MODELS for POSTTRAUMATIC STRESS PROCESSES and IMPLICATIONS for TREATMENT and PREVENTION

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To develop plans for disaster management, relief and rehabilitation implies to meet the needs of children in their total functioning as human beings. And psychological, emotional and mental development after traumatic shock experiences are eminent processes for future wellbeing not only of individuals but also of communities.
For the discussions to be conducted today it seems useful to give a brief introduction into models of variables affecting post-traumatic developments.
I speak to you from both from a theoretical/academic background and also from a practical perspective with more than two decades of experience in various fields of trauma. The academic background I am talking about is coming from my task as head of the Clinical Psychology Department and holder of Chair for Psychotherapy at the Department of Psychology, Ludwig Maximilians University Munich/Germany,. The practical knowledge comes from dealing actively in the field both with civilian kinds of traumatizations - like traumatizations of comparatively small scale, like: accidents in all kinds of transport systems, collapses of houses, even a school or other public buildings, hijacking of school children, all mentored by INNOT and war traumatization in South East Europe. For example, we had a presence in Sarajevo for 10 years, working with Unicef and the Volkswagen Stiftung. From there I also can draw from field experience, which matches with problems you might encounter in your work more or less every day.

I want to give you a very brief introduction into some models of understanding traumatized people and will focus my examples for special situations traumatized children have to encounter.
One of the reasons to do this, comes from observations in the field, that relief and rehabilitation projects seem to be more interested in getting children and their social environment away from dealing with trauma issues in reality and in their fantasies/cognitions. So, much of what goes on in the field is to get people, especially children to smile again, to enjoy their life, to feel more competent so on. This of course is very, very important, no doubt.
But the question one would like to ask has to deal with whether this is sufficient. Do we have to add something to a “fun-and-play-oriented” approach in order to get a long term outcome which is optimal for the child – still within a focus on resource and competence orientation. Isn’t it essential for healthy development of a traumatized child to be able to deal with its trauma memories in a relaxed and competent way? Or is it enough getting the children to act happy or lively again?

I suggest not to look at this question as mutually exclusive alternatives, we need both: It is very important to distract children from bad feelings and memories by offering them nice experiences and it is as important to strenghthen their ability to deal with their scary memories and emotions that accompany them. But as one can imagine, timeliness is a thouroughly important factor in this task.
Now I want to talk about some trauma models and various psycho-bio-social factors that are involved in the trauma process.

1. *The arousal - avoidance model.*

Is avoidance protective or destructive? A traumatized child, having had a shock experience, is aroused, often chronically. And this arousal is convening with the situation it experienced. A child of course wants to avoid to encounter arousing situations again. It wants to avoid the same arousal again.

This is a basic process not specific to culture - rather common to all human beings. You can see similar behaviours also in animals - they avoid what is obnoxious to them and they avoid situations which they learned to be likely to become abnoxious to them.

At the beginning of a trauma coping process avoidance of arousal is a very helpful reaction. But it can become destructive if the avoidance goes on too long. Children then avoid not only the arousal that is connected with the disaster situation, but hey also start to avoid other situations which might lead to arousal. Because the *inner* process of arousal, just as a feeling reaction, does not discriminate where it comes from.

It feels similar or the same for the child - whether it comes from say, an aftershock or from having to speak in the public or something like that. It might be, that if one too long supports avoidance behaviour in the children, which gives them relief at first, in a later phase might cause a withdrawal type of personality.

2. The *social interaction model*

This model understands psychological processes as internal representations of interactions: when we think, feel, anticipate etc. we are reproducing interactions we have experienced and extrapolate this experience into the future – as anticipations. Our psyche somehow constitutes itself through symbolic internal interaction. We become what we are by interaction and representation of this interaction.

In normal development children have a fair mixture of some good experiences and some that might be more painful, but usually no traumatic experience. And through this interaction with the world it gets an as fair concept of the world. As a result they develop a concept of ones *self* in the world. This is the result of a healthy development.

