

CHAPTER 3

CONCEPTUAL FRAMEWORK

EMOTIONAL TRAUMA IN CHILDREN

3.1 Introduction

In using music therapeutically with children, the researcher would be focussing on the emotionally traumatized child. As previously mentioned the South African Oxford Dictionary, (2002:973) defines trauma as “a deeply distressing experience”, “physical injury” or “emotional shock following a stressful event”.

In addressing emotional trauma in children the researcher is in essence concerned about the well-being of the child, the protection of the child from harmful environmental influences and the prevention of the child from future injury. Whether the child is a victim or outcome of environmental processes, is part of a systemic problem in the family or school, or is the immediate source of the problem, the number of children being referred for clinical intervention is fast increasing.

The constant changes and fluctuations in the development of infants, children and youth as well as their dependence on adults, makes them vulnerable and sensitive to environmental influences and to dangerous circumstances that may adversely affect their physical and/or emotional development.

Children may be exposed to a wide range of traumatic experiences including stressful traumatic situations within the family environment, neglect, abuse,

environmental and community stressors such as hijackings, violence, theft, destruction of homes by crime or natural disasters such as fire and storms. From observations as a therapist, the media and personal experience, trauma affects a child's physical, psychological and emotional development predisposing a child to behaviour, emotional and cognitive disorders. It is these responses of the child to trauma that is of particular concern and interest to clinicians working with children.

From the perspective of the Gestalt approach trauma can split the child's world, that is, the inner self into parts that is externalised to the family, therapist, teacher and environment as negative behaviours. Transformation of such a child through therapeutic intervention, involves integrating these parts to form a 'whole' self.

It is important to explore how the child experiences trauma and how trauma is seen in the South African context.

3.2 Child Trauma within the South African Context

According to Pavlicevic in Sutton (2002:110) "one understanding of trauma is the emotional and psychological impact of acts that impinge on the self, that is, the effects of violent acts of living in a violent environment."

Events that potentially trigger the onset of trauma and violence in communities, most often is as a result of poverty, poor socio-economic conditions, unemployment, poor or no social security. Pavlicevic (2002:110) explains that the tragedy of the South African society is that children, who in most cases are not responsible for the discomfort in their society, are victims of both 'invisible' and 'visible' violence. The 'invisible' nature of violence is manifest as a "slow eroding of life: a paucity of material well-being, the

absence of a sense of security, the absence of a supportive social network and fragile life relationships. It is socially sanctioned either through state bureaucracy, as during apartheid years, or less overtly, as in the current transition phase in the country” Sutton (2002:99). Pavlicevic (2002:110) continues to detail ‘invisibility’ in; economic violence that ensures individuals, which include children, will remain materially poor for the foreseeable future; socio-political-medical violence that prevents children from accessing the latest technology and treatment for serious and life-threatening diseases; educational violence that prevents large numbers of children in particular from the opportunity of expanding their thinking and social violence that has led to the imprisonment of caregivers.

On the other extreme is a kind of violence that is ‘visible’ and an expression of rage directed at others, the consequences of which may be destructive. Pavlicevic in Sutton (2002: 100) explains this violence as a kind of “survival mechanism and is finite: once my violent physical act is completed, there is a sense of relief from the intensity that prompted me to act”.

Within the South African context separation from the primary caregiver is a major issue finding its way into the lives of families, destroying relationships and creating extensive distress in children. This separation issue is frequently viewed on the local television news reports of children being abandoned or children missing from their families. The cause in reality is often as a result of urbanization, family violence, divorce, fatal crime and the present and most prevalent life-threatening disease of AIDS that has left countless children without a primary caregiver.

Children look to their primary caregivers, that is, mother and father for protection and are in need of constant physical and emotional proximity.

