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SOTSIAALKINDLUSTUSAMET

Toolkit of using therapy platform: Crises counselling service provision principles and protocols

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Material in English

1. Definition and prevalence of abuse

A large part of violence against children and adolescents includes at least one of the following types of interpersonal violence that children may experience: abuse, bullying, violence among adolescents, domestic violence, sexual abuse, emotional and psychological violence (WHO, 2016). In this paper we will focus on abuse in general, taking into account physical (including violent punishment), sexual and psychological/emotional abuse and neglect by parents, caregivers or other people important to a child.

Definitions of types of abuse:

- **Sexual abuse** – sexual activity or imitation thereof by an adult or adolescent toward or with a child whereby the offender uses their influence, makes threats or abuses the fact that the victim is not able to refuse.
- **Physical abuse** – all intentional behaviour which aims to cause bodily harm to a child (includes hitting, shaking, poisoning, burning, suffocating, etc.).
- **Emotional/psychological abuse** – child's psychological and mental abuse that results in serious damage to the child's emotional development.
    - For example, humiliation, criticism, the child is not allowed to express their opinion, non-age-appropriate expectations for the child, bullying, threatening, witnessing/participating in events that cause chronic negative stress, teasing, forbidding to talk to friends, parents' unavailable demeanour, and so on.
- **Neglect** – failure by people responsible for a child to satisfy the needs necessary for the child's normal age-appropriate development.
    - **Emotional neglect** – parent/caregiver intentionally or unintentionally constantly discards child's emotional needs (attention, security). Also includes failure to express caring, pushing the child away, and ignoring emotional needs.
    - **Physical neglect** – failure by parent/caregiver to provide everyday/usual care which results in a serious threat to the child's physical health (does not include poverty).

In 2017, around one billion children in the world aged 2–17 years experienced some form of abuse (WHO, 2018). About a quarter of adults have experienced physical abuse in their childhood; whereas, one out of five women and one out of thirteen men have experienced sexual abuse in their childhood (WHO, 2016).
According to the World Health Organisation (WHO, 2014), the lifelong prevalence of different forms of abuse is as follows:

- Psychological abuse – 36% of children in the whole world and 15% of children in Europe experience it at least once in their lives
- Physical abuse – 23% of children in the whole world and 12% of children in Europe
- Sexual abuse (girls) – 18% of girls in the whole world
  Sexual abuse (boys) – 8% of boys in the whole world
- Sexual abuse (girls, boys) – 9% of children in Europe
- Neglect – 16% of children in the whole world and 9% of children in Europe

If we were to take into account more specific target groups, the occurrence of abuse would be significantly higher. For example, about 3/4 of children placed in foster families have experienced neglect (American Society for the Positive Care of Children, 2019). It is also a known fact that if a child's parents have suffered abuse in their childhood or if they abuse alcohol or other substances or are associated (as a victim or offender) with other types of

violence (e.g. domestic violence), the risk of the child being exposed to abuse is higher (WHO, 2016).

3. Impacts of abuse on children and adolescents: post-traumatic psychological disorders

Childhood's traumatic experiences affect a child as a whole as well as the child's neurological, emotional and social development, resulting in short-term or long-term impairment in those areas. Depression, smoking, obesity, high-risk sexual behaviour, unintended pregnancy, alcohol and other substance abuse, being a victim of violence or perpetrating, but also a higher risk of cardiac diseases, cancer, suicide and sexually transmitted diseases are the most frequent forms of health damage resulting from abuse (WHO, 2016).

Experiencing abuse in childhood increases the risk of occurrence of various problems (WHO, 2014):

A. **Health issues** – 2.3 x greater risk of mental and neurological disorders, 1.5 x greater risk of health-damaging behaviour, 2.5 x greater use of health services;
B. **Social and behavioural problems** – 41.2 x greater risk of attachment problems, 3.5 x greater risk of poor emotional coping, 2.4 x greater risk of low satisfaction with life;
C. **Lower cognitive and academic capability** – 1.8 x greater risk of cognitive development gap, 1.3 x greater risk of academic difficulties, 1.3 x greater risk of linguistic development difficulties;
D. **Economic problems in a narrower** – 1.1 x greater risk for those who have been subjected to abuse to develop a gambling addiction in adolescence or adulthood – as well as broader sense – results in slower development of the country's economy and slower social development.

People may experience various psychological disorders after a trauma, specifically the post-traumatic stress disorder (PTSD), complex post-traumatic stress disorder (complex PTSD) and affection disorders.

Due to the limitation of this paper, this overview does not deal separately with dissociative disorders (however, a PTSD subtype with dissociative disorders is in focus), personality disorders or other psychiatric conditions which may also occur post-trauma.
Impaired reaction to trauma is based on impairment of the functioning of the central nervous system due to a traumatic event (areas of the brain that are responsible for processing and storing experiences are emotionally overloaded or in other words they function in a so-called danger mode), for which reason memories are not being processed and stored as usual. It means that information related to an event is mostly stored as situationally accessible information and verbal access to it is deficient (Brewin et al., 1996). Simply put, information is stored as experience perceived at the moment of a trauma followed by no reprocessing, which means that a threat/stress is perceived as if constant and permanent. It must be taken into account that if a trauma has occurred at an early age or if a traumatic experience has been constant, the brain activity is impaired more seriously. In any case, impaired reaction to trauma means deficient self-regulation capability and deficient or lacking working model of affection. More information about the impaired neurological development of a child after a trauma is available in Estonian in an article by Wieland and Riis published in magazine 'Social Work' in 2012.

