Understanding the Experience of Trauma in Childhood: A Socratic Ten Factor Model

Dr. Marta Garrett[1]

Abstract

Trauma work is considered a cornerstone of mental health counseling accounting for a significant portion of all counseling services sought today. Increasingly, children of all ages present in counseling with symptoms as a result of a wide variety of traumatic experiences. This article draws from extensive historical research in the areas of trauma and childhood development and proposes aten factor model to help mental health clinicians better conceptualize and understand how child clients internalize traumatic experiences. This model discusses common clinical symptoms and complaints within a quasi-Socratic framework for questioning how differences in these experiences may impact the child's or the care giver's response to the child's trauma to assist in selecting appropriate therapeutic responses to strengthen the child's probability for successfully addressing healing issues in therapy.

Keywords: Childhood trauma, counseling, case conceptualization

Trauma work is considered a cornerstone of mental health counseling accounting for a significant portion of counseling services sought today. Increasingly, children of all ages are exposed to traumatic experiences from abuse and neglect, to environmental disasters, to victimization from crime and war. As an example, a recent (U.S.) national survey reported that more than half of children are exposed to violence each year (Finklehor, Turner, Ormrod, & Hamby, 2009, as cited in Risser & Schewe, 2013). While not every potentially traumatizing event in childhood results in trauma or the need for mental health services, the number of children needing mental health services each year is growing (Landeghem & Hess, 2005).Often, clinicians who work with traumatized children rely on research that was conducted primarily with adult clients. Much of this work conceptualizes the potential impact of trauma without adequately weighing the differential aspects of child development or without considering how parents or caregivers may influence the child's experience of trauma. Addressing the unique developmental mental health needs of children is challenging enough but when child clients have experienced intensive or repetitive trauma or the primary caregivers are also suffering from traumatic experiences, therapists are often at a loss to understand the full impact of how the trauma has been experienced and how to help (Landeghem & Hess, 2005; Herman, 1997).

Some of the most frequently reported examples of trauma-causing events in childhood include: disruption of the attachment process (and other significant disruptions of normal developmental processes), child abuse or neglect, sexual victimization (e.g., Finklehor & Browne, 1984 as cited in Moroz, 2005; Malchiodi, 2014); interpersonal victimization including bullying (e.g., Halsan, 2013); the need for significant medical or health-related procedures (e.g., Horowitz, Kassam-Adams, & Bergstein, 2001); parental loss or frequent unavailability (e.g., Hall, 2008); natural disasters or situational crises, war, (e.g., Lubit & Eth, 2003); and severe poverty (e.g., Frederick & Goddard, 2007).The body of trauma-related research suggests that while there may be vast differences in the trauma that clients have experienced, there may also be similarities in client responses to various forms of trauma and similarities in how clients experience the trauma and make meaning from these experiences (Baroody, 2011).

---

[1] University of Mary Hardin-Baylor, Belton, TX USA.

While children of different developmental stages are likely to respond differently to similar trauma-causing events, it is typical for children of all ages who have been exposed to trauma to be referred to counseling services due to inappropriate attention-seeking behaviors. A better understanding of how trauma symptoms unfold in childhood can help therapists to plan more effective interventions to meet individual child-client's needs. This article proposes a model of 10-factors or inter-related constructs that potentially impact clients' experiences of trauma and their healing trajectories. These ten inter-related factors are: age or developmental status, time, support structures, relational issues (such as relationship to the offender or trauma causing agent),perception or threat of danger, injuries sustained, coping mechanisms, previous intervention attempts, extenuating circumstances, and legal or financial issues. A series of thought-provoking questions is offered to assist therapists in beginning an internal quasi-Socratic dialogue to better conceptualize how the differences in each of these inter-related factors could potentially influence how each individual child may react to a traumatic experience or how the child may internalize the trauma.   These questions are not intended to be asked of the client or the parents/caretakers but rather to spark an internal dialogue within the therapist to help the therapist better understand the child's unique experience of the trauma.   These questions are designed to help therapists begin to distinguish what they know or understand about the client's experience of trauma and what they do not know but could help them in planning treatment options for the client.   This quasi-Socratic questioning process is intended to help therapists clarify their thinking; challenge the assumptions they may have made; use evidence as a basis for the treatment plan; and consider implications and consequences of moving forward in any particular therapeutic direction (Carey & Mullan, 2004).   The first three factors discussed, age, time, and support structures, are foundational and the most crucial factors to consider (especially for younger children) because they are closely inter-related with each of the remaining seven factors (relational issues, perception or threat of danger, injuries sustained, coping strategies, previous intervention attempts, extenuating circumstances, and legal or financial issues).

1. Age or Developmental Status

The child's age or developmental status at the time of the trauma is perhaps the most critical aspect of understanding how a child will respond to a trauma-causing situation (Landeghem & Hess, 2005). Children are not small adults: their experience of any trauma-causing event must be considered within the context of their developmental status. Young children have varying levels of physical, cognitive, emotional, social, and ego development and therefore experience trauma very differently than adults or even older children would experience the same event. To better conceptualize where the child is developmentally, the therapist must understand: How old or what developmental stage was the child in when the trauma occurred? and What was the child's developmental trajectory before the trauma? For example young children who have not yet progressed beyond the stage of animism (or the attribution of lifelike qualities to inanimate objects) may respond differently to an experience like a fire or flood where toys and dolls are burned or drowned. Information about the child's developmental status or progress prior to the trauma and when the trauma occurred (if not in the proximal past) is typically reported by a parent or caregiver and may or may not be fully accurate. For a full assessment of developmental status, it might be helpful to consult with non-family members for a more professional assessment if there is any question of the accuracy.

