Understanding Children Developmentally

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A traumatic experience for a young child can leave that child scarred for a life time. Depending on the child's age and developmental maturity, traumatic events can profoundly affect the brain, the mind, the spirit and the behavior of children. It is important for caregivers to have an understanding of children and their developmental level.

Regardless of age and phase of development of a child exposed to a traumatic event, psychological trauma can interfere with established intellectual, emotional and physiological patterns. At the most acute and intense moments, traumatized children are unable to recognize or explain their experience. Often, they do not have words to describe their emotions. They feel confused, disoriented, and terrified.

While children and adults share many of the disorganizing effects of trauma, the adult capacity to adapt, figure out defensive strategies, and call on internal resources is vastly different from what is available to our children. Moreover, the self-protective mechanisms that they acquire through normal development are especially vulnerable to traumatic disruptions. A child's experience of helpless surrender to overwhelming circumstances threatens to undermine recently attained developmental capacities. In a regressive slide, traumatized children are apt to return to earlier ways of expressing their needs, fears, conflicts, and anxieties, as well as to previously reliable ways of negotiating them. As a result, young children who have been traumatized show a wide range of symptoms. These include:

- Increased clinginess and difficulties separating from parents
- Disrupted sleep, with increased nightmares, waking and panic
- Increased worries and hyper vigilance
- Avoidance of new or previously identified sources of danger (phobias about animals, noises, monsters under the bed, etc.)
- Toileting problems and physical complaints (headaches, stomachaches, or other aches and pains with no medical cause)
- Eating problems with increased fussiness, lack of interest, or insatiability
- Increased irritability and oppositional behavior with increased aggressiveness, angry outburst, and inability to be soothed
- Emotional upset with unusual and frequent tearfulness and expressions of sadness
- Withdrawal of interest in pleasurable activities and interactions
- Dramatic changes in or inability to play; playing less creatively; repeatedly reenacting a traumatic event, such as a car crash or a fire
- Blunted emotions with no show of feeling; disconnection, as though going through the motions of regular activities
- Unusual distractibility

- Refusal to engage in previous age-appropriate behaviors (self-feeding, washing, brushing teeth, self-dressing, etc.)
- Return to more babyish speech patterns.

While all children may be vulnerable to symptoms of trauma when real dangers converge with their worst fears, it is not surprising that children whose development is already fragile may be at greatest risk for continued long-term effects after sudden overwhelming events. Parents and caregivers fail children when they do not recognize that they have been overwhelmed by trauma and need help. (Steven Marans, Ph.D 2002)

Language Used with Children in Crisis Must:

- Be clear and correct
- Be checked for understanding
- Be developmentally appropriate
- Children must be given the opportunity to explain what they believe they heard
- Be sensitively delivered

A Child's Reaction to Death/Loss/Trauma

A child's comprehension of death—its finality, causality, irreversibility

Childhood developmental stages

- Stage 1: ages 3-5 = death is a departure with the deceased existing somewhere else
- Stage 2: ages 5-9 = death is personified and can sometimes be avoided
- Stage 3: ages 9-10 = the child understands that death is inevitable and affects all people including self. Nagy (1948, 1959)

<u>Ages and What to do</u>

<u>Newborn to 1 year</u>

- Infants function in the present.
- Death to a mother or caregiver is an "absence" or "sudden change".
- Response to new faces and voices (new caregiver or caregivers) in the environment may be expressed in change in eating, sleeping patterns, crying or irritability.
- An infant may perceive grief of mother, caregiver or others as s/he responds to death of a loved one.

What to do:

- Keep routine on schedule
- Minimize unusual sounds and events near the infant. Example: crying, loud voices, large numbers of unfamiliar people.

- Do whatever is needed for things to stay as normal as can be done. Familiar toys, sounds, crib, laundry detergent smells, etc. Keep environment the child feels safe in.

Ages 10 months to 2 year range

- They have the ability to display fear, rage, love, anger, jealousy.
- They recognize adults and interact with them.
- They sense moods and emotions of those around them.
- No concept of death, but loss.
- Understand concepts of hurt. They may not understand they can hurt somebody but they understand they are being hurt.
- Loss of caregiver is significant.