Children develop their sense of self and their sense of self in relation to another through this protective relationship. Pavlicevic in Sutton (2002:103) explains studies that indicate that children who do not have a warm, empathetic primary attachment are at risk of developing a limited sense of themselves as being valued by others. The consequence of this sense can develop into anger, repression of feelings, withdrawal, superficial relationships and numerous other inner conflicts created by emotional and physical absence. With the lack of nurturing that many children are exposed to in society, not only because of violence but also because of the need for mothers to work at an early stage after childbirth, children may present as being cold, distant and unable to relate often with negative implications for their cognitive functioning (often due to a lack of stimulation from an early age) and academic ability. These negative implications on a child's life as a result of trauma also has specific influences on certain neurological processes involving different parts of the brain.

3.3 The Neurology of Trauma

According to Sutton (2002:47) it seems that “different emotions are subserved by different neuronal networks involving many parts of the brain and are laid down over time as explicit memories resulting from personal experiences of life”. As trauma has a direct impact on an individual's emotional state, trauma is very much an emotional experience, although it also has implications for intellectual and physical function depending on the severity of the trauma and the emotional response of the person to the situation.

The anatomical basis for emotions has been debated for centuries. According to Roediger and Rushton (1984:388), the following structures have been found to be related most closely with motivation and emotion. Although not well

understood the limbic system has been found to be an important area in relation to emotional life. The structures of the limbic system lie within the temporal lobes. The limbic (border in Latin) system is a group of similar cell bodies in the thalamus, hypothalamus and part of the brain above these structures that combine to form a kind of border around the lower forebrain.

Roediger and Rushton (1984:52) explains the functions of various structures within the brain that are associated with memory, emotions and sensory experiences, all these being important for an individual's survival.

The *amygdala* appears to primarily facilitate aggression, the *septum* apparently restrains aggression and the *hippocampus* as been associated with memory.

The *thalamus* receives all sensory information from the eyes, ears and skin and relays this to higher centres in the brain. It also integrates information from parts of the brain and sends it to the *medulla* that controls heart rate, breathing and reflexes and *cerebellum* that coordinates movement .The function of the thalamus in relation to sensory information draws attention to the fact that familiar, sights, sounds and touch can trigger certain memories and emotions. The sensory modalities which are refined and associated with certain experiences take origin in the hippocampus.

Another important structure is the *hypothalamus* which among other things is concerned with regulating the internal state of our body and maintaining a state of homeostasis especially with regards to hunger, thirst and temperature. It also regulates the endocrine system which is a chemical communication system linked to the nervous system. The secretion of epinephrine and norepinephrine (synonymous with adrenalin) in stressful situations causes heightened emotional awareness and is reinforced by the endocrine system.

According to Sutton (2002:50), the long-term effects of living in a stressful situation means that the child's body will continuously be in a state of high emotional sensitivity, which can have detrimental effects to the child's physical and emotional state, influencing day to day functioning negatively.

The structures in the brain discussed above have specific and varied functions in relation to memory, survival and the maintenance of the internal balance of the body. With regards to memory in particular, Sutton (2002:48) explains explicit memory, which refers to the memory of things, events, and everyday activities and involves conscious perception of recent experiences and facts. These are slotted into a relevant network, a process which involves the hippocampus and in which any associated emotion may be expressed as feelings. This type of memory is more easily forgotten as compared to implicit memory (which are of threats and dangers, pleasure and pain, gratifications) which may not be felt at a conscious level, is not forgotten easily and may be reactivated by an appropriate stimulus after many years. Any emotion associated with this type of memory may appear to be illogical and surface for no apparent reason.

With this background on neurology associated with trauma, the researcher can understand the brain's response to trauma for example in a sudden or unexpected physical or psychological event that is of threat to the child, resulting emotional disturbances which may become ingrained into memory and surfacing at unexpected and different phases in an individual's life. These cerebral processes which have been disturbed as a result of trauma are varied and intricate, the exact nature of them requiring ongoing research and investigation.