It would also be important to understand: What developmental tasks are typically faced at this stage (when the trauma occurred) and how could they be potentially complicated by this particular trauma? For example, very young children or toddlers who might be considered to be in Erikson's stage of Trust vs. Mistrust are likely to experience any trauma from a safety and attachment perspective (Crain, 1985).   Children in this stage who are traumatized by a person (as opposed to an event such as a hurricane or typhoon) may experience a deeper level of attachment complications as are those who are forced to go without basic necessities such as shelter and food. These children are likely to experience longer-lasting negative attachment-related effects compared to slightly older children who experience the same traumatic events, but who may have already progressed through the attachment tasks of this level of development and have a more solid sense of trust that their caregivers or parents will provide for them again in the future (after the trauma has passed). Because child clients are under the care of an adult, it might also be important to ascertain the developmental status of the parent or primary caregiver for the child as this could influence how the caregiver responds to others' needs and his or her own needs following a significant trauma. In attempting to assess the child's potential needs in the therapeutic process, it would be essential to understand how does the child's development status potentially impact impending therapeutic interventions?

For example, a child under 4 or 5 years old (or a child who is older but developmentally delayed) will likely have a very limited feeling vocabulary and will be much more comfortable expressing him or herself behaviorally and will likely respond in treatment better to behavior or action-based interventions (Henderson & Thompson, 2011; Vernon, 2009). Regardless of the setting of the treatment or trauma that has been experienced, working with children requires that the therapist use the language most appropriate to childhood: play (e.g., Ray, Bratton, Rhine, & Jones, 2001; Landreth, 2002; Van Velsor, 2004). Finally, it is essential to attempt to understand: What if any meaning will the child likely make of the trauma and what meaning might the parent or caregiver attribute to the trauma? Small children have unidimensional thought patterns or the tendency to focus on one aspect of the trauma (which is not necessarily what an adult may focus on) therefore, therapeutic interventions that focus on helping the child to make meaning out of a traumatic experience will typically not work if the child is being asked to take a broader, more inclusive view of the trauma. A slightly older child (perhaps 6 or 8 years old) who may be able to differentiate more emotions in him or her and others may consequently experience the trauma differently (because he or she can understand that others may have also suffered or be affected by the trauma). However, children of this age still have a very ego-centric perspective and typically will assume responsibility for the trauma (e.g., "if I had listened to grandma, the tornado would not have taken our house away").When addressing the needs of pre-teens or teens who have experienced trauma, it is essential for therapists to fully understand the interplay between developmental tasks and support structures. Pre-teens and teens are typically more connected to peers and not as willing to rely on or listen to parents or other adult figures (Bergen, 2007). Addionally, pre-teens and teens often over-estimate their sense of self-sufficiency and abilities which could further impact the treatment and healing process (McWhirter, McWhirter, McWhirter & McWhirter, 2013).

2. Time

Time is the second of the ten inter-related factors that can help clinicians to assess a child's experience of trauma. Clinicians working with children who have suffered from trauma must consider how much time has passed since the trauma-causing incident occurred and how much time went by before help was sought. Crisis theory (Dass-Bailsford, 2007) informs clinicians that there may be differences in clients' reactions during the acute phase (immediately following the trauma), the recoil or reorganization phase (typically weeks or months following a trauma), and the re-constitutive phase (as the client begins to make meaning of the trauma and be able to move forward). While this model was based on adults' experience of trauma, it may also hold up for children but with some caveats. When working with non-adult clients, it is essential to remember that time is experienced very differently by children of different ages (a few days can seem like an eternity to a small child while "last summer" can seem like yesterday to a slightly older child). Research on adults who have experienced trauma indicates that if the adult client is still in crisis, the client may present with multiple and significant symptoms including crisis and disorganization, and the therapist must typically first address tasks of safety (e.g., Frazier & Burnett, 1994; Herman, 1997). In contrast, child clients are not as likely to experience such distinct and separate phases of symptomology in the days, weeks, and months following a significant trauma (e.g., Kempe & Kempe, 1984; Wachtel, 1994); but rather, children may experience patterns of behavior that are tied not only to the experience of trauma, but also to their developmental stage and their home situation (Moroz, 2005). For example, children who have recently experienced child abuse may begin experiencing immediate behavioral disruptions (e.g., anxiety, sleeplessness, nightmares, high activity levels, or increased aggressiveness) which can cause them to be referred for therapy or counseling. Children who were abused earlier in childhood but are referred for counseling or therapy later may also have additional post-trauma symptoms like academic failure, substance abuse, difficulty in interpersonal relationships and forming friendships, and challenging authority (Moroz, 2005).Additionally, because children are not capable of taking care of themselves independently, their level of crisis and disorganization is often related to the level of crisis and disorganization seen in their care givers and in their immediate living situation (which is also controlled by adults).

It is impossible to predict how any one child may clinically respond following a devastating single-incident trauma (e.g., car accident or flood) as compared to repeated trauma (e.g., years of child abuse; Kempe & Kempe, 1984; McCloskey & Walker, 2000; Seinfeld, 1989); however, because children's sense of time is so different than that of adults, and because childhood development changes so rapidly, it is essential to assess the length of time that the child experienced the trauma-causing situation or environment.

