# Do we need Trauma-Related Pedagogy?

**Or is it just a new hype?**

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- Approximately 60-80% of UK and US children are traumatized or neglected (Meltzer et al 2002, Burns et al., 2004).
- Stable number of in-patients in Austria and Germany - over 25,000 annually in Germany – it is about 70 a day! This is in spite of all Deinstitutionalizations efforts
- Psychosocial stress on adolescents in residential homes is more likely to increase by expanding outpatient care (deinstitutionalization)
- SOS Children Effect Study: Average of new income children has 5 or more psychosocial stressors on Axis-V of the Multiaxial Diagnosis System.

# What do we know about Trauma in child and youth care?

## Prevalence of trauma – children in care (Jaritz et al. in press)

-> Severe accidents 5%
-> Any psychosocial trauma (basic needs or accidents)75%
-> Witness to physical or sexual violence 50%
-> Sexual abuse 15%
-> Emotional abuse 31%
-> Physical abuse 35 %
-> Neglect of basic needs 31 %

**For youth welfare clients there are usually several reasons and causes of traumatization! Multitraumatization is the regular case in youth welfare. Multitraumatization means that between the traumatizing events there was no time for healing. It potentiates the danger and complicates the work with the clients.**

# What do we know about Trauma in child and youth care?

- **At least 75% of children and adolescents in residential youth services experienced traumatic events. Many of these children and adolescents are traumatized multiple times!**
  **The workforce of the residential youth welfare service is aware about this situation:**
  • But do they have a special educational training for this extremely traumatized children or are there specific pedagogical concepts for these mentally high-burdened, very challenging children and adolescents?

# The lesson is clear

Fischer and Riedesser define trauma in their textbook on psychotraumatology (München, 1998, p. 79) as:

**"[...] a vital discrepancy experience between threatening situational factors and individual coping possibilities, which is accompanied by feelings of helplessness and unprotected abandonment and so it causes a permanent shock of self-understanding and understanding of the world. "**

The medical classification system ICD 10 and its associated diagnostic guidbooke describe trauma criteria as:

**"[...] a distressing event or situation of shorter or longer duration, with exceptional threat or catastrophic severity that would cause profound despair in almost everyone (e.g. Natural catastrophe or humanly caused grave disaster - man-made disaster - combat mission, serious accident, observation of the violent death of others or victims of torture, terrorism, rape or other crimes)**

# Trauma and Society

## Risk factors for PTDS - Post Traumatic Stress Disorder

- previous traumas (for example, childhood abuse in advance),
- a young age at the time of trauma,
- low level of education (also from the parents)
- gender.

**However, these factors contribute to a much lower extent to a later PTDS than the event factors and the influencing factors after the actual traumatization.**

But the trauma is not the problem. Traumas are commonplace. The risk of trauma and the severity of the disease depend on several factors:

- The heavier the stressful the traumatic situation was (eg extent of damage or number of deaths), the more the probability of developing a trauma disorder increases.
- Probability is greater in prolonged and repeated traumatic events (for example, repeated sexual attacks within the family) than experience of a single trauma (for example, rail accident).
- Trauma caused by a rather short and one-time event is referred to as **Type I** trauma, and prolonged and recurrent trauma is referred to as **Type II** trauma.
- Furthermore, a trauma caused by humans (for example, rape, torture) is worse than a trauma that had unfortunate causes (for example, natural disaster, car accident).

The risk of PTSD and the severity of the disease depend on several factors: Event factors:

For the consequences of the traumatizing event, not only the external (objective) intensity of the event experienced, also the internal (subjective) perception is important.
With regard to age, there is a U-shaped course. Very young people and older people are more likely to get ill. In middle age, the likelihood is lowest.

# The risk of PTSD and the severity of the disease depend on several factors: Personal factors

**- The response of the individual during the traumatic event or immediately thereafter only to a limited extent predicts the severity of the traumatic disorders.**
**For example, while a person was able to maintain a low sense of autonomy during a rape or torture, the symptoms were less pronounced than in a control group whose members have given themselves up.**
**- If the dissociation (derealization and depersonalization phenomena) occurs during the traumatizing event, the probability of developing PTDS increases, on the other hand survival chances are also increased.**

The risk of PTSD and the severity of the disease depend on several factors: Initial reaction

- Support from the social environment and recognition as victims can have a positive influence on the course of post-traumatic events Exercise stress disorder.
- Similarly, it is helpful if the traumatized have a possibility of interpersonal embedding and can communicate about the experience (disclosure).
- The sense of coherence is a psychic construct developed by Aaron Antonovsky (1987). This is the ability to mentally classify, understand and give meaning to the traumatic event. Reports from concentration camp survivors indicate that such an active mindset was helpful in coping.