Let's move on to psychological disorders that may develop after a trauma:

- Post-traumatic stress disorder (PTSD) – diagnosed in the world as of 1980; criteria adapted

to preschool children were developed in 2013 (DSM-5);
- Complex post-traumatic stress disorder (complex PTSD) – diagnosed in the world as of 2018 (ICD-11), no child-specific diagnostic criteria exist;
- Affection disorders (as of 2013 diagnoses used are reactive attachment disorder and disinhibited social engagement disorder, DSM-5).

Disorders are described based on the following two disorder classification systems that are most common in the world: Diagnostic and Statistical Manual of Mental Disorders (APA, 2013; abbr. DSM; as of 2013 DSM version 5) and International Classification of Diseases (WHO, 2018; abbr. ICD; as of 2018 ICD version 11).

Post-traumatic stress disorder

Until recently PTSD was diagnosed in children and adolescents under the same criteria as used for adults. DSM-5 (APA, 2013) introduced child-specific criteria. ICD (WHO, 2018) uses a single diagnosis for all age groups even in its latest version.

The first criterion for diagnosing PTSD as a disorder is experience of a traumatic situation.

More specifically it means having experienced or witnessed an accident, violence or a seriously threatening situation involving people significant to the person, and in case of children also learning about a traumatic event involving their parent/caregiver.

PTSD is characterised by the following groups of symptoms:

- re-experiencing the traumatic event or events in the present in the form of vivid intrusive recollections, flashbacks and/or nightmares typically accompanied by strong or overwhelming emotions and/or strong physical sensations;
- avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and
- persistent heightened disturbance (for example, difficulties sleeping and concentrating, an enhanced startle reaction, irritability);
- negative alterations in mood and cognitions (only in DSM-5; for example, depression, hopelessness, blame; mood changes; negative self-image; inability to recall certain parts of an event).

For a diagnosis the symptoms must persist for at least a month (according to DSM-5) or several weeks (according to ICD-11) after the event(s). The symptoms must cause significant impairment in the functioning of a child/adolescent.

DSM-5 specifies a subtype of PTSD with dissociative symptoms, in which case in addition to the described symptoms one experiences significant impairment either in the form of a sense of depersonalisation (experience of being an outside observer of or detached from oneself) or derealisation (experience of unreality, distance, or distortion).

In small children (DSM-5, criteria for diagnosing PTSD in children ages six years and younger) **the re-experiencing of the traumatic event may be expressed as recurring play on the subject of the trauma or reflecting some aspect thereof (so-called trauma play).** It must be noted that regardless of re-enacting the event, children may not be able to put the substance of the experience into words (they act out the trauma, but cannot explain why). Recurring nightmares of the traumatic event are common but small children may have terrifying dreams without clear content (not necessarily directly reminiscent of the event). A general strong psychological disturbance is typical when being exposed to stimuli reminiscent or symbolic of the traumatic event.
The avoidance symptom in small children is expressed as a general attempt to avoid activities, places or people reminding the traumatic event, resulting in a significantly decreased interest or participation in areas important to the child (limited play); social withdrawal in interaction, lower emotional capabilities (e.g. decreased attachment) and loss of/decrease in abilities/skills acquired in the course of development (e.g. self-service, use of the lavatory, speech, interaction).
The disturbance symptom in small children is often expressed as difficulties falling asleep or restless sleep; irritability or aggression that may come as extremely intense tantrums or anxiety, disturbed concentration, restlessness, hyperactivity and heightened startle reaction.
In addition, to confirm a PTSD diagnosis small children must exhibit at least one of the following symptoms: post-traumatic fear of separation; aggression; or new fears (these may, but do not necessarily, have an obvious or direct link to the trauma, for example fear of going to the bathroom alone, fear of darkness, fear of being left alone). Most often children experience symptoms from this category.

Clinical picture of PTSD in school children (ages 7–12; Liivamägi, 2011, p. 101)

- Being occupied with remembering the experienced event, feeling of reliving the event over and over again;
- Acting out the entire event or parts thereof while playing;
- Symptoms of increased anxiety, fear for the health or well-being of people close to the child, sense of shame;
- Miscellaneous physical complaints (mostly headache, stomach ache or joint pain);
- Symptoms of altered vigilance (hypervigilance);
- Difficulties sleeping (difficulties falling asleep, restless sleep, bad dreams, altered sleep rhythm);
- Disorganised/disturbing behaviour: breaking, destructive, getting into mischief; letting everything out of their system, outbursts of rage;
- Communication difficulties, difficulties gathering thoughts and lower academic achievements.

Clinical picture of PTSD in adolescents (ages 13–18; Liivamägi, 2011, p. 102)

- The PTSD symptoms are mostly the same as for adults. In some cases pleasure seeking behaviour, defiant attitude or hostility toward parents, risky or asocial behaviour may develop. Others experience greater uncertainty, timidity, hesitation, avoidance of emotional situations and more limited ability to adapt in life.
- Typical are:
    - Heightened level of anxiety, difficulties with self-regulation and assertiveness;
    - Cranky mood (dysphoria) or depression (especially in case of sexual abuse);
    - Feelings of guilt, rage, fear and disappointment;
    - Fear for the future or sense of no prospects;
    - Tendency to overreact or underreact in various situations, risk behaviour is often manifested. From the behavioural aspect adolescents may show their disappointment by acting aggressive toward others or themselves (self-inflicted injuries, and threats and attempts of suicide) or by sexual behaviour seeking the approval of others or use of alcohol or drugs;
    - Difficulties with attention and abstract thinking and with understanding and solving problems;
    - Difficulties dealing with their way of life, provoking conflicts at school and at home, replacing friends with 'friends' with behavioural abnormalities.