Was the trauma a one-time incident or was it prolonged? Recent research on prolonged and repeated exposure to trauma in adulthood (such as multiple deployments to war) suggests that repeated and prolonged exposure to traumatic events causes differing patterns of client behaviors or symptoms in adulthood (Hoge, 2010: McCloskey & Walker, 2000; Foa, et al. 1999; Gleser, Green, & Winget, 1981; van der Kolk, 1988; Puller, 2000). In childhood, a growing body of research has demonstrated early exposure to traumatic events can cause significant and long-lasting differences in cognitive development and functioning (Perry, 2000; Nutt & Malizia, 2004; U.S. Department of Health & Human Services [USDHHS], 2009). A long gap between the trauma and seeking treatment can potentially assist in predicting treatment options as coping mechanisms (e.g., chronic hyper arousal, attempts to self-soothe, etc.) are typically more habituated and harder to resolve over time (Frederick & Goddard, 2007). This body of research potentially suggests that differing interventions would likely be more effective for children who experienced trauma in early childhood or who have a history of repeated trauma throughout childhood (e.g., there may be a necessity to address cognitive deficits or delayed cognitive development in addition to other mental health needs). If help was not sought in the immediate aftermath of a trauma, this may also increase the chances that the client has internalized some degree of self-blame, guilt, or shame regarding the trauma (Foa, et al. 1999). In regards to children who have experienced trauma, this lag in seeking treatment may indicate that the caregivers could be overwhelmed or unable to fully recognize or address the child's needs. Additionally, children who have experienced multiple traumas or on-going abuse over a longer period of time will typically need a more complex and layered approach to address the gamut of mental health needs that might arise. From a systemic perspective, these children would likely require additional parental/caregiver education and support to ensure a greater chance of success of treatment over time (e.g., Lewis, Beaver, Gossett, & Phillips, 1976).

Another aspect of how the concept of time can potentially impact a client's experience of trauma and potentially inform intervention includes the question did the client have an opportunity to heal physiologically or psychologically since the trauma. While the answer to this question speaks to how much time has passed since the trauma, it also encourages the therapist to consider the child's environment since the trauma (this will be more fully discussed in the section on support below). Within a supportive and loving environment, children can be surprisingly resilient and may be able to self-correct from a variety of traumatic events or experiences (Landreth, 2002). Finally, time should be considered in terms of how long the treatment recommendations might take. Children are at the mercy of parents or caregivers to follow up on all counseling referral and treatment options. Therefore, when considering treatment options that are lengthy or more challenging to those who facilitate getting and keeping the child in treatment (e.g., costs, transportation, parking, juggling work commitments with appointment demands, etc.), it is essential to balance the parents' needs with those of the child so that the child is kept in treatment long enough to facilitate the therapeutic process.

3. Support Structures

Because children are not fully independent beings and typically do not hold full legal or social status for seeking or refusing mental health care, they must be considered within the larger families, communities, or support systems in which they live. Parents, family systems, cultural groups, or whole communities can create environments that are potentially supportive or potentially unsupportive of the healthy development of children. As described, children who have experienced trauma often have complex and on-going mental health needs – especially those who have arrested or delayed deployment or cognitive deficits or those children whose parents or families may also have been exposed to trauma. To better understand how a child's support structure may positively or negatively impact the child's experience of trauma or predict the child's ability to heal from a trauma, therapists must seek to fully understand how the child lives and interacts within his or her family, community, church, or other influential systemic structures (Lewis, et. al.,, 1976). To help clarify the child's support structures and how they may impact the child's treatment, therapists working with children who have experienced trauma should ask themselves: Is this child living in an environment/culture that is supportive of the child and the child's mental health needs? Are the child's parents actively and positively involved in seeking care and therapy for the child? If not, are other caregivers providing adequate support? What other individuals, systems, or structures might be potential positive resources for this child? What, if any, negative support structures may impede the child's positive development? Again, when addressing the needs of pre-teens or teens that have experienced trauma, it is essential for therapists to fully understand that pre-teens and teens are typically more connected to and willing to rely on peer support (Bergen, 2007). Children are not always alone in experiencing a significant trauma.

When trauma has also impacted others around the child (e.g., siblings, pets, parents, caregivers, friends, etc.) it is important for therapists to consider the wider consequences of the trauma: Are the parents or caregivers able to advocate for the child's needs or has their ability to care for the child been compromised by their own trauma experiences?   In the case of larger traumatic events that can potentially impact an entire family, community, or nation (e.g., war, famine, or natural disaster), the consequences to the child's support structure can be even more devastating. One of the best predictors for secondary trauma in children is parental exposure to significant trauma (Ancharoff, Munroe, & Fisher, 1988). Surviving traumas that encompass an entire family or larger group can significantly impact a child's sense of hope but at the same time, a trauma that impacts the larger community or nation (e.g., war) may provide a sense of community or cohesion for individuals (similar to Yalom's therapeutic factor of universality [Yalom & Leszcz, 2005]).   Rebuilding support services in the larger community may take longer when the traumatic event is more widespread which can have a greater impact on young children who may be forced to spend a significant portion of their childhood living in chaos (Lubit & Eth, 2003).

