

Don't Get Trapped By Trauma: Part 5

Treating Children and Adolescents Presenting with Trauma

When treating children and adolescents suffering from trauma, there are several factors that need to be taken into account. These relate to differences in chronological neurodevelopment (what is going on in the biology of the brain at the age that treatment is sought); each individual's capacity to reflect and work with their thoughts, feelings and emotions; plus the nature and severity of the traumatic experience itself. This opens up a wide range of opportunities and different approaches to the ways in which EMDR can be delivered.

There are additional considerations for children who are on the autistic spectrum and /or those who are in care, adopted or fostered. These will be addressed in a future article.

The biology of the brain in pre-adolescents

We've talked about the way that in adults the AIP can break down/go off-line so that distressing events get locked into the amygdala (the smoke detector) so that the prefrontal cortex (the fire investigator) can't break through to make sense of the event and store it as a memory in the brain.

In children it's not that their AIP breaks down in distressing events. More to the point is the fact that they don't yet have a functioning AIP to work with i.e. the other half, the prefrontal cortex, has not yet developed sufficiently to support a fully functioning AIP system. This means that they respond to experiences in their world from the amygdala part of their brain: the emotional 'smoke detector' that operates on 'flight, fight and freeze'. In extremely distressing events this smoke detector will be aroused, producing an over-active stress response.

So what can we expect to observe in these children who are suffering trauma from a single event or complex trauma (chronic stress built up from repeated traumatic experiences)?

How children can express themselves

Finding language to express one's distress is difficult, even for an adult. For a child it can be almost impossible. So how can we expect a child to tell their story if they don't yet have the brain development to articulate their upset? We can therefore anticipate a lot of 'acting out' behaviours from them; and while some of these may appear to be extremely vocal and negative, they are actually pre-verbal in nature: an expression of and a means by which they discharge distress for which they can't find appropriate words.

When a child is struggling to communicate something for which they can't find words we might witness extremes of behaviour on the fight/flight/freeze spectrum. At the 'fight' end of the scale we might see temper tantrums, shouting, oppositional/defiant behaviour at home and/or school, refusing to go to school, or fighting. Toward the 'flight' end of the scale we might notice the child is quieter than usual, not interacting with friends, they might be anxious, particularly about being away/separated from safe caregivers and authority figures. They might avoid change or new situations and become somewhat withdrawn. In circumstances of extreme distress this can escalate to a 'freeze response', where the child completely withdraws and shuts down their senses in order to protect themselves from what they believe to be a hostile/stressful environment.

Appropriate interventions

When working with pre-adolescent children suffering trauma, we need to choose the appropriate way of delivering support and treatment that matches the developmental chronology of each individual. This means not only taking into account the stage of their brain development, but also their capacity to reflect, touch their feelings and emotions and verbalise them, plus the nature and extremity of trauma they have experienced or are continuing to experience.

Therefore, while the principles underpinning the treatment of children with EMDR are the same as for adults, the delivery, particularly for younger children, needs to be adapted appropriately.

As an example, the principle stands for both children and adults, to use ABLS (Alternate Bilateral Stimulation) to stimulate the information locked up in the amygdala, so it can be made sense of and stored as a memory. However, using tapping to deliver the ABLS is generally more effective particularly for younger children than using eye movements. Similarly, rather than putting a child under pressure to find words, drawing a picture of the worst part of the memory elicits a much more powerful and accurate representation of their traumatic experience with which to work.

Summary

In summary, EMDR is an effective treatment for helping children and adolescents recover from traumatic experiences. However it needs to be used flexibly and creatively to match the individual at their neurodevelopmental and emotional stages of maturity so they can access its benefits fully.

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