With regards to emotional coping, Lazarus in Sutton (2002:49) explains that the ability to cope emotionally, is dependent on many variables, some of which are inbuilt, for example personality traits and some environmental, like family support. Therefore an individual's potential to recover and for the body to regain a state of balance and homeostasis is dependent both on the cerebral processes in the brain and the external influences from the environment.

3.4 Developmental Variables with regards to emotional trauma in children

3.4.1 The Child's Age

Symptoms of stress and trauma manifest differently at different ages in children. According to Ronen (2002:92), "at the youngest ages children are more affected by their immediate environment, namely their parents. As a child grows, external events become more and more influential, reflecting the child's interest in their surroundings." Ronen (2002:93) discusses a study of children during the Gulf War, and explains that young children between the ages of eight years to twelve years showed a higher rate of behavioural symptoms, anxiety and fears following the war than did the older children, who revealed more signs of cognitive concern and interest in occurrence.

3.4.2 The Child's Cognitive and Emotional State

Ronen (2002:93) also discusses how maturation with regards to the cognitive and emotional state of a child has a major role in influencing how a child responds to traumatic events. He explains that at various stages in a child's development, children exhibit different ways of understanding situations and dealing with complex emotions. They also have diverse needs, fears and use different coping mechanisms.

As cognitive functions mature and become more advanced, new emotions develop that are added to the child's experiences enabling the child to better comprehend and differentiate emotional understanding. It can then be deduced, that the higher a child's cognitive ability, the greater the ability of a child to deal with complex problem situations and the stress or anxiety attached to the event.

3.5 Types of Trauma facing Children and indications for treatment

For the purpose of clarity, the researcher will first draw distinctions between single, multiple, continuous and complex trauma as explained by Straker (1991:65).

(1) Single Trauma

Single trauma where a single unexpected traumatic event, such as an armed robbery occurs. Single trauma can differ in intensity, from being pushed down by an attacker to being shot in a robbery.

(11) Multiple Trauma

Multiple trauma is when a child is exposed to more than one incident of trauma, for example, being involved in an armed robbery and then being attacked by an animal on a separate occasion. A single trauma can also develop into multiple trauma, for example, if a child is injured and then is hospitalised, then confined to a wheelchair, it would be considered multiple trauma. Another type of multiple trauma is when a child experiences the trauma of a parent being killed, in addition to the trauma, the child also has to deal with issues of loss and bereavement.

(111) Continuous Trauma

Continuous traumatic stress is the term used to describe a situation where a child is continuously exposed to ongoing levels of trauma. When there is constant threat of trauma or people known to the child are continuously being traumatised by a situation, there is an increase in the child's sense of personal vulnerability. According to Walker (2002:41) the nature of South African Society is such that most children are exposed to continuous traumatic experiences either directly as victims or in-directly as witnessing trauma or hearing about trauma. These children live with the constant threat of danger and violence. Straker (1991:56) emphasises that Posttraumatic Stress Disorders is a misnomer in the South African context because the stress is current and ongoing.

(1V) Complex Trauma

Complex trauma refers to prolonged, repeated trauma, however in this case there is a relationship between the victim and the abuser. The victim is usually under the control of the perpetrator and cannot escape. Examples of these situations are hostage situations, concentration camps and domestic violence. Although the first trauma is unexpected, after time the victim who is exposed to complex trauma usually begins to expect the abuse.

3.5.1 DSM 1V R Classification - Diagnostic and Statistical Manual of Mental Disorders – Posttraumatic Stress Disorder (2002:427)

There are many and varied ways that trauma is inflicted on an individual. However central to our understanding of all trauma is the fact that it is a distressing physical and/or emotional experience that has lasting effects. The symptoms of trauma are detailed specifically under Posttraumatic Stress Disorder (PTSD) although there may be other associated features and disorders that may precede and follow the onset of Posttraumatic Stress Disorder.