4. Relational Issues

A fourth factor to aid in understanding how children experience trauma is the construct of relational issues which includes the child's relationship to the offender (if there was one), to other victims (if they exist), and/or the child's relationship to the trauma causing agent (for example, a house fire is experienced differently by a child who started the fire compared to a fire caused by lightening).   To understand and assess potential relational issues that could impact the child's experience of the trauma and healing trajectory, the therapist would want to consider the following types of questions: Was there an identifiable perpetrator or offender in this trauma? If so, what was the child's relationship to the perpetrator prior to the trauma? How well did the child know this person? Was the offender a family member or caregiver or a distant neighbor? Does the child still have contact with the perpetrator since the trauma? Were there any other children or adults or animals/pets that were also affected by the trauma? How does the child know about who else may have been hurt or traumatized (e.g., was the child forced to watch others being hurt or has the child been watching television news reports)? What level of current contact does the child have to others who also suffered from this trauma?

Research indicates that most individuals will respond differently to trauma that is inflicted interpersonally (e.g., physical violence or sexual abuse) as compared to trauma that is less personalized such as a natural disaster or other trauma-causing event (Brown, 1996; Moroz, 2005).   Younger children, who because of their developmental status, generally process all new information from a physical perspective, may experience traumatizing incidents physically, but when there is an added relational component (trauma causing incidents with an identified perpetrator or responsible party), children may also experience the trauma from a relational perspective.   Some forms of traumatizing events can cross this interpersonal boundary concept where the incident is not necessarily relationally inflicted, but also has a relational component (e.g., car accidents, house fires, etc.).   These multi-faceted traumascan create complex responses that are more challenging to address clinically (Landeghem & Hess, 2005).   Because children's sense of personhood and self-esteem are fragile and continue to develop throughout childhood, children are more vulnerable to potential damage caused by traumatic interpersonal relationships (Bagley & King, 1990). Therefore, negative or traumatic interactions with individuals who are expected to treat the child with love and kindness (such as a parent, caregiver, or family member) can have devastating and long-term impacts on children's mental health and wellbeing (e.g., Kempe & Kempe, 1984).   These children are more likely to experience relational problems such as excessive dependence, isolation, or disrupted attachment (Moroz, 2005). Additionally, children who witness trauma to pets or peers may experience isolation, added challenges in building trust, hopelessness; and may internalize the view that the world is not a safe place (van der Kolk, McFarlane & Weisaeth, 1996).   Children who witness violence in person may experience trauma very differently than those who watch it on television (e.g., (Risser & Schewe, 2013; Lubit & Eth, 2003).   Finally, children who experience on-going exposure to an individual who inflicts trauma may not be afforded the opportunity to heal without re-victimization or re-traumatization (Bagley & King, 1990).

5. Perception or Threat of Danger

The fifth of the ten factors offered to help mental health practitioners better conceptualize how children experience and internalize trauma is the perception or threat of danger. Socratic questions to consider in this area include such issues as: How was the child threatened? And how did the child internalize or perceive this threat?

Research with adults who have been victimized by violent crimes has shown that it is nearly universal for victims of interpersonal violence to perceive the danger as life-threatening regardless of whether or not risk of death was high or imminent (e.g., Brownmiller, 1975; Benedict, 1985; Dass-Brailsford, 2007; Parrot & Bechhofer, 1991).This suggests that intense fear negatively impacts some cognitive functioning in adults. In considering the cognitive capacity of children and their inability to fully grasp the concept of death and the risk of death, up to the age of roughly ten or twelve, it stands to reason that children who are exposed to significant trauma may also experience this same high level of fear of death but not fully understand the fear or comprehend why the fear is experienced so intensely. This is likely to cause a differential pattern of behavioral responses that may not seem rational or predictable to others. When young children experience intense emotional reactions (e.g., anxiety or fear) they will often act out behaviorally because they lack the cognitive ability to fully estimate the risk, they feel they cannot control their emotional response, and they lack the verbal ability and language to effectively communicate about the experience (Finkelhohr, 1981; Crain, 1985). This behavioral response can create interpersonal issues within the family or add stress to the parents or caregivers. Older children who may have reached the developmental ability to comprehend the permanence of death still may experience an unrealistic sense of their own mortality believing that death is something that happens to others (Bergen, 2007). However, without the ability to verbalize these fears and lacking the insight to process intense feelings internally, older children and teens may turn to substance use to calm or numb these intense feelings. Pre-adolescents and teens may in their acting-out also engage in impulsive activities that can be increasingly more dangerous, thrill seeking, or risk-taking. (Slone & Friedman, 2008; Risser & Schewe, 2013).

Research has demonstrated that children who witness violence can also experience the same level of trauma and resulting symptoms as those children who are victimized (Risser & Schewe, 2013). This can include children who witness violence to others, violence to pets, and violence in the media. In trying to assess the level of exposure to violence for a child-client, one might need to determine how much time does this child have access to media? Is this exposure to media monitored by parents or caregivers? As discussed, children live within ecosystems created by their parents, caregivers, or larger community systems and as such, it is crucial for therapists to remember to consider the following questions about the perception or threat within the child's environment: How do/did others (specifically parents or caregivers) perceive the level of threat to the child and what are the expectations of this child's family, culture, or community regarding danger? For example, is there an expectation that children must be nurtured and protected or is there an expectation that children must persevere through danger in order to mature to adulthood? While there is no particular answer that can predict a child's path to healing following a trauma, if the familial culture is one that expects the child to face danger nobly or without seeking assistance, this can surely impact the trajectory of help-seeking.