The risk of PTSD and the severity of the disease depend on several factors: Health-promoting factors (resources)

# Types of Trauma (Terr, 1991)

## Typ – I - Trauma

Single, unexpected traumatic experience of short duration. e.g. Traffic accidents, victims / witness of acts of violence, rape in adulthood, natural disasters.

## Symptoms:

- Mostly clear and very vivid memories
- Full picture of PTSD
- Rather good treatment prognosis

## Typ – II - Trauma

Series of interrelated events or long-lasting, repetitive traumatic experiences. For example, Physical sexual abuse in childhood, persistent interpersonal violence experiences

## Symptoms:

Only diffuse memories, strong dissociation tendency, attachment disorders

-> Harder to treat

- **Typical main symptoms after traumatization:**
  - Intrusive experiences, in their extreme form, the flashbacks, which - triggered by certain key stimuli - recall the memory of the past trauma.
  - Avoidance (Avoidance of thoughts and feelings that might be reminiscent of the trauma, avoidance of the trauma or no longer go out of the house, avoiding painful memories through dissociation or through partial amnesia)
  - Hyperarousal (increased anger, difficulty concentrating, increased alertness to danger-stimuli, easy frightfulness) Even though traumatized persons are constantly restless and aghast, externally a strongly controlling behaviour may appear
  - Emotional deafness (ability to rejoice, to love, or to grief is limited)
  - Mental anticipation of the worst, so as not to be surprised again. (the environment might acknowledge it as one annoying kind of persistent pessimism)

# Symptoms PTSD I

**<u>disproportionate response to external or internal influences (triggered by triggers):</u>**

- for example, panic attacks, anxiety disorders, obsessive-compulsive disorder, self-injurious behaviour, and dependency syndrome may be characteristic of trauma-related mental disorder, as well as recurring nightmares and dissociative conditions.
- "Recurring fears related with the experienced event: Key stimuli (trigger) such as similar smells, sounds, pictures, films but also anniversaries can trigger memories of the traumatic situation. These key stimuli can persist into old age. The traumatized are mainly emotionally reminded of the trauma (usually in the form of fears). For example, the sound of a New Year's Eve rocket may cause panic anxiety in a person who has witnessed a bomb attack as a child, even if the traumatic event is no longer consciously remembered.
- In many people, these symptoms recur some time after the traumatizing event ( Remission), and the traumatic experience can be integrated normally into the daily life.
- For some people, however, the mental health can not be restored by the self-healing powers even after a long time and it comes to the emergence of potentially very serious trauma-related sequelae. These may also become noticeable months or years after the traumatizing event and may be associated with altered brain activity and neuroanatomical changes.

# Symptoms PTSD II

PTDS range from a common and undefined feeling of suffering and anxiety to serious mental disorders. The scientific investigation of the origin, effects and therapeutic possibilities of traumas is one of the tasks of **Psychotraumatology**.

# PTSD I

# Emergence of Trauma Disorders:

- Due to the unpredictability of the traumatizing events, it is hardly possible to examine the emotional, cognitive and neurobiological states of the affected persons before and after the traumatization.
- Consequently, the mechanism leading to the development of trauma disorders is largely unknown.
- It is also becoming clear that traumatic disorders are the result of both physiological, psychological and social processes.
- Despite this difficulty, a number of psychiatric abnormalities and neuronal changes have been identified in several studies in traumatized individuals, and attempts have been made to develop models that can explain the development of traumatic disorders based on these findings.

## PTSD II

**-> Memory model**

During the traumatization, the massive release of neurohormones leads to a malfunction of the hippocampus formation, whose task is to collect newly arriving sensory impressions from the different sense organs and to embed them in an autobiographical overall context. Due to the traumatic condition of the malfunctioning, the spatial and temporal coverage is massively disturbed. As a result, the sensory impressions from the different sense organs are incoherently perceived by the patient as acoustic, visual, olfactory and kinaesthetic information fragments, which can not be fed into the consciousness "hippocampally" ("explicit memory") but "amygdaloidal" ("implicit memory“ – meaning memories are not putted to “one” picture they stay fragmented). When a flashback appears triggered by some key stimuli then these fragmented memory contents will be retrieved.

**-> Hormonal stress system**

PTSD patients show an increased activity of the noradrenergic stress system compared to healthy subjects. This leads to the accompanying symptoms such as insomnia, lack of concentration, over-excitement or dreadfulness.

