can be a worthwhile place and be a safe place and can be a loving place, not a frightening place, and that’s vital for overcoming the traumatic event and for overcoming the overwhelming feelings one has. Often if one has been injured and goes into a hospital, again, there’s a loss of the closeness. We want to have flexibility where an elderly person can have a person sleep in the room in the hospital with the spouse and have a cot or a bed there. This is just like we have for babies or for three-year-olds; they’ll have a place for Mom to sleep in the room with little Susie or little Johnny. This is vital for helping the elderly person or the child or someone at any age begin to establish that sense of nurturing and security that’s needed. This is not a time we want to ignore that critical emotional factor.


The third element in the program is to communicate with the traumatized individuals around anything they want to communicate, with the simplest gestures – exchanging smiles, or frowns or using hand gestures. Individuals who are too traumatized to talk may be able to engage in nonverbal communication just around negotiating basic needs for food, for going to the bathroom, or for the other basics of life. Just reestablishing that one can communicate, one can control one’s environment through nonverbal and verbal forms of communication enhances that sense of safety and security and helps one regain a sense of trust in the world. With individuals who are able to be verbal, we should make available opportunities for nonverbal and verbal communication by having an adult he or she can talk to. For an elderly person who’s lost speech, there should be opportunities for nonverbal communication. With a child who’s not speaking, he or she needs opportunities for playing. With a child who is speaking, we need to make sure there are opportunities for talking, but taking care not to probe the event and not ask



what happened; rather, just letting unfold whatever is on the individual's mind. It may be, "Where is my next food coming from?" or it may be reassurance that the bombs won't drop again or that the person with the guns won't hurt anyone. See where the individual is coming from and maybe just let him talk about the frightening and scary feelings and be a good listener and a good empathizer. Listening and empathizing, helping individuals talk more about what they want to talk about or communicate more about what they wants to communicate about reestablishes their sense of control over their world. That's what's important now – not having them feel more helpless or intruded on or controlled.

The fourth principle, once these first three are established for some time and a sense of security has been reestablished, which can take anywhere from days to weeks to months – sometimes years – is the importance of helping individuals, if they can verbalize what happened, to tell the story of the traumatic experience in their own words, in their own way, and delve into the feelings and delve into particularly the scary, frightening feelings and their own reactions to it, particularly reactions they may have that they're ashamed of, such as being angry or feeling overwhelmingly helpless, or feeling bad for not helping someone else as much as they wanted to, or feeling guilty that they survived and someone else didn't survive. But don't jump into those feelings; don't have preconceived notions about what they ought to be. Each individual will have his own reactions. Some individuals may be feeling ashamed of surviving instead of so-and-so whom they didn't like. So there can be many different reactions, including feeling ashamed and also feeling proud. There may be things that the individual is proud of because they've helped other individuals and they have a sense of pride over that, but there may be profound loss and sadness and mourning for loved ones who were lost. So it's very important to let the individuals tell the story in their own way and then help them broaden that telling to cover all the different angles, and this should occur over many months in a therapeutic relationship. Most all individuals who have been exposed to trauma should have a relationship with a mental health professional who is very skillful at helping individuals describe and cope with and elaborate feelings.

As a next step, it's very helpful for individuals coping with trauma and loss to be able to do something that helps others – to take an active step and turn their passive and helpless experience into something that's constructive. So whether they raise funds for future victims of a hurricane or put together a pamphlet or send cards to other children who have been exposed to trauma or natural disasters – whatever form it takes – doing something that's helpful, where they feel they can turn that passive and overwhelmingly helpless state into something active and constructive – can be very, very important and that's where children, teachers, and parents can make suggestions of possibilities, but we




want to let it come from the individual. Organizations can work with the adults on that, too. For elderly individuals experiencing loss they can do similar kinds of things and be very helpful to others if their physical and mental state allows them to do that. It's a very, very important component, but this can only come in once the healing process is well on its way.

The key in these steps is trusting relationships, initially, with family members of close friends and then with a mental health professional or team of professionals to help mediate these different steps. Also, organizations can create programs that incorporate these principles. So, individuals, friends, family members, and organizations and local and national government policies should support these kinds of steps. Obviously, for many disasters and many traumatic events the key is prevention – preventing it from happening, particularly with things like the mass shootings at Virginia Tech or other such events, including nine-eleven type attacks, and this is all part of our handling of trauma.