6. Injuries Sustained

Whether or not injuries are sustained during a traumatic experience has been shown to impact the therapeutic trajectory for clients; therefore, understanding clients' experiences of their injuries can help the mental health therapist better select intervention strategies that support positive therapeutic trajectories (Benedict, 1985; Cross on-Tower, 1988). To better understand how injuries might impact the child client and his or her experience of the trauma, the therapist might want to first consider questions such as: Did the child sustain any physical injuries as a result of the trauma? If so, were these injuries adequately treated? And what is the healing prognosis for these injuries (within the context of the resources available to this client)? If there are no visible injuries or reports of injuries, it might still be essential to understand: Is it likely that the child suffered from any injuries that were not reported or not treated? What potential problems could these injuries or stressors possibly cause the child? Because children experience on-going physical, cognitive, and social development, injuries can significantly impede normal childhood developmental processes (Bergen, 1985; Crain, 1985). Additionally, regardless of whether physical injuries are sustained, significant trauma and the stress of a lengthy trauma can be devastating to the long-term physical health of a child and significantly impede normal development (USDHHS, 2009; Lubit& Eth, 2003). As described earlier, younger children tend to experience their worlds from a physical perspective – they focus on how something feels and whether or not an experience caused pain (Landeghem & Hess, 2005; Moroz, 2005).

However, not all physical injuries are experienced physically and some may not cause pain but they may still create devastating long-term complications for the child's overall well-being. For example, trauma in childhood can impact later developmental issues such as delayed speech, social phobia, sexual development, or fertility but these effects are not likely to be addressed initially. Additionally, injuries related to sexual trauma might not be discussed or addressed due to a social stigma or feeling of shame (Bagley & King, 1990; Crosson-Tower, 1988).

Physical injuries that are significant or noticeably impair a child's ability to progress or develop normally are most likely to be addressed by the medical and helping professionals (e.g., injuries that impede cognition, speech, mobility, hamper academic or learning skills, or obstruct the ability to make friends and/or relate to peers). However, even small injuries can impact a client's view of him or herself which can impact the overall prognosis for growth and mental health (e.g., Springle, 2008; Wood, 2006). Trauma without visible injuries may give the illusion of wellness but clients who have no visible injuries often feel an incongruence between what they are experiencing internally and what they see when they look in the mirror (Wood, 2006; Wood, 2011a; Wood, 2011b). Because of this potential for incongruence, it might be helpful for therapists to understand: How are the client's injuries or lack of injuries potentially perceived by the client? By others? By parents? By the community? And how might these perceptions help or hurt the client's ability to move forward and heal?

7. Coping Mechanisms

Regardless of their age or developmental status, when individuals are faced with a crisis or trauma that is beyond their expectations, they rely on coping mechanisms to survive, adapt to, or overcome the situation (e.g., Frazier & Burnett, 1994; McCombie, 1986; Parrot & Bechhofer, 1991). For every action taken or not taken, there are generally both positive and negative consequences for the client. Understanding clients' coping mechanisms immediately prior to, during, and following a significant trauma can help therapists better predict what types of interventions may be helpful in moving the client towards health and healing. Understanding the client's choice of coping style without passing judgment on how this has been positive or negative for the client can help the therapist to better understand the client's preferred style of interacting and managing stress and may help determine the best treatment plan in the future. Research has shown that coping strategies during a crisis can generally be categorized into the following broad domains (e.g., McCombie, 1986): (1) cognitive responses (e.g., assessing the situation for possible alternatives or escape, weighing the potential outcomes of variable behavioral options, focusing on life situations before the crisis or what life will be like after the trauma, etc.); (2) verbal responses (e.g., involuntary verbal responses such as screaming, talking or self-talking, or engaging in other verbal strategies such as stalling for time, reasoning or bargaining); (3) behavioral responses (e.g., fighting, attempting to escape, involuntary physical responses such as vomiting or passing out, etc.); and (4) no response (e.g., physical, cognitive, or verbal paralysis). After the trauma has subsided, individuals often shift their focus from survival to meaning-making thus changing the focus of the mechanisms they rely on to cope (e.g., Parrot & Bechhofer, 1991; Ledray, 1994). At this point, individuals may rely on additional coping strategies or mechanisms in an attempt to understand the trauma and how it has impacted their life and their understanding of the post-trauma world in which they now live (e.g., McCombie, 1986). Some of the more common post-trauma strategies include: explanation (finding reasons to understand the trauma and why it occurred); minimization (downplaying aspects of the fear or danger experienced); suppression (avoiding thinking about the trauma or resulting difficulties caused by the traumatic experience); or dramatization (repeatedly processing the event, or making dramatic changes in their lives in an attempt to exercise control over their post-trauma lives; McCombie, 1986).

Socratic questions to consider in conceptualizing a child's coping mechanisms might include: What coping strategies did the child rely on just before, during, and after the trauma? How successful where these strategies? How does the child feel about the coping mechanisms he or she relied on now? How do the parents or caregivers feel about these coping mechanisms? What have been the positive and negative consequences of the client using these coping strategies? Based on children's developmental status, their trauma-coping strategies are more likely to be behavioral than verbal or cognitive and their ability to internally process their thoughts and feelings about the coping strategies they used may be limited due to their abstract cognitive limitations.