Then the disaster shock experience happens and the child realizes: my concept of the world and therefore of myself is completely wrong; it does not work anymore. In a situation like this, when ones concept of “self” and the “world” collapses, one tends to look very much on others, what do they do and what do they say. In this phase the child is extremely open to be printed or reprinted again. That means, the child behaves similar as its models behave.

And if the models behave normal and friendly the child starts to behave normal and friendly again. This does not mean that the child as a whole feels normal and friendly and so on, but it just orients its self, what is the need of the situation and what is the “language“ of social interaction now.

So the rebuilding of the concept of the world and the concept of your self develops after the traumatic shock step by step. And, of course, on a level which is presented by the people that surround the child. And again, at the beginning avoidance of remembering the shock experience is supportive for this recovery of the concepts of one’s self.

But after a while avoidance of the memories might lead to the concept of the child, that this again is not the whole truth of world and of interaction of world with it. At a certain point there needs to be something like a re-encountering with stored painful experiences and this re-encountering then most likely would be also painful as the experience in the first place.

And it is painful for the child *and* for the caregiver. So both tend to avoid the memories and have good reasons in their mind to do so. Because if the child starts to cry again this is not good for the child the caretakers might think. And they do everything just to make sure the child does not cry again.

But, as a matter of fact, there is a tendency that this concept of the child and its world leads to a split from the experience that is stored from the other world - the shock with its painful experiences and the friendly encounter do not fit into the same frame of "world" and "self". The childs capacity to cover such an extreme range of experiences is just overloaded. It has to kind of switch, depending on what the situation – and the childs fantasies – create..
And the longer this split persists, the more it consumes energy necessary for the development of the child in its everyday normal behaviour. Because operating in one mode, e.g. the normal one, is one thing, but at the same time to keep out of ones mind all reminders of the other mode is quite exhausting and occupies a lot of a childs mental capacities,
We think, that this is one of the reasons why posttraumatic symptoms sometimes appear rather late. Some children show no symptoms shortly after the incident, but after one year, maybe even longer, suddenly some symptoms may appear.

3. The Developmental Trauma Model

We do not stress the importance of trauma symptoms too much; Basically, we are not so much interested in symptoms but rather in self development of the child. Symptoms are just indicators of difficulties the childs self encounters on its attempt persueing its development. Therefore, in a very brief overview, the developmental model says; The normal child develops with some constant changes of his concept of himself and the world. The disaster destroys it and then the question arises, how complete and realistic are the childs concept of its *self and its world* reconstructed. And how does this process of reconstructing its self affect its normal development, which would have taken place if there would not have been a disaster.
Now, if the child experiences extreme shock with fear and harm, it somehow is pushed back in an earlier stage of development. That means it feels more like a baby, even if it is 7, or 10 or even 15 years old. Even adults may feel and behave like dependent children under extreme stress and very often in a disaster they may do it in the presence of the child.
This is an additional stressor for the child which might destroy the last anchors of security.
The child/person drops back to an earlier stage of its development and on this earlier stage the disaster seems to be stored, **according to the cognitive and emotional capabilities tha are available at this developmental stage**.
This has important consequences, because going eventually back to more normal life conditions, of course the person/child recovers quickly to its "real" age of 7, 10 or 15 years, but the disaster memory remains stored in a layer of its psyche connected to earlier childhood. In developmental psychology such layers have been called "templates" of developmenta modes of mental operations. Normally, children leave this templates behind when entering new ones. But still having the experiences of the earlier templates somehow transformed into the new ones. You might use, just as an analogy for better understanding, the example of installing a new computer in your office, whereas the new one can integrate all your old data, but can do more elaborate things with it compared to the old one.
The question that arises now asks, whether a healthy personality, operating at its "normal" mode again, can integrate these early and more primitively stored experiences of the traumatic experience if they themselves at that earlier level could not have been integrated well.
And, as you all know, what we normally do is, that we try to keep these memories away from the child and by doing so keep the child in its "normal" mode, protecting it from falling back into disaster memories with all its experiences of helplessness and agonies. But by doing so as the only method, we might take away the childs chance to integrate the traumatic experience forever. Is it our own fear that keeps us from helping the child to expose itself to the disaster memory step by step? Is it us who don't trust in the childs ability to cope with its memories on all developmental levels?

