# Restoring hope t traumatized child

This year, the Mental Health Week focussed on the effects of trauma and violence on children. In the absence of timely intervention, the consequences may be disastrous

BY DR RUBEENA KIDWAI

THIS article presents a brief overview of some of the salient issues a clinician must keep in mind when working with child victims of abuse, trauma or violence. The exact numbers for prevalence of child abuse in Pakistan are currently unknown. However, clinical evidence and anecdotal accounts, as well as human rights' reports and news in the print media, indicate that Pakistani children are often exposed to direct or indirect abuse, violence, trauma or neglect. Child abuse, which may include commission of physical, sexual or emotional abuse or neglect of the child, as well as exposure to or witnessing of societal or familial violence, may leave indelible marks on the child's psyche. Exposure to such forms of trauma may cause the child to experience psychological, interpersonal, academic or familial distress. The victim may exhibit symptoms of anxiety, depression, post-traumatic stress disorder, dissociative disorders, verbal or physical aggression, poor impulse control


psychological safety of the child. If the child continues to be vulnerable to the possibility of abuse and harm, then the therapist must assess and implement any steps that the therapist, the child's guardian or other family members, or other professionals (such as teachers, doctors, nurses, etc) may take to prevent further abuse/trauma. The first few sessions may involve a crisis intervention mode, as the therapist assesses issues of current danger to the child, from others (abuse) or self (suicidal thinking or acts). The therapist may make medical/psychiatric

peers, neighbours and other professionals. In the initial phase of therapy, the therapist will be in a more directive mode and may have to facilitate the child in accessing these resources to address medical, legal or financial needs.

An important aspect of the beginning phase of therapeutic work with abused or traumatized children do effective therapy. The purpose here, other than ongoing assessment, is to allow the child to tell his/her story. The therapist explores the victim's personal experience of the trauma and her/his idiosyncratic meaning and interpretation given to the event. Depending upon the child's developmental level, therapy may involve verbal mode (talking) or may employ non-verbal, symbolic tools such as drawing, painting, dolls or puppets, clay material, role playing, games, story telling, sand-tray, collages, etc.

Along with the telling of

verbal or physical aggression, poor impulse control and substance abuse, to name a few.

Psychotherapy with such children, along with familial and community support and interventions, may help the child victim and his/her family resolve some of the pain and conflict brought on by the trauma or abuse. Therapy with victims of child abuse may broadly be conceptualized into three phases: the initial phase, the intermediate/middle phase and the late-middle phase.These are not distinct phases; they represent a process where one phase may naturally evolve into the other, at times, overlapping.

The initial phase looks at the more immediate concerns following the first contact between the therapist and the child victim. These concerns include ensuring the immediate physical and

acts). The therapist may make medical/psychiatric referrals to address physical or psychological trauma (for e.g. for bruises, lacerations, malnutrition or signs of clinical depression or anxiety). During the assessment of abuse and it's aftermath, the therapist must be careful not to display shock, horror or disapproval, and must maintain a non-judgmental and accepting stance.

The therapist may explore the child's internal and external coping resources that may be employed in dealing with the crises. The child's internal resources include the child's own coping skills, his/her intelligence, resourcefulness, self-sufficiency, ability to manage/regulate emotions, ability to ask for help, etc. The external resources may include help, support, resources and interventions from family, community,

apeutic work with abused or traumatized children involves creating safety for the child within the therapy. This is achieved by providing the child with a safe, non-threatening and warm space both physically (setting of the room, availability of soothing toys) and psychologically (the therapist's demeanour). This is also the stage where the therapist builds a rapport with the child by promoting trust and empathy. At the same time, since social withdrawal, mistrust and even paranoid ideation is not uncommon among abuse/traumatized children, the therapist must allow the child to open up at his/her own pace and comfort level.