However, children's sense of self-esteem or self-worth may still suffer if they perceive they should have reacted differently to the trauma or if they receive negative feedback about their coping strategies from peers, parents, or caregivers (Dass-Brailsford, 2007; Frazier & Burnett, 1994). Common behavioral responses to trauma for children may include acting out, negative attention-seeking from adults or care-givers (White&Allers, 1994; Kottman, 2011); repetitive play (which has been likened to repetitive verbal processing of emotional issues in adults), traumatic play (e.g., Fromberg & Bergen, 2006; James, 1997); isolation, and new or increased substance use in older children and teens (Moroz, 2005).

As many of these behavioral responses result in negative attention from adults, it may be helpful for the therapist to help parents and caregivers understand that the child's behavior is purposefully motivated (for example a child may act out in an attempt to increase emotional self-regulation [Cole & Putnam, 1992, as cited in Moroz, 2005]).

8. Previous Intervention Attempts

Understanding the therapeutic interventions that the child or the child's family have previously attempted to address the traumatic exposure may help the therapist to avoid repeating interventions that were not successful and choose a therapeutic path with a greater likelihood of success. Thus, the following questions may help therapists better conceptualize the child's experience of the trauma and his or her experience in therapy: Did the child receive any counseling, mental health, medical services immediately following the trauma? Did the child express some desire to seek help or was the intervention solely at the behest of the parent or caregiver? Was any coercion involved in the intervention process? (for example, was the therapy forced on the child? or, was there a forced hospitalization or police action that may influence how the child views helpers now?). If coercion was used, who was responsible?(parents? the court system? the school?).What specifically was already attempted to resolve the child's symptoms or behaviors? How successful were these attempts? How did the child respond to these pervious interventions? While it is generally assumed that play-based and strength-based interventions will be successful with younger children who have experienced trauma (Ray, Bratton, Rhine & Jones, 2001; Ginsburg, 2011; Henderson & Thompson, 2011), other interventions or family-based play interventions may also need to be considered (Figley, 1988; Gil, 1994).

9. Extenuating Circumstances

There are often extenuating circumstances that influence how a child will respond to a traumatic event and to subsequent attempts to resolve related issues or problems. The following questions may assist the therapist to discover potential extenuating circumstances that could be influencing the child's experience of trauma: Does the child have a known or suspected history of previous exposure to violence, abuse, victimization, or trauma? Did the child have any pre-existing medical or mental health issues that were exacerbated by the trauma? Did the child's primary caregiver have any problems that were exacerbated by the trauma? Is there any situational complication that will impede the child's opportunity for growth and positive development? (for example, is the child living in extreme poverty or a war-torn region?). Are there any known or suspected details of the trauma that may make it more challenging for the child to overcome? (for example, was there a sexual component or other shame-based aspect of the trauma? Was the child in any way responsible for the trauma?etc.). Finally, was there a component to the trauma that may not be initially apparent to helpers or caregivers? (For example, did social media or technology play a role in the trauma?). Newer research in the area of multiple or repeated trauma suggests additional complications in addressing issues related to multiple or layered trauma (Sontag & Alvarez, 2008; Willerton, Wadsworth & Riggs, 2011; McCloskey & Walker, 2000).   It is essential that a therapist understand that any child, even a very young child, could have already experienced multiple traumas or been significantly influenced by a parent who has an extensive trauma history (Ancharoff, Munroe, & Fisher, 1998; van der Kolk, 1988). A family history of medical or mental health issues may also impact the child's trajectory for healing and wellness (Wachtel, 1994). As described, other extenuating circumstances that the therapist might need to consider include such events as a child assuming responsibility for the trauma (e.g., a house fire or car accident), a child being ashamed or fearful to reveal aspects of the trauma (e.g., being sexually assaulted [Ledray, 1994] or bullied); or a parent not being able to fully comprehend the child's experience of trauma based on generational or lifestyle differences (e.g., trauma that can be inflicted or reinforced via social media).

10. Legal or Financial Issues

The final of the ten factors or inter-related constructs that potentially influence the child's experience of trauma is the area of legal or financial issues. As the world has become increasingly legalistic it is essential for therapists to consider the potential legal issues that can influence a child's ability to flourish and heal following a traumatic event or exposure to trauma. Questions the therapist might want to contemplate include: If there was an identifiable perpetrator in this trauma, was this person apprehended? If so, will there be a trial? Will the child be expected to testify? Are they any other legal issues related to the trauma? (Such as divorce or custody hearings that could follow a family-based child sexual abuse case).The child could also be asked to testify in legal proceedings if he or she witnessed any aspects of the trauma (e.g., war crimes). It might be prudent to consider if the child (or his or her family members) had any role in the trauma (e.g., setting a fire, causing an accident, etc.). Are any charges pending for this child? For the caregivers or parents? (This could certainly impact the child's therapeutic healing process).

Finally, financial issues must be considered as they relate to the child's trauma experience and the child's ability to seek appropriate services to ameliorate trauma-related issues. To fully understand a child's experience of trauma and anticipate how to possibly best help this child, the therapist must fully understand the cost of the trauma to the child and his or her family. What resources were lost due to the traumatic event? What is the likelihood that these resources can be replenished (or are they permanently lost)? What resources have already been lost or promised because of this trauma? What resources does this child or family have to devote to the therapeutic process? Are these resources sufficient to address long-term needs that will likely arise? What sources of help might be available to this child if there are not sufficient resources to complete the therapy needed? The answers to some of these questions may test the professionalism and resolve of the therapist as they speak to the possible need to refer a child to other services that may or may not be available, discontinue services before the child is healed, or seek alternative funding to address the child's mental health needs.