The developmental model states that we need to help the child to reencounter traumatic memories from a healthy and well supported self structure,. But the process of reencountering bad memories should provide space and time for reexperiencing very difficult feelings belonging to this experiences an by experiencing them to develop new skills to integrate ones hard life events int a wider mental system: the richness of a traumatized person which could integrate its experiences into a strong and at the same time humane, not rigid personality.

4. Conditioned agony and helplessness

To what extent traumatic events have an impact on the psyche of a person has to do with its experience of agony and helplessness in and after the shock situation. This agony and helplessness can be conditioned not only as cognitive memory of the shock situation ("knowing it") but also with feelings of arousal and fear the person has experienced ("feeling it"). This conditioning process is bilateral if not symmetrical: Remembering the situation of traumatic threat causes fear arousal and maybe associated responses (like dissociation, immobility, etc.) but arousal, caused by what ever reason, directly leads to the recall of the traumatic event.

In that case arousal becomes an inner signal for eliciting conditioned agony and helplessness.

And what has to be done, generally speaking, is to work against this conditioned agony: in a way, that the child is desensitized towards that conditioned link between arousal and memory. But even more important, that it learns to kind of answer again to "the world" which threatens it. Agony means to be silent, not to respond anymore, to be passive: One waits without any motion until the shock is over. This might be suitable in the real shock situation. But it is certainly not suitable in some conditioned repetition of an immagined shock situation.

But if one repeats this passivity trigger in fantasy, this forms a stron conviction that this might be the only way to respond to threat and all kind of arousals.

What we try to do to counquer this process is to get the inner self of the child ready to approach the world again and to risk experience of exchange, of interaction again. This may start with quite artificial social interaction skills, which might be helpful to be restored. Later on, the child, after some time of more automatically showing social behavior again, starts to genuinely enter into more satisfying interactions with "the world".

If this does not happen the child is in danger of developing a kind of artificial personality, which can do all social skills but does not feel personal integrity of a healthy, expressive and active self.

5. Dependency and Learning from Models

People, especially children under stress tend to rely on others, to accept help more easily than they would under normal circumstances. They also tend to idealize their helpers. This lays great responsibility on the shoulders of helpers and caregivers. On the one hand, they are models for their clients, the people in need. They imitate their behaviour, their optimism and also their attitude to life. On the other hand, they are at the same time quite unprotected against abusive applications of help in the sense that they are very vulnerable against political and /or religious influences. At the time of great need they might accept the new ideas of their helpers quite readily, but after some time of recovery this throws them into great conflicts, since it is not well connected with their previous culture. As a result this very often creates shattered or fragmented personalities which, after being destabilized by disaster, have been destabilized a second time by political or religious abuse.

The dependency reaction might also lead to a chronic self concept as a victim, expecting from helpers to go on like this forever. This not only can lead to serious collisions with helpers who in turn now feel somehow abused by chronic dependency of their clients and develop negative feelings about the people they are supposed to help. Leading them back step by step to their competence in taking care of themselves is important and should be stressed right from the

beginning of care giving. Stressing independence development is not contradictory to the goal of sustainability – it just has to be clear that support develops with and in line with the development of survivors and does not mean that everything, starting from nutrition, reconstruction to schooling, is done for them without their own active contributions.