“The diagnostic criteria for 309.81 Posttraumatic Stress Disorder as detailed in DSM 1V R (2002:427):

A. The person has been exposed to a traumatic event which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- (2) the person’s response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings or conversations associated with the trauma
- (2) efforts to avoid activities, places or people that arouse recollections of the trauma
- (3) inability to recall, an important aspect of the trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect (e.g. unable to have loving feelings)
- (7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With delayed Onset: if onset of symptoms is at least 6 months after the stressor.”

It must be noted that not all persons experiencing severe emotional trauma will develop post traumatic stress disorder. In many cases after a two day period of experiencing the trauma, the acute and distressing symptoms start to subside but this is not the case in all persons experiencing severe emotional trauma.

Acute Posttraumatic Stress Disorder and chronic Posttraumatic Stress Disorder are specified in terms of the duration of the symptoms.

3.5.2 Severity of Psychosocial Stressors

Whitfield (1987:55) compiled a table from the DSM (111) classification on examples and degrees of stressors in adults and children. For the purposes of this research only stressors facing children will be discussed in Table 3.1.

Table 3.1 Classification on examples and degrees of stressors

<i>Severity Rating of Psychosocial Stressors</i> <i>(from DSM 111)</i>	
<i>Code Term</i>	<i>Child /Adolescent Examples</i>
1 None	No apparent psychological stressors
2 Minimal	Vacation with family
3 Mild	Change in school, teacher; new school year
4 Moderate	Chronic parental fighting, change to new school; illness of close relative, sibling birth
5 Severe	Death of peer, divorce of parents; arrest; hospitalisation; persistent harsh parental discipline
6 Extreme	Death of parent or sibling; repeated physical /sexual abuse
7 Catastrophic	Multiple family deaths

According to Mabanglo (2002:241), studies analysing the findings on childhood trauma were divided primarily into three categories of trauma;

- (1) community violence
- (2) accidents and natural disasters
- (3) family or individual trauma (mostly in the form of physical and sexual abuse).

The researcher is of the opinion that in the new millennium, traumatic life events facing children continues unabated. These predominantly include, physical and sexual abuse, neglect, domestic violence, suicide threats, death of loved one and other extraordinary events. With AIDS on the increase, death of a parent or family member or even their own deaths, stares many children in the face on a daily basis, that actual living and survival becomes traumatic, to the extent that all the potential of the ‘true self’ within a child does not arise.

3.6 Indications for Treatment of Trauma in Children

Stressors such as those mentioned in table 3.1 above, are present in families and the environments around the child and tend to stifle the growth of the ‘true self’. When these stressors persist and the child lives for a prolonged period of time in a seriously troubled or dysfunctional family or in similar environments, the trauma inflicted on the child is known to be more damaging and more difficult to treat.

According to Whitfield (1987:56), treatment also then tends to become difficult if traumas are of a human origin and if those around the affected person tend to deny the existence of the stressor.

In treating children, clinicians should not only address factors specific to the traumatic situation but also consider the child’s unique qualities, such as the individual’s dynamics and personality, the developmental stage of the child, the level at which the child relates to persons, objects and experiences in their environment and prior history of trauma; in order to understand the complexity of the experience and treat the child appropriately.

With regards to the level at which the child relates to persons in their environment, the primary caregivers have a significant influence on the child’s recovery, post trauma, and need to be encouraged to take an active role in the child’s therapy to increase the child’s hope and reduce their powerlessness, even if it involves the caregivers being part of the therapy sessions.

3.7 Conclusion

A child's recovery, after their lives have been disrupted by the violence of a traumatic situation, is based largely on basic needs being restored by their primary caregivers and the therapeutic environment that the child is in. Using the gestalt approach and the medium of music, it is this process of recovery that the researcher hopes to explore to enable the traumatized child to assimilate and integrate all fragmented parts of themselves into a 'whole' 'true self'.

In chapter four a contextual framework for the study will be presented, integrating the concepts of music and emotional trauma within the context of the gestalt approach, in helping children who are victims of trauma.