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THE CHILDHOOD FACTOR IN TRAUMA SURVIVAL

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A child that has been traumatised is in nine cases out of ten socially maladaptive in later years. Either there is an excessive dependence on defence mechanisms or the adoption of exaggerated postures of defence that create anarchic conditions. Even constructive outcomes of trauma like over-achieving and over-vigilant behaviour are frowned upon in society since they are known to originate from a troubled psyche. Thus many survivors may feel ostracised or outdistanced by the world which relies on set parameters of evaluating merit and consistency. Two other qualities that are likewise not accepted in traumatised individuals are rationalization and intellectualisation as they are seen as defence mechanisms. Few people including clinicians realize that the tendency to judge and prescribe is the undoing of many sensitive individuals who were unfortunate to go through a traumatic experience. For this reason their contributions are often overlooked or read dubiously. Only a productive change in clinical outlook can bring about the needed change in society and its institutions.

Perhaps the worst fallout of trauma is agoraphobia, which many clinicians agree on. Many individuals are not able to cope with the repetition of stressors, however free they might have been for some time. This makes the one afflicted with trauma avoid society at large, and the very things that make people accepted. They prevaricate and avoid daily commitments as they find them too demanding on their meagre coping capacities. But very often these people suffer from low self-esteem and not knowing their strengths. With the proper guidance and human insight many such people, “damned” as they would say from childhood, can lead quite normal lives, identifying their right company and capabilities. It is the onus of the clinical psychologist to redesign the fate of many such jettisoned lives.

The trauma of a ten-year-old child trapped in a crisis-ridden spot waiting for hours for help is, no doubt, psychologically devastating. This period in the chronological and mental age of the child can have far-reaching effects on personality and self-esteem due to the impressionable age of the child. On Piaget’s scale of four stages the child will have arrived at the age of reason which is termed the Concrete Operational stage. He has just other five or six years to reach the last crucial stage of development, the Formal Operations Stage. Applying reason seems possible but there are certain indications of prolonged trauma which become evident later in life as post-traumatic stress disorder (PTSD). This is due to the epigenic personality of children as suggested by Erikson, reported by McLeod (McLeod, 2008). McLeod states the Eriksonian concept of psychosocial stages that differ from Freud’s psychosexual stages by the emphasis on the conflicts within the ego itself. Erikson, in his *Childhood and Society* (1950) puts forward eight stages of human development, all of which impact self-esteem and self-reliance in later life. Of these, the most crucial are the first,sixth and eighth stages, namely, those relating to trust of the world or mistrust, intimacy or isolation in relationships in general and ego integrity battling with despair, respectively. The first five are dominant up to eighteen years and the last three in adult life. A child whose trauma is reinforced by delayed help and accentuated helplessness is sure to lose faith in life in general, reading his plight against life in general than society in particular.

A more innovative insight on the basis of the life-story or narrative interpretation of life experience is provided by D. P. McAdams, pioneer of the life-story insight school of psychology. According to McAdams it is the constant activity of humans leading them to define their lives on the basis of “personal myths” or self-constructed stories that shapes what they are, as stated in “The Psychology of Life Stories,”*Review of General Psychology* (McAdams, 2001). By this token, a child harassed by angst of torment is likely to implant within his psychological mechanism harrowing ideas of life and society. Immediately after rescue he should be taken into PTSD treatment to relieve him of his symptoms at the earliest and bring him back to normal life. Since he is at an impressionable age he will respond readily to imagery-based treatment that is seen to succeed in the case of most PTSD victims as he is more flexible in his mindset without stern bedrock assumptions that hinder most adults, as suggested by B. Naparstek in the book *Post-Traumatic Stress Disorder: Reduce and Overcome the Symptoms of PTSD* (Naparstek, 2006). Careful and sustained treatment will be needed in such cases that have worsened due to prolonged trauma.

The tendency to be agoraphobic, as Naparstek observes, is a bid to detach from the traumatic memory during which the victim may adopt a totally unrelated manner of working or seek new surroundings, and continue the myth maybe for years. But this is not proof against a relapse. Stressors or their reminders may return to bring the victim back to square one. This warrants sustained and efficient therapy that analyses etiology expertly and proceeds with a workable psychodynamic model.

Childhood trauma is very often related to sexual assault though there are other kinds of trauma too that have chronic effects. Parental abuse, harassment of orphans and the unsupported, peer abuse in schools for racial or other reasons, or disasters and calamities in the neighbourhood of presence are quite devastating to psychological security of the child.Abused orphans are often more adaptive than children abused by parents as they acquire a survival intelligence. Parental abuse, on the other hand, brings with it a distrust of domestic security that in later life impairs marital harmony. It would further invoke cynicism regarding social relations and institutions. In such cases it would be ideal if a sympathetic teacher or well-meaning friend of the family intervened and puts the child across for professional help. Likewise, natural disasters like quakes or man-made crises like shooting incidents that expose children to overpowering danger can leave the children totally dissociated. Naparstek encapsulates the trauma incident recollected thus:

> Memories of the traumatic event are immediate and intense, experienced as if they were happening all over again in the present. Unlike normal, narrative memories that shift, distract, and fade over time, traumatic memories remain fixed, timeless, and contemporary, delivering the same intense sensory material and emotional punch each time. These terrifying sights, sounds, smells, body sensations and tastes, re-experienced with extreme vividness, resist integration or absorption. They are unaltered by the passage of time and don't change with subsequent experiences. (82).