A child's/adolescent's traumatic experience affects the functioning of the family. Parents may feel as failures in ensuring the safety of their child and may therefore become overcaring of the child. Parents may be significantly upset due to what happened and may experience strong emotions (guilt, anger, shame, sadness and so on); all this affects family relationships and the general functioning (among other things, the child's chance to get support). If a traumatic event occurs within a family (for example, abuse by a parent), this adds confusion, fear, guilt and other different emotions in connection with solving the situation.

In conclusion, **PTSD in children and adolescents manifests as follows:**

- **Attachment** – problems with relationships, boundaries, empathy, social discard
- **Physical health** – somatic complaints, inhibited sensorimotor development, coordination problems, medical issues
- **Emotional regulation** – difficulties noticing and naming feelings and communicating needs
- **Dissociation** – memory problems, altered states of consciousness
- **Cognitive capability** – problems with focusing, learning, acquiring new information, learning a language, planning activities, having a sense of time and place
- **Self-image** – problems with consistent self-perception, problems with body perception, low self-esteem, guilt, shame
- **Behavioural control** – difficulties controlling impulses, aggression, disturbed eating and sleep patterns, behavioural problems, re-experiencing trauma.

Complex PTSD

As of 2018 under ICD-11 (WHO, 2018) there is an official diagnosis of **complex PTSD, which develops as a result of traumatic childhood experiences and prolonged and/or repetitive traumatic events**.
Complex PTSD develops after exposure to traumatic events characterised by extremely traumatic nature and sense of no escape.
Complex PTSD is characterised by the above symptoms of PTSD plus severe problems with:
- dealing with emotions (affect regulation);
- self-image (beliefs about oneself as diminished, defeated or worthless, accompanied by severe and persistent feelings of shame, guilt or failure related to the traumatic event); and
- persistent difficulties in sustaining relationships and in feeling close to others (for children, above all, affection problems).

Likewise PTSD, this causes significant impairment in important areas of functioning. The need to distinguish complex PTSD is justified, among others, by the need for psychotherapeutic intervention unlike for PTSD (Liivamägi, 2011, p. 115).
At present, no child-specific impairment characteristics have been officially approved and so the criteria intended for adults are used in assessing the level of impairment. In general, complex PTSD (i.e. complex trauma) in children and adolescents is understood to mean impaired attachment security; impaired affective, behavioural, biological regulation; impaired self-image and interpretations; and problematic disassociation (Cook et al., 2005).

Attachment disorders
The attachment pattern develops by the 8th or 9th month of life and it becomes a so-called working model in the functioning of subsequent relationships, which means **a typical way of reacting to the absence of an important person – safe connection, anxious-avoiding, disoriented and disorganised connection**.

The attachment pattern is characterised by reciprocity (strong mutual dependence, intense mutual feelings) and emotional connection (Maar, 2016). If in the course of development a child is exposed to abusive behaviour, including neglect, by a parent/caregiver, the attachment disorder is developed.

At present, under DSM-5 and ICD-11 problems related to the attachment disorder are presented as two different syndromes instead of the previous one syndrome – reactive attachment disorder – and these are conditions only diagnosed in children.

1. **Reactive attachment disorder** is a rare, but severe disorder which manifests in an infant or small child not developing a healthy attachment to his or her parents or caregivers. A precondition for the disorder is neglect or abuse by parents/caregivers, which essentially means that the child's basic needs for comfort, affection and nurturing are not sufficiently or appropriately satisfied by the adults caring for the child.

According to DSM-5 (APA, 2013), the disorder is characterised by:

- Development gap
- Poor self-care behaviours and habits
- Motor development gap and muscular hypertension
- Disoriented, unfocused, scattered state (for example, unfounded reserve, fear, sadness or irritability)
- Expressionless face, no glow or joy in the eyes (for example, sad and numb state, not smiling)
- Does not react to interaction as usual (for example, does not seek comfort or respond when comfort is offered; no interest in interactive games, for example, a game of hide-and-seek)

Children suffering from this disorder are not likely to engage with other people because they have had negative experiences with adults in the early stages of their lives and this has made them cautious; they have difficulties with calming themselves when something irritates them and they also do not seek comfort from people close to them. These children do not appear to have emotions or they have minimum emotions (AACAP; 2016).

Children who are raised in a children's home or other institutions; who must frequently change their place of residence (for example, children's homes) or caregivers; whose parents have mental health issues, criminal behaviour or substance abuse problems affecting their parenting; or who have been forced to be away from their parents/caregivers over a long period of time (for example, in hospital) are at greater risk of this disorder.

2. **Disinhibited social engagement disorder**

Likewise the reactive attachment disorder, a child suffering from this disorder has not developed a healthy attachment to their parents/caregivers and this is a result of neglect or other abuse.