6. Some Protectors

What are possible protectors of healthy development in post traumatic phases.
One of the most important protectors in reality and in our mental representation of reality, which psychologically can be even more relevant for posttraumatic adaptation is of course a sense of belonging.
The human psyche, if it is organized interactionally, as we asume, then must also be based on interactional experience, which requires **a sense of belonging**. In the sense of belonging we experience some kind of feeling of being at home. One fatal aspect of traumatic disaster is that it destroys our feeling of belonging, which leads to isolation and despair reaction. S,o one of the basic tasks in posttraumatic support is to provide conditions that enable traumatized children to rebuilt their ability to feel at home again, to experience belonging to their kind again.
Another one of the protectors of course is a **feeling of physical and social security.** These feelings are mediated by **social support -** from other people and eventually from "inside", when the child learns how to support itself again. To make it sound even more complicated – research shows that it is **"perceived social support"** that plays an important role as a protective factor. Other protectors are connected with rebuilding a childs **competence.** simple competence in fields where the child has been competent before, but also in new fields, works wonders.
What I have been seeing you you doing in your child centers and schools was an excellent step into that direction – to provide children with competence is a very important step to support protection. It gives them some feeling of strength and self security and value.
And, just to name one more protective factor, knowing that I might have missed ot some others, is then of course **desensitization**.
Desensitization, as stated to some extent above, means that conditioned fear arousal coming from the traumatic shock experience tends to seduce the child to withdraw from all similar situations. To built up safety feeling you have to help the child go back to those situations where at the moment there is no threat of shock. From the experience of safety in reality you gradually invite the child to expose itself to situation which might elicit fear reactions but are not dangerous now. A sensitive approach, taking the childs capability to tolerate stress and still remain active and contactful seems essential during such exosure exercises.

What about **trauma symptoms**, like intrusive thoughts and visual images/flashbacks, chronic arousal, dissociations, numbing, sleep disorders, nightmares etc..?

Trauma symptoms can be understood as a kind of language, about what is going on in the psyche of the child. We might not fully understand this language yet but we have to try to find out, what it says.
If there is any avoidance behavior, we ought to check whether this avoidance is productive or counterproductive? And is there a denial on the side of the child towards his inner feelings? Is there an alexithymia, - that means the loss of ability to feel oneself, to have feelings like sadness and joy and so on.

Children might behave sadly, or they might behave joyful, but do they feel sadness and joy inside? Because to allow these feelings to appear could be the beginning of other feelings which might be too threatening for the child.
And is dissociation something that is protective or counterprotective?. In general we think that the symptoms are protective at the beginning of the coping process, but they are counterprotective when they become chronic.

Almost everything I said about the child perhaps I could as well say also about care givers.
Especially if they live in the same area where disaster strikes they are vulnerable to similar processes. Avoidances of the caregiver might trigger avoidances on behalf of the child. This is only one example how process of care givers affect childrens processes. Therefore, we have to be careful about this and ongoing supervision is one tool to help in such situations.
This was a very, very brief view towards some basic concepts of traumatization, as we use it as heuristic tools for our work. Its focus is ***interactional***, it is ***honouring the resistances*** *and avoidances* at a certain stage of the development but questioning all these defences at later stages of the development. With the focus eventually to ***integrate*** the traumatic experience in the psyche of the child cognitively and emotionally. If we can reach such a point we are very, very happy.

This is what I can summarize in some 10 minutes about the basic concept of trauma psychology.

Maybe there are some questions.

Question: We had not only one trauma, but many and life after the main incident has changed for worse. How do you see that multiple trauma effects?

The traumatic incident itself might be not as important as the immediate time and care situation after it. We know from our studies in war and postwar zones that of course though there are extreme traumatic experiences in war situation, but the very bad living conditions afterwards add to this traumatization. This is an empirical fact. And it adds even more over time than the single incident of say, being yourself in an extreme situation or some threat on your relatives. That means it is very important to have very soon, very quick relief work going on with the focus of stabilizing the community, stabilizing the people involved and providing security on several levels - physical nutrition, protection from new disaster and so on. So, this is the first focus. The question is then, do you keep the community together or do you put them apart. The general rule from our point of view is to have the systems as complete as possible as they have been working before. So if the main interaction was within families you try to get the families together and do not separate them. But if it was used to have some separation in the society before, like the fathers do other things than the mothers, then it would be ok to do the separation. But basically to get back as much as possible from what has worked in the pre-disaster society.

Question: How culture dependent is trauma? Is this a western concept?