# PTSD III – 2 explanations for PTSD

Common mental disorders after trauma include:

**1. Adjustment Disorder**

Psychological stress reactions triggered by events that do not conform to the medical definition of trauma are diagnosed as adjustment disorders. The events are more about the death of a relative or a stressful divorce. The adjustment disorder is at the borderline between a comprehensible disturbance due to a difficult life event and a patient's tendency to depression and anxiety.

**2. Acute stress response**

In an acute stress response, the symptoms immediately follow the event.

# PTDS related psychic disorders I

3. Post-traumatic stress disorder
A post-traumatic stress disorder is, if the symptoms persist over a longer period than **four weeks** and thus shows a chronic course. If symptoms persist for a **further period of eight months**, post-traumatic stress disorder can no longer be expected to spontaneously remit.

4. Complex Posttraumatic Stress Disorder
Since around 2000, multiple trauma and its broader psychic and interpersonal consequences have led to increasing acceptance of the concept of complex posttraumatic stress disorder, and these traumas often require a different therapeutic approach. As **persistent personality change** after extreme stress, a similar phenomenon has been described, which also manifests itself through multiple trauma and thereby possibly caused continuous changes in the individual and interpersonal behavioural patterns.

# PTDS related psychic disorders II

- Secondary mental disorders:
  - Trauma increases the risk of developing almost all other mental illnesses. These include: dysthymia, somatoform disorders, agoraphobia, generalized anxiety disorder, drug and substance abuse, nicotine abuse
  - Suicidality
  - Specific phobias, obsessive-compulsive disorder and eating disorders are often not considered as secondary mental disorders, but traumatization is considered to be an indirect risk factor for the emergence of one of these mental disorders.
  - For the "Borderline personality disorder it is also considered that traumatic events are significant factors.
  - “Sexual violence can lead to various disorders of human sexuality (both in the form of inhibition and exaggeration);
  - the past exposure to torture, on the other hand, is often associated with idiopathic pain.

# Further possible consequences of traumatization

- Trauma Therapy addresses patients who have been exposed to a potentially traumatic event. These should come to rest, talk to their confidants about their experience, and, if possible, contact a specialist psychotherapist or therapist. Their specialization includes a trauma therapeutic training and the experience in the respective therapy form.

**Psychotherapeutic treatment**

- Each large psychotherapeutic school has developed its own approach to the treatment of traumatic disorders, such as methods of cognitive behavioural therapy or psychoanalytic procedures.
- They are based on their school inherent ideas and on neurophysiological findings, such as that traumatized people have different psycho-dynamics and psycho-physiology than people suffering from other psychological disorders.
- However, the thesis that traumatized people show a different dynamic and physiology from other psychological disorders is not yet proven sufficiently.
- The goal of the psychotherapeutic procedures is to achieve a processing of the trauma in a good manner and the trauma-typical symptoms to limit or either control or dissolve.
- The different methods can be seen as complementing each other as multi-dimensional approaches for a multidimensional event. Helpful for integrating the various approaches is the newly gained knowledge of neurophysiological findings on traumatization.

# Traumatherapy

- Trauma – informed pedagogy (trauma of ancient Greek τραῦμα "wound", pedagogy of Greek παιδαγωγία "education, instruction") is referred to as a collective term for pedagogical approaches and methods in working with children and adolescents, especially in residential child and youth care suffering on PTDS.
- Trauma pedagogy is based on the cooperation of therapy and pedagogy and represents an overall concept, which is based on the knowledge and the findings of educational sciences, psychotraumatology, attachment theory, resilience research and trauma therapy and postulate that the knowledge about traumas and PTDS is an important part of any pedagogy
- The goal of trauma-pedagogy is the emotional and social stabilization of children and adolescents. The basis for this is the creation of a safe place with reliable and trusting relationships. Building trust and giving support to manage traumatic events plays an important role here.

# Traumatherapy is not Trauma-related (or informed) pedagogy!

Mode of action and backgrounds:

- Traumatization affects a person's entire life.
- It is not uncommon for people to develop post-traumatic stress disorder (PTSD) after traumatization.
- People with traumatic experiences tend to have decreased stress tolerance, high risk behaviour, attachment problems, problems in the regulation of emotions and impulse control issues, also other symptoms of PTSD.
- All of this leads to an immense reduction in quality of life and behaviour patterns that appear irrational and incomprehensible.
- These behaviours restrict the person and interfere with their relationships.
- Children and adolescents in residential care facilities have likely experienced a lot of traumatizing life events, so they are bringing their problems and challenging behaviours with them.