The typical characteristics of this disorder are (DSM-5, APA, 2013):

- Reduced or absent reticence in approaching and interacting with unfamiliar adults
- Overly familiar verbal and/or physical behaviour (considering culturally sanctioned and age-appropriate boundaries), for example hugging a stranger
- Diminished or absent checking back with a parent or caregiver when in unfamiliar settings or the parent/caregiver ventures away
- Willingness to go off with an unfamiliar adult with minimal or no hesitation

Compared to children with the reactive attachment disorder these children are more emotional and social. They are often intrusive and with deficient social and physical boundaries, they are also typically seeking attention (AACAP; 2010).

Children who have been exposed to emotional neglect, who have been forced to frequently change their place of residence and caregivers so that they have not had time to form stable relationships, and who have been raised in settings that limit opportunities to form selective attachments (for example, institutions with high child-to-caregiver ratios) are at greater risk of this disorder.

4. Assessment of risk factors and post-traumatic problems

Risk factors

Certain factors (related to children, their families and the wider environment), on one hand, increase the possibility of a child becoming a victim of a traumatic event and, on the other hand, increase experiencing the post-traumatic stress disorder or other psychological problems after being exposed to a traumatic event.

According to WHO (2016, 2018)**, there are several risk factors which increase the likelihood of a child becoming a victim of abuse**. For example, age (childhood or adolescence), being raised in a family where the child was not welcome, special needs or emotional sensitivity (for example, the child cries a lot). Children and adolescents whose appearance or behaviour is different from conventional (in a group, society) (for example, distinctive physical features, homosexual orientation, altered gender identity) or who have problems with, for instance, alcohol consumption are at greater risk. Therefore, such children and adolescents are at risk of negative attention. Different features definitely result in several psychological issues – higher level of stress, low mood, self-esteem issues and other – which make children and adolescents vulnerable to abuse.

When talking about risk factors in the context of children and adolescents, one cannot overlook aspects related to their parents and families. Children whose parents have difficulties forming an attachment to them and have scarce parenting skills (including satisfying the child's needs) as well as knowledge of the development of a child or have unrealistic expectations towards the child are more likely to be exposed to a trauma.

Parents who have been exposed to trauma as a child, who abuse alcohol or other substances (especially during pregnancy) and/or who have encountered criminal or economic difficulties affect their child's risk of becoming a victim of trauma. If a child has experienced a trauma, the development of the child's post-traumatic state is affected by the extent to which the child's closest relationship environment can provide help and support. The situation is significantly aggravated for the child if the perpetrator was a person close to the child or even a confidant.
In a wider context, the probability of a child's traumatic experience is affected by the child's family members' health issues (especially mental health issues), parents' divorce or violence among family members, isolation from society or lack of supporting relationships (WHO, 2016). The same source also specifies factors that affect the probability of a child becoming a trauma victim at the community and society level. Such factors may be, for example, easy access to alcohol and drugs, social inequality, high unemployment and poverty rate, child abuse, deficient or non-existent legal framework concerning pornography, prostitution and child labour, and social and cultural standards regarding violence, including physical punishment.

Children's post-trauma reactions are affected by most of the above aspects, but also their temperament (children with so-called difficult temperament experience more post-traumatic difficulties, see the text box) and being exposed to their family members' severe anxiety or despair (especially for small children); the nature and course of the reactions of adolescents is also affected by feedback from their peers in addition to family. The risk of developing the disorder is increased by the recurrence of the same type of trauma or a chronic psychologically traumatising situation as well as earlier traumatic experiences and prior mental disorders (especially those that have gone untreated).

Text box: Temperament (Chess, Thomas, 1996)

Temperament is an innate tendency of how a child reacts to its surroundings, including other people. There are three types: easy, slow-to-warm-up and difficult babies; whereas, none of them mean that the baby is good or bad, they are just ways how a baby reacts.
~~Easy babies (about 40% of infants) adjust easily to new situations, generally display positive moods, have non-intense reactions to the surroundings, are curious about new situations, have a normal biological rhythm (eating and sleeping patterns).~~
~~Difficult babies (about 10%) exhibit heightened, often impulsive activity, hypersensitivity to sensory stimulation, lower adaptability to change, intensity in expressing emotions, irritability by external influences and stressors, negative moods and inability to self-calm, irregular biological rhythms, such as eating and sleeping patterns, easily getting tired of activities.~~
~~Slow-to-warm-up babies (about 15%) greatly coincide with difficult babies, but they are able to adapt if given the chance to do so at their own pace (i.e. they cannot take any pressure).~~

~~Read more in Estonian: Liisa Keltikangas-Järvinen 'Temperament and academic success'.~~

PTSD assessment
In the treatment of PTSD it is important to discover impairment as early as possible because the sooner treatment is started, the greater the chance of recovery and the less resources (for example, duration of psychotherapy) needed. For that purpose alone, any usual practices of psychiatric and psychological assessment in working with children and adolescents should include questions about possible exposure to trauma, even if the referral lacks any reference to trauma (AACAP, 2010). Assessment is divided in two: initial screening and psychological assessment.
Text box:

Assessment means systematic collection of information about the functioning of a person, including their emotional state, ability to cope, mental development and personality.
An assessment is conducted to understand the problems of a child and to plan psychological help.
Screening – initial screening for problems and/or symptoms (often outside the context of clinical psychology and psychiatry, for example by a social worker or family practitioner), which usually uses short and little time consuming (adapted and standardised) tests; the objective is to screen for potential children with the disorder;
Psychological assessment – diverse and thorough assessment in respect of disorder characteristics which applies various methods, such as a clinical interview (questions as to the disorder characteristics), structured or semi-structured diagnostic interview, behaviour observation, standardised psychological tests, etc.; the objective is to assess the nature and intensity of manifestation of problems and whether or not the symptoms meet the disorder criteria. Psychological assessment is conducted by a clinical psychologist.