There's also a phenomenon that we want to talk about, which is secondary trauma. This happens to those individuals who are not directly affected, but who are affected by seeing what's happened and worrying whether, "Could this happen to me?" or maybe even feeling guilty that it happened to someone else and not them and they need the reassurance of knowing that there are preventive strategies in place and that they can count on their government or other organizations to take active steps. This is very vital to their sense of security for those suffering the secondary effects of trauma. For the secondary effects of trauma these same principles are very important, but they're easier to implement and progress will be much quicker, especially for children, and they'll be able to get to that last step of helping others much more quickly because they weren't directly affected by the trauma; nonetheless, it can be scary for them and there will be worries and anxieties and fears.

Now I'd like to just share two brief vignettes of individuals, one a child and one an adult, who have recently been exposed to a traumatic experience. Little Johnny was a three-year-old little boy who lost his mom in an auto accident when he was just beginning to talk in full sentences. When asked a question like, "Why do you want to go outside?" he was able to say, "Because I want to play." So he was becoming aware that something was happening, but for the first day or two he didn't know what had happened to Mommy, and although Daddy didn't tell him, his grandparents moved into the house with them. He wanted his Mommy, however, and started crying and started having terrible, scary dreams and so gradually they told him that Mommy had been in a car accident and then Mommy went to heaven. He alternatively cried and looked despondent and very sad and started talking about, "I want to go to heaven with her. I want to be with


Mommy. What do I have to do to go to heaven?” He saw something on television about how people who die go to heaven and then he talked about jumping off the house so he could die and go to heaven with Mommy. A mental health consultation was sought because Dad and the grandparents became very alarmed and concerned. They tried to reassure him that they loved him and would be there for him and that they would all think about Mommy together and that she was there in spirit, but none of this seemed to work to calm little Johnny down. Fortunately, I was able to see Johnny and he was maintaining his ability to be related and interactive and verbal and he could engage in symbolic play and still think logically, but he was very despondent and very concerned about “being with Mommy.” His reaction was one mostly of sadness and longing, not one of aggression or agitation, and he also had a lot of fears about something similar happening to Daddy or his grandparents. We instituted a program that incorporated these four steps. I asked Daddy to take off work for three weeks – this was time for his summer vacation break and little Johnny needed the security of Daddy being there. He knew his grandparents, but not as well, because they hadn’t lived in the same city, and I suggested he find out if they could make a longer term commitment to stay with Johnny and they could – fortunately, they had that flexibility to be able to relocate. So they moved in and Daddy was there and then just that extra sense of security and extra sense of safety and extra sense of nurturing and consistency with Daddy and the grandparents began softening Johnny’s desire to join Mommy in heaven. He began saying that Mommy was there with them, sharing with them in their views that her spirit or her feelings were still in the house. She wasn’t there for them to see, but they could kind of feel her warmth and feel her presence. He looked at pictures of her; he looked at old videos of her with Daddy and with his grandparents, and even though that could’ve awakened more loss, that was something he wanted to do and something his daddy and grandparents wanted to do. They kept communication going and they did a lot of Floortime-type play to establish the communication patterns. He played out being the boss with animals dying and also with one animal being angry. It was clear he was coping with a lot of anger over Mommy not being there, so he played that out indirectly with lions and tigers who were angry and eating up other animals. There was vacillation between themes of loss and themes of anger and themes of fear in the play, and I coached Dad just to empathize and be a counter player to whatever theme Johnny chose – not to try to relate it to Mommy; not to try to play “junior shrink” and make interpretations, but just to play it out. I also asked Dad to bring him to a colleague of mine who could see him in ongoing regular therapy sessions twice a week, where they basically did the same thing – play it out – but I wanted a skilled therapist working with him. After about six weeks we established that Johnny could go back to his preschool program and get back into a routine and so missing Mommy and longing for Mommy and looking at her pictures became a part of



his daily and then weekly routine, and he returned to a state of sad and missing feelings, but not overwhelmingly despondent feelings. He continues now to function well, but we instituted these four steps and we also instituted a fifth step of what he thought – this was about a year later when he was four years old – would help children who had lost a mommy or daddy or a grandparent. He thought having a special scrapbook with pictures and things he and Mommy used to do together that he could look at would be helpful, so he and his daddy, who was actually quite a good artist, designed a little scrapbook that they could put on a website that any family could download to use to remember someone who was lost and who was loved.