# Trauma – related Pedagogy I

- This "bringing along" provides for educational professionals an enormous challenge and burden.
- “ It is not only important to help the children and adolescents adequately in the processing of their trauma, also to counteract the overload of the care workforce.
- Trauma pedagogy serves to understand the behaviour of traumatized children and adolescents, to open new perspectives and to show new ways of acting.
- "Consequently, the trauma educational work serves to reduce feelings of helplessness and ineffectiveness among staff.
- "The children suffering from PTSD learn to understand their own behaviour and thus get the opportunity to break old patterns of behaviour and to develop alternative patterns of action.
- Consequently, trauma pedagogy acts as a relief for all those involved in the everyday life of the child affected.

# Trauma – related Pedagogy II

- Promoting self-esteem via psycho-education:
through Giving to the child explanation models for the child's behaviour and which processes in stress and trauma in the head happen, self understanding is growing and the feeling of “being something wrong” gets in the background.
- Promotion of body and sensory perception: For example, young people learn to distinguish pleasurable from unpleasant stimuli.
- "Stimulating emotion regulation:" Emotional regulation is enhanced through psychoeducation and direct learning.
"Promoting physical and mental resilience:" In this context, resilience, skills, strengths and interests are promoted.

# Trauma – related pedagogy – Techniques I

- Promotion of self-regulation: Emergency strategies, reorientation methods, relaxation methods are taught as well as knowledge and understanding of flashbacks and dissociation.
- Opportunities for social participation: Offers of active life, of retreat and as well as opportunities for participation are offered (for example, participation).
- Group Pedagogy: In group life, trauma-related aspects of group dynamics are made understandable and a targeted approach is learned.
- Bonding pedagogy: For this purpose bonding experiences are recorded as well as bonding-promoting behaviour and stabilization.
- Parent work: The parents and the entire environment of the children can be involved in the process.

# Trauma – related pedagogy – Techniques II

- The work attitude of the care giver is of enormous importance
- Trauma pedagogy builds on an appreciative and understanding attitude of the care givers.
- Trauma pedagogy focuses on the resources and resilience of children and adolescents.
- The trauma pedagogy postulates that for such an attitude the knowledge about consequences of traumatization and biographical loads are indispensable.

# Trauma – related pedagogy – Techniques III

According to the German Work Group for Trauma-pedagogy it is based on five pillars:

1. The assumption of a good reason: "To survive traumas, children and adolescents develop certain behaviours. These behaviours often have a negative impact on the care givers and other group members. Due to the strain that occurs, it may happen that the appreciation of behaviour as a necessary survival strategy is lost. Trauma pedagogy sees itself as a measure to counteract this development / attitude.
2. Appreciation: Trauma – related pedagogy aims to create a safe place where children and adolescents can develop a positive self-image. Self-esteem and self-confidence of the children and adolescents should grow through the esteem of the trauma- informed care givers. At the same time, distorted cognitions and attitudes in the process of trauma-pedagogical work are to be corrected.

# Trauma – related pedagogy – Techniques IV

3. Participation: To counteract low self-efficacy expectations and the feeling of loss of control, it is important that children and adolescents work actively on their living conditions. The experience of autonomy, competence and affiliation serves as a necessary motivation and must be taught by the trauma informed care givers.

4. Transparency: It is necessary for children and adolescents to get a sense of predictability and transparency. This is especially true in terms of their own behaviours. If children are not offered explanations and interpretations of their own behaviour, they run the risk of devaluing themselves.

5. Fun and joy: To counteract stress and feelings such as fear and shame, it is essential to create fun and joy in everyday life. Existing resources must be strengthened and new ones discovered.

# Trauma – related pedagogy – Techniques V

# Anwendungsmöglichkeiten

Traumapädagogische Arbeit bietet sich vor allem für die stationäre Kinder- und Jugendhilfe an. Traumapädagogische Weiterbildung eignet sich besonders für Sozialarbeiter/-innen, Sozialpädagoginnen und -pädagogen, Sozialbetreuer/-innen und die Führungskräfte von Sozialeinrichtungen. Außerdem können Therapeuten und Therapeutinnen, Psychiater/-innen und Psychologen und Psychologinnen, die in diesem Feld arbeiten, auch davon profitieren.

# Application of trauma informed pedagogy

- Trauma-informed pedagogical work is especially suitable for residential child and youth services.
- Trauma pedagogical training is particularly suitable for social workers, care giver, social-pedagogues and executives of social institutions.
- In addition, therapists, psychiatrists, and psychologists working in this field can also benefit from it.

# Trauma-related Pedagogy

# Thank you for your attention.
# Obrigado pela sua atenção.