NICE (2017) guidelines on child abuse and neglect stress that **in case of abused/neglected children the below circumstances must be considered**:

- They may not be ready to talk about their experience because they feel guilty, confused, ashamed or stigmatised; they are afraid to talk because they were threatened; they do not see the experience as abuse or they feel attachment to the perpetrator whom they do not want to let down;
- Children and adolescents often express their experiences indirectly – through their

behaviour, appearance, impairment symptoms;

- The conversation should be free of directly leading the child, that means more open-ended questions should be asked and assumptions and prejudices should be refrained from;
- If the child/adolescent opens up about abuse, it must be considered that it may have happened earlier (it may not be a recent event).

5. General principles of psychological help.

This chapter describes the general principles that trauma-focused psychotherapy for children and adolescents should follow.

Helping a person who has been exposed to trauma starts with an appropriate psychological assessment as thorough as required. Trauma-focused approach is warranted when a child or adolescent experiences symptoms characteristic of a trauma disorder and significantly impairing everyday coping which started post-trauma. It is important to consider the effect of a recurring and/or prolonged trauma.

In other cases the following is warranted: maintaining contact without therapeutic intervention (so-called careful observation, which means a meeting or contact over the phone to assess the state); psychoeducation (providing information and teaching skills) about the short-term and long-term effect of trauma and basic self-help techniques; supportive (not trauma-focused) psychotherapy or counselling to alleviate distress caused by trauma; and/or regular psychotherapy (according to identified problems or disorder).

Trauma therapy (in this context, trauma-focused psychotherapy in its general meaning despite the underlying theory or model) must be integrated into the rest of the interventions (e.g. if the child is going to psychotherapy) and networking (e.g. the case requires cooperation between various authorities) and it must involve adults important to the child (non-offending family members or caregivers) and this should be carried out by a child protection worker or, if the child protective services have not been involved, the specialist to whom the child went first. It is important to share information on the principle that it is important/helpful to every member of the network. The confidentiality and customer well-being principles must be carefully obeyed, which means sharing as much as useful/necessary to the customer and as little as possible, keeping in mind that one must be as laconic as possible when talking about the event itself. For example, when starting cooperation with a child it might be useful for the psychotherapist to know that the one who abused the child is a parent currently living with the child, but at the same time it is not necessary to provide details of what exactly the abuser did to the child; or it might be good for the child protection worker to know the current stage of the psychotherapy with the child – either stabilising or trauma-focused stage – the latter requires more resources of the child but it is unimportant to know what is being discussed in every session. In conclusion once again, it is important in networking to provide information that affects dealing with the child's traumatic experience – provides information for understanding, reflects the child's progress in therapy or refers to needs to design the child's environment to support recovery.

Trauma therapy must be available to children/adolescents/families (e.g. information on the web, from specialists, general awareness in society) and offered as a choice (i.e. child/family and adolescent must be ensured comprehensive information about the possibilities of going to psychotherapy and the chance to make their choice; they must also have the possibility to choose from among different interventions); cooperate with the family and various network members important to the child and family; the methods applied (see Chapter 6) must be standardised and validated, culturally sanctioned and development-appropriate.

Trauma-focused psychotherapy includes (irrespective of school background) educating about the effect of trauma (we inform that at the moment of experiencing trauma certain behaviours may be necessary in order to cope because they protect from excess distress, for example dissociative detachment may protect from the intensity of the traumatic event at that moment but may not support post-trauma adjustment, then it becomes avoidance that prevents the necessary process of information processing) and considers trauma-related aspects (nature, time and recurrence of event, possibility for the trauma to recur/continue).

Traumatic event processing must only be carried out when the child/family has been carefully prepared, the child/family has a support network outside therapy, and when the therapist has adequate training, competence and supervisory support. A general principle is also that trauma processing is started only after the end of the event (it means that if the trauma continues, it is recommended to first ensure security and support coping).

Trauma processing must consider the readiness of the customer to deal with the trauma. It is important for psychotherapeutic intervention not to flood the customer emotionally or sensory-wise nor be substandard, which means that successful treatment requires the nervous system to be optimally activated (working within so-called windows of tolerance, Siegel, 1999). This means that before getting to the processing in trauma therapy the person may need support and skills to calm their nervous system (e.g. breathing exercises for calming the body) or prior work to raise activation (for example, improvement of avoidance behaviour, including coping with dissociative symptoms).
Trauma therapy must be adapted to the child's/family's situation, age, gender and gender identity, cultural background, development capability, physical health and special needs as well as personal and family strengths and resources. It means that the specialist providing trauma therapy must be flexible and able to independently form psychotherapeutic treatment, which is why it is extremely important for trauma therapy to be carried out by a specialist with necessary basic education and thorough training in trauma-focused psychotherapy (see Chapter 9).

It must be kept in mind that trauma therapy must always reinforce the child's/family's resources, not spend them! The latter may happen, for example, when the therapist rushes through the stabilisation phase into the processing phase, for which the customer is not actually ready. Resources are also spent if the therapist decides to work only with the child, not involving the family. It significantly prolongs the psychotherapy and may not support the child's/family's optimum recovery. However, one must be aware that even if carried out correctly and considering the readiness of the customer in every way, dealing with trauma means strong emotions and learning to cope with them.