Now another example – very different – is that of a 42-year-old man who was overwhelmed when he became ill with a malignancy and came very close to passing away. He had a very good response to both an operation and chemotherapy, which saved him from a very poor prognosis for a rapidly growing tumor. Initially, he was very despondent and depressed and was suicidal; he was going to take his own life before the tumor did. He didn't want to leave it in the control of others; he had been a dynamic, successful executive and was not used to being passive and helpless and letting events control him. Once he saw that he had a chance at survival, however, his depression lifted a little bit and he went into his coping mode, but he became very agitated and almost unrealistically grand in how he was going to get cured and how, after he was cured, he was going to dedicate his life to curing the whole world of malignancies and raising funds for research and services. But he did this in a very unrealistic way – he became kind of agitated and grand in his fantasies. Post-surgery and post-chemotherapy he continued to be agitated and grand and also got very aggressive with his wife and children. They were concerned that some of this was a result of the chemotherapy or that there might have been some central nervous system damage from the chemotherapy. The tumor had not gotten out of his body into the central nervous system, as far as could be told by different types of radiographic studies, but nonetheless there was a concern about this. He was sent to a psychiatrist for treatment, who just wanted to put him on medication and monitor him once a month.

I had a chance to see him because he and his wife were concerned about the children – the effect on the children – and I saw that he was receiving very little of these principles that we have just described. His wife had become depressed and overwhelmed and was not only not very nurturing and engaging with him, but she, herself, required considerable help, and the children were very agitated and frightened. They were all acting out at school and not doing their homework and getting into “hot water” (there were three children). The first step was, therefore, to settle the family down and find a



therapist who could work with the whole family – Mom, kids, and Daddy – to establish routines and reestablish a sense of safety and security. Then we established patterns where Mom and Dad could hear each other and listen to each other and calm each other down, and Dad also needed intensive talking therapy where he kind of felt out the grand plans and the scary feelings and the overwhelming and helpless feelings that were underneath those plans. So we got Dad involved in therapy three times a week with a very nurturing therapist who was not intrusive and who listened empathetically and who was very supportive. This was also the person who saw the children and Mom, so we did some couples work and family work and we got the family more nurturing and interactive with each other and more safe and secure and Daddy, with a very nurturing relationship, until Mom, herself, calmed down and could be a little less overwhelmed and be more available. She had been a very nurturing, caring wife and she had looked after her husband quite well. With this pattern of care, especially reestablishing a sense of nurturing engagement and safety and security in the family, Dad was able to calm down enough to really get into his feelings, particularly in his individual sessions, in therapy, and talk about his fears and anxieties and worries. Then the grandiosity and the agitation and the aggressive behaviors subsided and he got back to where he was, after which he was able to institute that fifth step – not in a grand way – and in his company he started a fundraising foundation on behalf of research for the type of tumor that he had had and he felt he was giving something back to the community and was very grateful. He also became a little more religious. He had been moderately religious in his own religion and became a little more religious and thankful for having survived and vowed to lead a more balanced life in terms of giving to the community, and he became a little more active in community organizations, generally, and actually was a more nurturing and empathetic father and focused more on family life. His personal therapy continued for about three or four years after the event to kind of work things through and do some work that he would have needed to do anyhow, even without the trauma of this acute medical illness, but for him this was acute in the sense of his having been healthy until this malignancy was discovered. The key for him, though, was not just being on medication (eventually, the medication was discontinued, and it had been used just to curb the agitation, initially), but it was to institute these four principles that allowed him to work on the feelings level in a specific way, which couldn't be done until we had safety and security and engagement and basic lines of communication reestablished.

In summary, then, there are traumas of many forms that can occur and individuals have many different reactions to trauma. There are many pathways to the trauma – one's physical make-up, whether one is more under reactive in a sensory way and low key may lead to more self-absorbed behavior; if one is more sensory craving and active, it may



lead to more agitation and may impact whether one is prone more to depression or grandiosity. There are many, many different reactions to fighting overwhelming feelings, but there are certain common features and all individuals benefit from establishing safety and security, from engagement, from basic communication, and eventually from working on the scary experiences and one's reaction to them, and ultimately from being able to do something active to help others.

Thank you for joining us and we will be with you next time.