I think not only in situations in this part of the world but also in North-America when there happens a very big disaster at first the community and the people are the resources to help each other and if there are some ways to organize this help, this would be perfect. If you do the same here, you organize the resources that are there already in the field.
But the basic processes of trauma are the same all over the world. Maybe in the long run, ways of dealing with such experiences might differ, the shock reactions are pretty the same.

But I think, even if you rely here more on self-help concepts, you organize these self help resources better if you have some understanding of what might go on in the individual minds and in social interactions of people in coping with what they have experienced. The understanding of trauma gives you a guideline on how to organize self help activities in the community and maybe here and there you might add something to that by some teachings and so on. But, of course, disasters like the tsunami or the earthquake in Pakistan is not the situation where you can start off with individual counselling, not at all. And besides that the spread of the experience is much bigger if the community itself interacts. As you know, rituals are very powerful tools in these situations, rituals of getting people together, rituals of spiritual kind help people very much in these situations and we have to make use of these resources.

Question: Should we distract children from their bad memories or help them to face them? An if so, how?

Our psyche is very flexible, especially flexible in children. They adjust to new situations very quick. And many children will profit a lot from this possibility to go out and have new experiences as you described it the other day. Maybe we tend to react and attend to the needs of the more healthier ones and overlook others? The question is, does this hold for all children and for all situations. And can we support those childrens process that tend to withdraw aas well? Maybe they need other kinds of care. So that we do not leave them for themselves but somehow accompany them and communicate with them also about what is going on. But I think the most difficult thing is, if you come at a certain time to a point where you invite the child to remember certain aspects of the most difficult and tabooed memories. What I want to stress here is, that it is easier for us to go on with the taboos and it is very difficult also to find an adequate way to invite the child to think about something or to draw about something which might elicit painful memories again. And some of them might be able to draw, some might not, but eventually all the others will follow. That means that the kind of desensitization with respect to the tabooed memory takes place and so this tabooed memory is not something horrible, denied and completely repressed in the psyche of the child but eventually the child can speak freely and normally, maybe with some feelings about what it has experienced.
Because if the child with night mares sees all other happy in school or playgrounds it might feel bad about himself not only because of its experiences but also because it does not manage its life as easily as others. Being a failure in not reaching others happiness and social behaviour.

Question

What is the importance of pre disaster life experiences with respect to post disaster experiences and the second question focuses on the role of security of post-disaster situation.

Our psyche wants to form stories about our life. It does this actually all the time. If you are asked, who are you?, you are immediately making up some story of your life. The story means connection over time and connection with field and people. This is the connectedness a healthy psyche has to produce. This connectedness is disturbed by the trauma. If you go back in storytelling with the children to the pre-disaster time due to disaster interrupted stories of what their life is about is somehow healed. Even though it might lead to strong emotions. If you remember, how you were sitting with your family at a table at a certain situation and two members of the family are missing since that day, this of course, brings up some sadness or whatever feelings. But it is very important to have this reintegrated in the story of your life. Your life does not begin after the shock incident. Even though you might have had good care

after the shock incident, but if you define yourself only after this you have the risk of getting a kind of split personality type of development.
Security – our psyche is constantly producing security feelings. And if this is going right, we do not notice that it happens. We only notice that it happened, when security is not given anymore. And how much our whole perception of life is changed if security feeling is gone. Only a small incident, suddenly you are close to an almost psychotic like confusion of what is going on. Thanks to god, you might think, at least the moon is still there. You try to grasp what is still in your world as facts and to build up security again. In the early stage of the trauma of course the security has to be provided from outside, physical security, social security and if possible emotional security. Sometimes even at the cost of truth. If you know as a caregiver, there is no security and if you know as a caregiver something bad happened to other family members of your survivor, in the first moment you will say, everything is fine, don't worry, all will be good, everybody of your family will be taken care of. You know that the shooting is going on, but you tell the injured person, we have everything under control, we will take care of you, don't worry, just relax and be calm. We lie to protect security, to promote security feelings in the person. The security feelings are necessary for psychological stability of any person and especially for the very young one. If you do not feel secure, you do not want to risk anything in social interactions, for instance. If you feel very insecure, you think: "ok I will withdraw, I let the others talk and when the others finish then maybe I feel more secure" and so on. Without security we do not risk any participation in the world. And that is very important. The interesting thing is, there is almost no literature about psychology of security. It seems that it is such a very basic psychological process, that publicly it is not noticed as a scientific issue. But if we fell secure, whether realistically or not, it is so normal in everyday life, that everybody does not see the possibility of rapid change. Except those, who are in contact with extreme situations and who know what it is like to *really* feel insecure.