Psychotherapy with children/families who have experienced trauma, especially complex trauma, is based on the principle "not just trauma", meaning that dealing with trauma takes into account what is going on around the customer: trauma therapy is flexible as to time and subject and adapts to the customer's needs, containing, among other things, involvement of resources outside therapy to help cope with various security problems.

After a serious accident or catastrophe one possible intervention method is school-based assessment and therapy. A precondition, however, is that the traumatic experience must be shared (children from one or several institutions were involved in one and the same accident) and it must be easier to access them, for example to conduct screening or observe their state, on the basis of their educational institution (school or kindergarten).

Children's therapy or other treatment decisions must be based, above all, on the actual severity of their symptoms and coping regardless of whether or not they have been diagnosed with PTSD.

Involving parents in children and adolescents' trauma therapy improves the psychotherapy results. In that case it is possible to support the parents and lower their level of stress and teach them necessary skills to support their child. That way it is also possible to identify the impairment of the parents, including their own traumatic experiences either in connection with the event in question or earlier experiences that may have gone untreated. In the latter case it may prove useful to refer the parent to individual therapy.

The first recommendation in the treatment of children and adolescents with PTSD symptoms is always trauma-focused psychotherapy. Medication is secondary and only on the basis of the principle that as long as the child's symptoms can be treated with trauma-focused work, no medication is used. However, if a child is, for example, so depressed and suicidal that his or her life may be in danger, administration of antidepressants is an option. Medication is also considered in a situation where the child's support network is deficient and so the child cannot rely much on external resources. This is where medication offers the necessary support. Pharmacological intervention is not recommended for the treatment of attachment-based disorders.

Recommended therapy models in trauma work with children and adolescents.

Trauma-focused cognitive behavioural therapy (Cohen, Mannarino, Deblinger, 2006) is based on learning and cognitive theories and on the idea that the way a person feels and behaves in a situation is affected by their interpretations of the situation and them in it. The objective of trauma-focused cognitive behavioural therapy is to decrease negative emotional and behavioural reactions arising from the effect of the traumatic experience and to adjust inappropriate beliefs and interpretations in that respect for the purpose of increasing the sense of security. Another objective of the therapy is to provide support to (non-offending) parent and teach them effective ways to cope with their own excessive distress as well as deal with that of their child.

The trauma-focused cognitive behavioural therapy model is intended for children aged 3 to 18 years, it is module-based and it involves in therapy the child/adolescent who was exposed to trauma as well as their parents/caregivers.

- **Psychological education and parenting skills** – educating about trauma, typical post-traumatic reactions; normalising reactions, supporting security and normal behaviour (including healthy sexuality); creating hope, motivating for therapy, including talking about the benefits of (early) intervention; teaching parenting skills.
- **Self-regulation skills** – controlled breathing, progressive muscle relaxation, skills to express emotions, stopping and replacing thoughts, noticing, interpreting and alleviating body symptoms and other skills.
- **Emotional regulation skills** – noticing, recognising and directing feelings.
- **Cognitive coping** – determining and working through non-adaptable beliefs and interpretations (cause of event, responsibility, etc.), teaching cognitive coping skills (for example, inner speech, positive thoughts).
- **Trauma story** – creating a trauma narrative by gradual approach; includes a verbal, written and/or symbolic component (including use of dolls, toys) when narrating a story of the trauma. Creating a narrative is based on a time-frame which includes the pre-

trauma, trauma and post-trauma period.

- **Exposing/getting used to triggers *in vivo*** (in actual situation) **and in imagination** – dealing with trauma reaction triggers for the purpose of teaching the child to tell the real and imaginary (= arising from trauma memory) danger apart and rehearse it in behaviour. It is essential to stress here that one is not exposed to the traumatic experience, but to triggers. For example, if the traumatic experience is an attack at the park, one is not exposed to the experience of attack, but to being at the park because being at the park has now become a trigger of a traumatic memory.
- **Joint parent-child sessions** – parents participate in the therapy process in parallel (after every session) to the child's sessions and in joint appointments; the parent is encouraged to apply that learnt in therapy at home – to be a so-called home therapist for the child; it includes educating the parents, teaching skills to cope with symptoms, noticing the need for help and providing help to the child, and advancing communication between family members (including fun activities and playing).
- **Growth and development in the future** – one focuses on how to maintain security in the future, teaches relevant skills and raises awareness.

EMDR (Eye Movement Desensitization and Reprocessing; Shapiro, 1989; 1993; Greenwald, 1993) is an integrative therapeutic method for advancing coping with traumatic memories and PTSD symptoms – it activates and guides trauma processing, promotes trauma-related adaptive interpretations/meanings and alternative positive beliefs, coping strategies and behaviours. The method integrates the bilateral stimulation (BLS) technique with the psychodynamic, cognitive behavioural, interpersonal, experiential and somatic therapy techniques. Versions of the BLS technique include, for example, alternating eye movements, observing alternating sound and/or light signals, for children frequently alternating taps (for example, on the back of the hand).
The underlying idea of the EMDR is that due to traumatic events people's natural cognitive and neurological coping mechanisms may be overloaded and the processing in the brain of memories arising from events experienced is therefore insufficient (memory is stored in isolated memory network). The objective of the EMDR is to process traumatic memories in the framework of an eight-phase approach, reducing their negative effect and helping clients develop new coping mechanisms.