What to do:

- Keep household and care routine as normal as possible.
- Keep feeding schedule and types of foods without interruption.
- Keep play time, storytelling, reading time on schedule.
- Keep nap time and bedtime hours and rituals consistent.

Ages 2 to 5 year range

- Define death for them—the body has totally stopped.
- Not a form of sleeping. The body will not wake up.
- Encourage question, participate in family discussions.
- Use many "very's" when discussing age/sickness.
- Ask the child, "What do you think?"

What to do:

- Stick to family routine.
- Provide extra comfort.
- Avoid unnecessary separations.
- Permit regressive behaviors within reason.
- Limit media exposure.
- Encourage expressions through drawings, play, storytelling, puppets, etc.
- Provide opportunities for physical comfort (rocking, favorite foods, etc.).
- Encourage communication in the family unit as well as with school, church, etc.

Up to age 6 expect:

- Repetition of story of the trauma
- Behavioral, mood, personality changes
- Specific trauma-related fears
- Regressive behaviors
- Separation anxiety
- Involvement of others in trauma play
- Magical thinking
- Somatic complaints

Ages 6 to 9

- Can conceptualize the fact of the trauma. They know the difference between fantasy and reality.
- They can experience guilt.
- Death is forever—means change—new feelings.
- If death happens to someone I know, it can happen to others I know. Can happen to me?

6 to 9 years old may

- Repeat the same questions
- Blame themselves (guilt)
- Need reassurances about the future
- Ask what happens to the body
- Pose questions related to religion, faith or cultural beliefs and practices
- Ask about the health of family members
- Show a lack of interest in school
- Show some regressive behaviors

What to do ages 6 to 9:

- Be open and honest, sensitive. They want and need to know what happened.
- Be alert to their emotional reactions.
- Find time to listen; to quietly speak with them about their fears and worries.
- Let them speak freely.
- Don't lecture.
- Be factual and comforting.
- Encourage expression through writing, drawing (write cards, draw pictures, etc.)

9 to 11 years old may

- Develop phobias
- Have good memory of the trauma
- Likely to have detailed, long term memory
- Factual accurate memories embellished by fears and wishes
- Conceptualize the fact of trauma and death
- Know the difference between fantasy and reality
- Can experience guilt
- Know that death is forever—means change—new feelings
- Understand that if death happens to someone I know, it can happen to others I know and it can happen to me.
- Know that death is permanent
- Grasp the significance of rituals
- Understand how death occurred
- Realize the impact of death on the family

Elementary age: What to do

- Provide extra attention and comfort.
- Set gentle but firm limits for acting out behaviors.
- Listen to the child's repetition of the story of the trauma experience.
- Encourage expressions of thoughts and feelings through conversations and activities.
- Provide home chores that are structures but not too demanding.
- Discuss and rehearse safety measures for future incidents.
- Explain how people helped each other by kind deeds or words during the experience.

Pre-adolescent: What to do:

- Be available. Spend quiet time one-on-one.
- They may want to be alone with pictures, thoughts, music.
- Explain how they will receive continued care.
- Invite them to be part of planning for the future.
- Explain that there is "no replacement."
- Do not ignore excessive anger, acting out or violent behavior.
- Likely to want to be with peers. Support as appropriate.

<u>Adolescents</u>

- They have a sense of themselves; personal values, strengths, weaknesses.
- Understanding of death is comparable to an adult but their emotional state is in constant change and turmoil.
- They think abstractly and can reason.
- May be self-conscious about their reactions.

<u>Adolescent reactions</u>

- Withdrawal, self-focusing
- Vulnerable to depression, phobias, flashbacks and triggers
- Personality changes
- Pessimistic worldview
- Trauma driven acting out behaviors
    - Sexual / recklessness / accident proneness

What to do:

- Be available. Spend quiet time one-on-one.
- They may want to be alone with pictures, thoughts, music.
- Explain how they will receive continued care.
- Invite them to be part of planning for the future.
- Explain that there is "no replacement."
- Do not ignore excessive anger, acting out or violent behavior.
- Likely to want to be with peers. Support as appropriate but monitor.
- Know where they are.
- Keep structure in lives.

Special Considerations are Necessary for:

- Medically challenged
- Physically limited
- Developmentally limited
- Communication limited
- Emotional / behavioral identified
- ADHD children
- Previously diagnosed mental or physical illness