Summary

This article proposed a model of 10-factors or constructs that potentially impact children's experiences of trauma. These ten inter-related factors were described as: age or developmental status, time, support structures, relational issues (such as relationship to the offender or trauma causing agent), perception or threat of danger, injuries sustained, coping mechanisms, previous intervention attempts, extenuating circumstances, and legal or financial issues. A series of thought-provoking questions was offered for each of these constructs to assist therapists in beginning an internal quasi-Socratic dialogue to better conceptualize how the differences in each of these inter-related factors could determine how a child may internalize trauma (Carey & Mullan, 2004). The answers to these questions may or may not be easily ascertained by the therapist, but were offered to provide an on-going internal dialog for the therapist to contemplate in trying to comprehend the complexity of the trauma and its impact on the child.

References

Ancharoff, M. R., Munroe, J. F., & Fisher, L.M. (1998). The legacy of combat trauma. International handbook of multigenerational legacies of trauma. NY: Plenum.

Bagley, C.& King, K.(1990). Child sexual abuse: The search for healing. New York: Routledge.

Baroody, A. N. (2011). Spirituality and trauma during a time of war: A systemic approach to pastoral care and counseling. In Everson, R. B.,&Figley, C. R. (eds). Families under fire. Systemic therapy with military families. New York: Routledge. pp. 165-190.

Benedict, H.R. (1985). Recovery. How to survive sexual assault for women, men, teenagers, and their families. (Rev. ed.). New York: Columbia Press.

Bergen, D. (2007). Human development: Traditional and contemporary theories. NJ: Pearson.

Brown, D. (1996). Counseling victims of violence who develop post traumatic disorder. Elementary school guidance & counseling, 30, 218-224.

Brownmiller, S. (1975). Against our will. Men, women, and rape. New York: Columbine.

Carey, T.A., &, Mullan, R.J. (2004). What is Socratic questioning?,Psychotherapy: Theory, Research, Practice, Training, 41: 217-226.

Crain, W. C. (1985). Theories of development. Concepts and applications (2nded.). NJ: Prentice Hall.

Crosson-Tower, C. (1988). Secret scars: A guide for survivors of child sexual abuse. New York: Penguin.

Dass-Brailsford, P. (2007). Apractical approach to trauma: Empowering interventions. Thousand Oaks: CA: Sage.

Figley, C. R. (1988). A five-phase treatment of post-traumatic stress disorder in families. Journal of Traumatic Stress, 1
          (1), 127–141

Finkelhohr, D. (1981). Sexually victimized children. New York: Free Press.

Foa, E.B., Davidson, J.R., Frances, A., & Ross, M.A. (1999). Expert consensus treatment guidelines for posttraumatic
          stress disorder: A guide for patients and families. Journal of clinical psychiatry, 60,   69-96. Retrieved April
          5, 2011, from Expert Consensus Guidelines webn site: http://www.psychguides.com/ptsdhe.pdf

Frazier, P. A., & Burnett, J. W. (1994). Immediate coping strategies among rape victims.   Journal of counseling and
          development, 72, 633-639.

Frederick, J., & Goddard, C. (2007). Exploring the relationship between poverty, childhood adversity and child abuse
          from the perspective of adulthood. Child abuse review.,16: 323–341.

Fromberg, D. P., & Bergen, D. (Eds.). (2006). Play from birth to twelve: Contexts, perspectives, and meanings.
          New York: Rutledge.

Gil, E. (1994). Play in family therapy. New York: Guilford.

Ginsburg, K.R. (2011). (2nd ed.). Building resiliency in children and teens. Elk Grove, IL: Academy of Pediatrics.

Gleser, G. C., Green, B. L., &Winget, C. (1981). Prolonged psychological effects of disaster: A study of Buffalo Creek.
          New York: Academic Press.

Hall, L. K. (2008). Counseling military families. What mental health professionals need to know.Routledge: NY.

Halsan, A. (2013, Feb. 26) Being bullied can cause trauma symptoms (Gooderham, R.E., trans.). University of
          Stavanger Research News.   http://www.uis.no/research-phd-education/research-news/being-bullied-can-
          cause-trauma-symptoms-article62673-10738.html

Henderson, D.A., & Thompson, C. L. (2011) Counseling children.8thed. New York: Brooks/Cole.

Herman, J. (1997). Trauma and recovery. New York: Basic Books

Hoge, C. W. (2010). Once a warrior always a warrior. Guilford, CN: GPP Life.

Horowitz L, Kassam-Adams N, & Bergstein J. (2001). Mental health aspects of emergency medical services for
          children: Summary of a consensus conference. Journal of Pediatric Psychology vol 26: 491-502.

James, O. O., (1997). Play therapy. A comprehensive guide. Northvale, NJ: Jason Aronson.

Kempe, R.S.&Kempe, C. H. (1984).The common secret: Sexual abuse of children and adolescents. New York:
          Freeman.

Kottman, T. (2011). Play therapy and beyond. (2nd ed.). Alexandria, VA: American Counseling Association.

Landeghem, K. & Hess, C. (2005). Children's Mental Health: An Overview and Key
          Considerations for Health System Stakeholders.   Washington, DC: National Institute for Health Care
          Management Research and Educational Foundation.