8 phases of therapy:

- **Phase I History Taking** – psychological assessment, appraisal of readiness for therapy and discussing the treatment plan, including identification of potential goals (disturbing subject, event, feeling or memory) and inappropriate beliefs.
- **Phase II Preparation** – acquiring skills to cope with processing (positive resources), such as a "safe place" – an image, memory or sensation that creates comfortable feelings and positive self-perception. A safe place is also used to sum up a therapy session where activities are not finished.
- **Phase III Assessment** – identification of so-called snapshot images that represent the target and related impairment, related negative cognitions and contrasting positive cognitions.
- **Phase IV Desensitisation** – processing of snapshot images by applying bilateral stimulation, which means simultaneous memory visualisation, focusing on body symptoms, observing bilateral stimulation and repeating negative cognition in thought.
- **Phase V Installation** – positive cognitions are installed by applying bilateral stimulation.
- **Phase VI Body Scan** – surveillance of the body for the purpose of identifying sensations of pain, stress or discomfort in the body, which are processed, if present, by way of bilateral stimulation.

- **Phase VII Closure** – sharing the experience (so-called debriefing), the therapist provides information and support, if necessary.
- **Phase VIII Re-evaluation** – re-evaluation and ending the therapy. Disturbances related to the issues dealt with in previous sessions are assessed.

Other methods of therapy in work with children and adolescents who have been exposed to trauma and their families.

Family therapy – is based on several theories and models (including the systems theory, communication theory, etc.). It is a school of psychotherapy which aims to systematically solve problems that arise for people in relations with their close ones and other important people. Family psychotherapy is cooperation with the client and the group which forms the client's closest living environment, that is family, in the course of which the therapist knowingly and purposefully uses psychological techniques to help the client and their family to understand and change mutual relations, communication patterns, emotions, mutual perceptions, conceptions of role and role behaviour toward decreased symptomatic/problematic behaviour. It is important to educate family members about the client's problems and teach coping techniques.

In the context of trauma therapy family therapy is used as a so-called supportive method next to trauma-focused intervention and family therapeutic interventions are part of an integrative model. An example of the latter is parent-child interaction therapy (Hembree-Kigin, McNeil, 1995), which is also aimed at possible post-traumatic behavioural problems. The model focuses on teaching parenting skills behaviourally in the so-called here and now format, meaning that the parent is instructed to regulate the child's behaviour in the current moment.

Group therapy – in this context it is not a method as such, rather a format. There are different trauma-focused group therapy models, including those based on cognitive behavioural therapy as well as integrative ones. Group therapy is recommended for school children in a situation where the trauma is a shared experience (either as to event or target group) (NICE, 2018), but it may also prove useful for parents whose children have been exposed to trauma (however, one should remember that working with only the parents does not cure the child's post-traumatic symptoms). In any case, group therapy is a great method of intervention in a situation where people share an experience.

Play therapy – in the context of trauma it is also not a method as such, but a format. A precondition is that playing is a natural environment for the child in which it is easier for the child to express himself or herself and implement an emotional and behavioural change. Play therapy combines spontaneous playing with structured activities for the purpose of achieving the objectives set in therapy (Gil & Johnson,1993). Such objectives include raising one's awareness of their inner world, supporting the child's capability to respond to their needs in an appropriate manner, increasing the child's connection with people important to the child, including parents, and enforcing the development of inner resources (Saunders, 2003). In the context of trauma, it covers dealing with feelings and thoughts related to trauma and supporting coping with the effects of trauma.

Narrative-exposure therapy (Schauer et al., 2011) – the main objective is to help people who have been exposed to trauma to describe their experience and create a true, harmonised and time-wise accurate narrative of their lives, natural part of which is the traumatic experience. It is important to emotionally process the traumatic experience in a way that fits naturally into

the rest of the narrative. Besides creating a narrative the therapy process also applies cognitive behavioural therapy techniques. For children there is an adapted model called the KidNET which has been found to significantly decrease PTSD symptoms (Ruf et al., 2010).
Creative/expressive art therapies – they combine the purposeful use of art, music, dance/movement, drama and poetry in the context of psychotherapy (Foa et al., 2009). Creative methods have a function similar to that of so-called traditional psychotherapy techniques. For instance, creatively imagining trauma is more or less similar to imaginal exposure, and imaginal expression of an experience in several different ways (for example, role play) has a strong effect on restructuring cognitions related to trauma. Creative art therapies also focus on teaching self-regulation skills and advancing resources by applying a sensory and somatic approach.

Creative methods provide for a so-called way to express one's traumatic experience and it is a normalising experience, especially for children. It is important that it provides a possibility to conduct therapy in situations where communication is inhibited for some reason (for example, insufficient language skills or cultural differences).
When applying creative methods in the context of trauma therapy one should keep in mind that it must be carried out by a specialist with special training who has completed psychotherapist's basic training and trauma-focused creative art therapy training, the client must participate voluntarily and the creative art therapy must be carried out in cooperation/coordination with other ongoing treatments and therapies and therapists (Foa et al., 2009).

7. Competencies of specialists providing trauma-focused psychological help

Competency is defined as the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served (Epstein & Hundert, 2002, p. 227; reference to APA, 2015).

This Chapter deals with competencies related to working with trauma, which means minimum knowledge, attitudes and skills necessary for helping people who have been exposed to trauma. Below is an overview of a guideline developed by the American Psychological Association (APA, 2015) which defines the minimum requirements for the competence of psychologists working with trauma. Naturally, one must keep in mind that such a document cannot be used one-to-one outside the country of origin. It is recommended to have the same discussion about necessary competencies in Estonia and for this discussion to involve practitioners, representatives of educational institutions as well as institutions governing the area.