In the same passage the explanation is given that the amygdala causes a hormonal flooding that saves the victim from danger to life and limb, but on the flip side it also makes reviving of the incident in memory happen. In the case of a child who expects external protection more than adults, an impulse to dissociate quickly results due to the impact of trauma. Distortion of time and distractedness in receiving and storing information also occur. The clinician should be astute enough in handling both the effects of prolonged trauma and sudden trauma.

Moving from trauma to coping, researchers give two broad conceptual methods: (a) problem-focused/emotion-focused and (b) approach-focused/avoidance-focused. The second element of the dialectic in each of the two paradigms of coping relates to the more reactive personality among the clients, while the first demonstrates a more proactive approach. In the first paradigm the proactive client prefers to get at the roots of his problem in as objective a manner as possible while his reactive counterpart hinges to his emotions and hopes to be miraculously rescued. So too in the second paradigm the proactive respondent insists on approaches by which he may address the problem while the reactive counterpart tries to avoid or delay solutions which require inconvenient effort on his part. Avoidant coping has been proved by most researchers to be a serious impediment to trauma recovery. In the research of Ullman, Filipas, Townsend and Starzynki (2007) avoidant coping is shown as correlating highly with PTSD. It also brings in its wake negative social reactions.

Transitions Theory made a breakthrough in trauma survival research and stress management by proposing "[a] reconstruction of a valued self-identity as essential to transition" (van Loon and Kralik, 2005). The authors review the various definitions of transition and collate the hypothesis that "transition occurs over time and entails change and adaptation, for example, developmental, personal, relational, situational, societal or environmental change, but not all change engages transition" (72). To make the transitional change mean something it must be accompanied by a stronger sense of self-worth and composition of individual identity. It is the task of the clinical practitioner to be the agent of such a constructive change.

Based on the recommendations of van Loon and Kralik, a 10-point model for trauma therapy has been proposed. But this is seen to fit in more with the needs of adult survivors than children. It can be tweaked to suit the psyche and the perception of children by making some minor adjustments. The adult model and the child model (the present author's improvement on the original) can be placed side by side in a table with the original model to the left and the child-friendly model to the right. The recommendations can be viewed side by side (See table below):

Step	Adult Model	Child Model
1	Provide a safe place for the client	Bring the child to likeable surroundings
2	Assure client of empowerment and collaboration	Promise the child he will feel a lot better and tell him that he is special
3	Communicate to sustain hope, respect	Give reassurance as the child talks, showing belief in him noticeably enough
4	Facilitate disclosure without overwhelming	Allay the fears of the child and encourage him to shed inhibitions
5	Therapist must know the different models and tools of therapy	Therapist must be particularly good with children and show great sympathy, support

6	View symptoms as adaptations	Therapist should assure the child that his reactions are normal, but temporary and surmountable
7	Use his knowledge of theory and practice to impart psycho-education	Teach the child how games and books or even toys can distract him when he has painful thoughts
8	Teach adaptive coping methods like self-care, distress tolerance, arousal reduction	Help the child in selecting and introducing games that will curb unhappy thoughts
9	Teach monitoring of thoughts and responses	Must encourage the child to open up to him (therapist) whenever he feels uncomfortable with himself
10	Teach interpersonal and assertiveness skills	Make the child believe there is still goodness in the world though it is a bit tough at times

Once a child undergoing a crisis experience is given assurance of a happy recovery by the clinician the child's post-clinical stages too must be periodically reviewed and anything in the form of aberrations must be immediately addressed. An adult survivor will have somewhat adjusted to the needs of the real world but great care should be taken to see that the child is not intimidated by the prospect of living in an unfriendly world. It could also become counterproductive, leading to psychopathic behaviour if unchecked. Nor should bedrock assumptions be encouraged which could shatter self-making of identity and security.

Positive psychologist S. Lyubomirsky lists the results of her happiness-oriented therapy based on positive inducement of trauma-affected clients (Lyubomirsky, 2006). Clients who responded positively were recorded as having a greater endurance level, generally improved relationships, knowledge of proper and dependable company, and feeling more in tune with the world, and having a more mature philosophy of life (161). A child with a prehensile mind is likely to be less philosophical but more resilient to trauma if properly guided by a clinician. Neglected childhood symptoms are dangerous in childhood and adult life. A responsive clinician can do wonders to save many lost survivors of heart-breaking trauma.

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