Question: We did not see the same trauma reactions in Banda Ardeh after Tsunami. In some villages people were completely traumatized and in others, though striken similarly, the seemed to be untouched.

First of all I do not claim to have an answer to all problems. Your observations in Arceh are very valuable to me, I would not have expected it and I would like to have my own look at it also. But – as we know – if a disaster strikes the whole community the individual traumatization probability is less, is reduced, because you share the same fate, but if it hits certain people outside of the community and others not at all, like it might have been the case with the Tsunami somehow, then this makes a difference. In war situations also, people, due to the war situation seem to be more protected against this massive impact of traumatic experiences than if the same would have happened in not-war situations. There are differences regarding the whole setup of the situation. Now, I do not know what the difference in this community is, but if somebody says, enough of all the problems, now we go on and do what is necessary, this is a perfect resource for the neighbours also. This is concerned with getting yourself now after the event back to life. This is, what we want to get. If we do not find it we want exactly try to support this kind of decision making. A Jewish philosopher, Martin Buber, whom I adore very much because he is the philosopher of dialogue, as we call him, he says it is important to know, what happened to you, but at a certain point you should go on from there and not look back all the time without changing your script about it. If it is just repeating, repeating, repeating it is of no use. You have to write the story about what happened in a new context anew. Then you can go on from there. I would ask in that example you gave, where the master of the community says, lets stop the sufferings and go back to life, how after one or two or three years they tell their life history. Maybe it will be important at

that time to support them, to integrate the peak trauma period, the traumatic period and the post-traumatic period. Because what our psyche wants is a whole complete story of what our life is. And if this is not the case, we support them to do it, to be active, to be competent, to return to life again in the post-traumatic period, whatever is the best step to do and to encourage them to do.

Question: But isn't it sometimes too much what help organizations do in a post-disaster phase? And couldn't it be more coordinated. We feel sometimes as being invaded by international helpers.

We know this from Germany also, when something happens, all the different organizations rush into the field and fight grasping traumatized babies, if you want to say it like this. This is not a sign for good organisation of structuring post-disaster help systems. And it must be done and only the Government has really the authority to do this. If you leave it to the community under stress, they usually are unable to do it. If something bad happens in a German small town, the major of the town can not decide, who is good or who is not good and what is needed in which sequence. Because those who come, think, what they have to offer is the most needed at the moment, and they give it for free and whatever, they have a good intention. But it is not sure that this good intention leads towards good action. What is really necessary is a good structure of post-traumatic service coordination in advance. INNOT, the company which sent me her and which I cooperate with has been actually founded because of this kind of situations in Germany. INNOT is offering a kind of Einsatzleitung – something like a coordination of emergency situations, also on the psychosocial side. This normally does not exist. Now we found out, that the government is very fond of having somebody who prepares his mind on how to coordinate and establish networking among several organisations. If something happens and they all rush in again, there is already somebody there, they know him, they tell him what to do at what time. We had one bad accident in Bad Reichenhall, last year, and INNOT was doing it then. And it was a great difference. So I suggest to transfer this also into other countries. You have to have a plan also on the psycho-social side on what happens after trauma.
The community shall be empowered to do what the counsellor tried to do with the child. Why a counsellor comes from somewhere else, to deal with a child, that does not speak his language. Long time care need empowerment of the people to cope for themselves. Everything else, especially if the health organisations have short time programs is of not much use. A drop on a hot stone.