A psychotherapist working with people who have been exposed to trauma must be prepared to understand the effect of trauma on a person, their health in general and reactions arising from trauma and on the basis thereof carry out trauma assessment and interventions by taking into account individual, cultural and other features. Among other things, a psychotherapist must be able to take into account developmental factors related to relationships (above all, how does trauma affect the functioning of the family), and the complexity related to trauma (for example, disorder comorbidity, the meaning of various behavioural expressions in the context of trauma, and so on). A psychologist must know how to assess the effect of trauma in psychotherapy – from establishing and maintaining a therapeutic relationship to choosing and applying the appropriate intervention, and be prepared to adapt the psychotherapy process to suit the needs and readiness of the person in need of help. Another essential skill is to take into account, assess and support the resources of the person who has been exposed to trauma – their personal

strengths, resilience and post-traumatic development potential.

A psychotherapist's competence must also include their ability to self-reflect (it is vital here because the emotional load arising from work is vast and the work is very intense), update their competencies and work in a network (cooperate with specialists dealing with the case).
Specific trauma-focused competencies have five subcategories:

I Scientific knowledge of trauma – trauma prevalence, effects of trauma on an individual, relationships and wider groups; target groups at risk; trauma reaction mechanism; evidence-based interventions; skills to critically assess publications on trauma and trauma disorders; skills to make the client understand evidence-based knowledge.

II Psychosocial assessment competencies – readiness to ask all clients questions about traumatic experiences; assessment of occurrence and effects of trauma in case of various traumatic events; taking trauma-specific symptoms into account in assessment (for example, dissociation, avoidance, triggers); assessment of strengths and resilience; taking cultural, age group and other contextual effects into account in assessment; adapting the assessment process to the target group and type of trauma experienced; critical assessment of assessment tools.

III Psychological intervention competencies – knowledge of empirically researched interventions (psychological, pharmacological, somatic) in the treatment of trauma-related disorders; skills to critically consider the person in need of help when adapting the intervention (which intervention, in what time-frame, for which client, etc.) and assess its course throughout the therapy process; understanding the elements and mechanism of the change process; ability to deal with another person's experience non-judgementally and supportively (empathy, respect) and express belief in recovery; ability to avoid avoidance in psychotherapy, i.e. be open and consistent; ability to cooperate with the family and social network of the person who has been exposed to trauma as well as with other specialists; ability to establish and maintain a therapeutic relationship promoting the development of a sense of security, trust and openness.

IV Professional competencies – skills to take in their work into account in a sensitive manner legislative and other rules set by outside systems, expectations and their effects on the person who has been exposed to trauma (for example, procedural acts in an investigation; confidentiality; requirements arising from law and so on); sensitive consideration and application of ethical aspects; sharing knowledge of traumatic experiences on a wider level (public information space, authorities, etc.).

V Competencies related to relationships and wider network – understanding of how trauma affects the relationship network (systematic effect of trauma); readiness to cooperate on different levels in social systems surrounding the person who has been exposed to trauma (for example, family, classmates, involved specialists); readiness for interdisciplinary intervention according to the needs of the person who has been exposed to trauma; skills to educate different target groups about trauma (from single clients to wider groups affected by trauma, e.g. an organisation); awareness of how different systems (family, institutions, community) may affect primary and secondary trauma experience and, if necessary, be ready to intervene to prevent or assist; awareness of how different relationship systems can help strengthen resilience in a situation of a traumatic experience and skills to apply it.

8. Maintaining the work ability of trauma-focused specialists – training and supervision

Specialists working with traumatised target groups, especially with children, are at potential emotional risk: burn-out as well as compassion fatigue, i.e. vicarious traumatisation (McCann, Pearlman, 1990). The latter is specific to specialists working with trauma clients – it refers to a state of emotional tension created by listening to other people's extremely complicated and difficult experiences and by having compassion for their pain, fears and horrors. This state of tension may be expressed on the level of personal symptoms in different ways and it affects the specialist's self-image, conception of the world, psychological needs and beliefs.

The ones at greatest risk are beginner therapists (Ghahramanlou and Brodbeck, 2000; Pearlman and MacIan, 1995; reference to UKPTS, 2017); therapists with personal trauma experience (Jenkins and Baird, 2002; Van Deusen and Way, 2006; Cunningham, 2003; reference to UKPTS, 2017); and those with a vast caseload of trauma patients (Schauben and Frazier, 1995; reference to UKPTS, 2017).

A complex PTSD intervention guideline published by UK Psychological Trauma Society (2017) sets out recommendations for minimising vicarious traumatisation:

- Knowing and noticing the early signs of traumatisation
- Regular supervision
- Support among colleagues, working in a team, including self-help (support) groups at the workplace
- Limiting the caseload (limiting the number of cases dealing with trauma)
- Working time management (day, week and in a wider sense)
- Balanced professional and private life

I would like to add a possibility for regular refresher training.

In conclusion, helping others is extremely rewarding but also emotionally demanding. Therefore it is vital for specialists working with trauma to be aware of the risks they are at and be prepared to prevent as well as cope with excessive emotional load. It is also important to have the support of colleagues and to notice one another and for employers to apply preventive measures and help with overload (for example, supervision, refresher training, self-help; carefully thought-out and flexible working time and engagement in exercising).