The middle phase of therapy involves talking about what happened, although the therapist does not need to know all the details of abuse or trauma in order to

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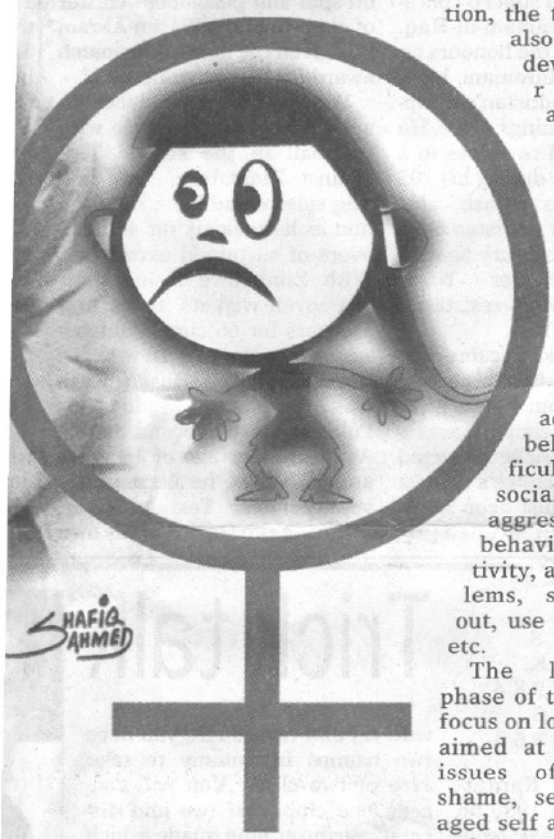
Along with the telling of the story of abuse, the therapist also facilitates the child in expressing any emotions related to the abuse/trauma, such as feelings of anger, horror, fear, sadness, ambivalence, helplessness, hopelessness, shock, betrayal, guilt, shame, fear of abandonment, self-loathing, etc. The therapist allows the child to identify and express these feelings, either through verbal or symbolic (play) mode. The goal, in addition to expression of feelings, is to help the child in learning to deal with and to manage and regulate these emotions. Additionally, since it is not uncommon for abused children to hold their own selves responsible and culpable for their victimization, the therapist must also help the child develop a more realistic appraisal of the culpability and responsibility for abuse/trauma. Another important aspect of this phase of therapy is addressing any behavioural difficulties, such as social isolation, aggressive or hostile behaviour, hyperactivity, academic problems, sexual acting out, use of substances, etc.




The late middle phase of therapy would focus on long term goals aimed at dealing with issues of guilt and shame, sense of damaged self and self worth and issues of trust at a deeper level (e.g. beliefs about betrayal or abandonment by God, parents, other adults, etc). The therapist should aim to instil in the child, a sense of control and capability, self-efficacy and mastery, along with a restored sense of hope and trust in self and the world.

As with any therapeutic work with children, it is ideal to include parental/guardian figures in the therapeutic interaction. This many include parental education e.g. educating parents regarding the process of trauma recovery or teaching appropriate disciplining skills to replace abusive parenting. The therapist may use the non-offending parent or other familial and communal resources to strengthen the child's emotional and social support system. Family therapy may include addressing and resolving issues related to the abuse or trauma, issue of losses (e.g. loss of trust, loss of innocence or loss of family members due to violence) and issues of separation (if the child has been separated from family/ community).

When working with the family, the therapist must be willing to identify denial and minimizing of trauma or abuse by family members, specially the parents, without attacking or blaming them for the abuse. The therapist may focus on family dynamics and any family dysfunction or pathology (e.g. substance abuse, mental illness, patterns or incest) with the goal of facilitating healthy relationships leading towards long-term change in the family system.

Abuse, trauma and violence are unfortunate realities in the lives of some children. For these children, the very meaning and experience of "having a childhood" are altered forever. However, recognition of this malady in our culture and in our homes, along with timely interventions by the family, community and professionals, may help restore in these children a sense of self and trust that may otherwise be adversely affected. ■