Landreth, G. L. (2002). Play therapy: The art of the relationship (2nded.). NY: Routledge.

Ledray, L. E. (1994). Recovering from rape. (2nded.). New York: Henry Holt.

Lewis, J. M., Beaver, W. R., Gossett, J. T., & Phillips, V. A. (1976). No single thread: Psychological health in family
          systems. New York: Brunner/Mazel.

Lubit, R, and Eth, S. (2003). Children, disasters, and the September 11th World Trade Center attack. In Ursano, R.
          and Norwood, A.(Eds.), Trauma and Disaster Responses and Management. Washington, DC: American
          Psychiatric Press.

Malchiodi, C. (2014). Creative arts therapy approaches to attachment issues. In Malchiodi, C., & Crenshaw, D.,
          (Eds.). Creative arts and play therapy for attachment problems. New York: Guilford Press.

McCloskey, L.A., & Walker, M. (2000). Posttraumatic Stress in Children Exposed to Family Violence and Single-
          Event Trauma. Journal of the American Academy of Child & Adolescent Psychiatry, (39)1, 108-115.

McCombie, S. L. (Ed.). (1986). The rape crisis intervention handbook: A guide for victim care. New York: Plenum
          Press.

McWhirter, J. J., McWhirter, B. T., McWhirter, E. H., McWhirter, R. J. (2013). At risk youth. A comprehensive
          response for counselors, teachers, psychologists, and human service professionals (5thed.). NY: Cengage.

Moroz, K. J., (2005). The effects of psychological trauma on children and adolescents. Report prepared for the
          Vermont Agency of Human Services, Department of Health, Division of Mental Health, Child Adolescent,
          and Family Unit. Available from www.mentalhealth.vermont.gov

Nutt, D. J. &Malizia, A. L. (2004). Structural and functional brain changes in posttraumatic stress disorder. Journal of Clinical Psychiatry, 65, 11-17.

Parrot, A., & Bechhofer, L. (Eds.). (1991). Acquaintance rape: The hidden crime. New York: Wiley.

Perry, B.D. (2000).   **Traumatized children: How childhood trauma influences brain development.**The Journal of the California Alliance for the Mentally Ill, 11:1, 48-51.

Puller, L.B., Jr. (2000). Fortunate son: The healing of a Vietnam vet. Reprinted in paperback by Grove Press.

Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. International journal of play therapy, 10(1), 85-108.

Risser, H.J., &Schewe, P. A. (2013). Predictors of treatment engagement for young children exposed to violence. Journal of aggression, maltreatment, & trauma, 22, 87-108.

Seinfeld, J. (1989). Therapy with a severely abused child: An object-relations perspective. The clinical social work journal, 17, 40-49.

Shallcross, L. (2010). Treating trauma. Counseling today, 52(10), 26-31.

Slone, L. B., & Friedman, M. J. (2008). After the war zone. A practical guide for returning troops and their families. Philadelphia, PA: Perseus Press.

Springle, C. (2008). "Painting a moving train…" Preparing community providers to serve returning warriors. Retrieved on July 17, 2011 from http://www.usmc-mccs.org/cosc/conference/documents/Presentations/Wednesday%2013%20Aug/Track%20C/1300%201%20Springle%20-%2008COSCPAMTpresentation.pdf

Sontag, D. & Alvarez, L. (January 13, 2008). Across America, deadly echoes of foreign battles. New York Times. Retrieved on July 15, 2011 from http://www.nytimes.com/2008/01/13/us/13vets.html

U.S. Department of Health and Human Services (2009). Understanding the effects of maltreatment on brain development. www.childwelfare.gov/pubs/issue_briefs/brain_development/

van der kolk, B.A., McFarlane, A.C., &Weisaeth, L. (Eds.). (1996). Traumatic stress. NY: Guildford.

van der Kolk, B. A. (1988). The trauma spectrum: The interaction of biological and social events in the genesis of the trauma response. Journal of Traumatic Stress, 1(3), 273–290.

Van Velsor, P. (2004). Revisiting basic counseling skills with children. Journal of Counseling and Development, 82, 313-318.

Vernon, A. (2009). Counseling children and adolescents (4thed.). Denver, CO: Love Publishing.

Wachtel, E. F. (1994). Treating troubled children and their families. New York: Guilford Press.

White, J. &Allers, C. T. (1994). Play therapy with abused children: A review of the literature. Journal of Counseling and Development, 72, pp. 390-394.

Willerton, E., Wadsworth, S., & Riggs, D. (2011). Introduction: Military families under stress: What we know and what we need to know. In Wadsworth, S., & Riggs, D. (Eds.). Risk and resiliency in U.S. military families. New York: Springer.

Wood, D. (2011a, October 13). Beyond the battlefield: Military turning to wounded vets' families as a key part of healing process. Huffington Post. Retrieved from http://www.huffingtonpost.com/2011/10/13/beyond-the-battlefield-4-families_n_1000532.html

Wood, D. (2011b). Beyond the battlefield: The war goes on for the severely wounded.Amazon e-book.

Wood, T. (2006). What was asked of us. An oral history of the Iraq war by the soldiers who fought it. New York: Little, Brown and Company.

Yalom, I. D. &Leszcz, M (2005). The theory and practice of group psychotherapy (5thed.). New York: Basic Books.