Trauma and Inner-City Children- the Scope of the Problem

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When children grow up in impoverished, violent, urban neighborhoods they cannot escape the sense of danger and helplessness that permeate their environment. The experiences that young children live through become impressed upon their developing minds and bodies, staying with them long after childhood is left behind (Pynoos, 1993). The sounds of gunshots, police radios, fire truck sirens, people screaming and fighting, the pulsing of helicopter blades, tires screeching down the street; these sounds of danger and violence are the background to a game of hide and seek inside their apartment. Walking down the street, the sight of yellow police tape, young men in wheelchairs, razor wire atop chain link fences, the flashing lights on police and emergency vehicles, fences around front yards, bars upon the neighbors' windows and doors, deserted night time streets, all send a silent message about the dangers of living in these neighborhoods.

In South Los Angeles, a neighborhood that Police Chief William J. Bratton explained "if it was a separate city, would be one of the most dangerous cities in the world," children are exposed to violence almost daily. On June 10th, 2006 the Los Angeles Times newspaper reported the crime statistics for the city of Los Angeles. It was reported, in a city which has seen 4 years of continual reduction in crime, the South Los Angeles area is still a concern. In an area that constitutes 13% of the cities population it witnesses 43% of the cities homicides. Combine this with the social and economic poverty of the area, where 38% of residents live below the poverty line, one begins to appreciate the violence and stress children are forced to cope with daily.

Tragically, the violence is not only outside the home. In an urban pediatric setting, a sample of low-income families revealed that half of all violence exposure to children under the age of 6 is in the home (Taylor, Harik, Zuckerman, & Groves, 1994). This is both physical and sexual abuse perpetrated upon the child, as well as being exposed to domestic violence. National statistics report that children under the age of 6 account for 40% of abuse victims (Children's Defense Fund, 2000) and 85% of all fatalities to persons under the age of 18 (National Clearinghouse on Child Abuse and Neglect Information, 2002).

In this setting of violence and poverty children are at risk for and exhibit symptoms of traumatic exposure. The age and developmental maturity of a child influences all aspects of a child's ability to cope with trauma. How the child perceives the trauma (Keppel-Benson & Ollendick, 1993; Siegel, 1992), what the child experiences as traumatic, how the child expresses symptoms of traumatic exposure (Marans & Adelman, 1997; Pynoos, Steinberg, & Wraith, 1995), and what type of treatment is appropriate are all mediated by the age of the child and their stage of development. For example, the child's stage of cognitive development will influence what the child understands as traumatic (Keppel-Benson & Ollendick, 1993; Siegel, 1992). This can be different from what an adult will perceive as traumatic.

Unfortunately, little is known about the specific effects of trauma upon children under six years of age. Research has shown that the younger a child is, the less posttraumatic symptoms (PTSD) the child will express (Pynoos, 1993). Children do suffer from traumatic stress, but the model of adult PTSD symptoms may not be appropriate to young children (Drell et al., 1999; Osofsky, 1995; Osofsky, Cohen, & Drell, 1995).

Not only is expression of the child's symptoms developmentally mediated, the symptoms in turn influence and impact the child's development. Living with long-term stress will adversely

affect a child's physiological system. A child will also experience developmental delays and if the trauma is chronic these developmental delays may become pervasive (Osofsky, 1997a; 1997b, Pynoos, 1990).

If little is known about the symptoms of trauma in young children, less is known about treatment for young children who have been exposed to traumatic events. To date, there is no age appropriate intervention for children under 6 years old who are suffering from traumatic symptoms. An optimal therapeutic intervention for young children is child-parent psychotherapy (Lieberman & Van Horn, 2005). But, for low income parents who are often forced to work 2 jobs, attending weekly therapy sessions may not be possible. In school and childcare setting child-parent therapy may not be practical. Cognitive behavioral therapy that focuses on the traumatic event (TF-CBT) is one of the leading therapies for adults suffering from traumatic symptoms. This therapy may not be suitable for young children who do not yet have the cognitive capacity to analyze the event and their reaction. One type of therapy for children exposed to trauma is group therapy. But, this therapy may be counterproductive for very young children as they may become more traumatized when listening to the frightening stories of other children. Play therapy is a standard therapy for young children in general. This type of therapy may be too general for children exposed to traumatic events. A more structured and theoretically based type of play therapy is Sandplay. Case studies have shown Sandplay therapy to be effective even with young children who were exposed to traumatic events pre-verbally.

Trauma

Trauma is usually defined as events that are outside the range of normal stressors and are perceived as life threatening, either to self or others (Osofsky, 2004). Research suggest that

events an adult would perceive as life threatening maybe very different from what a young child perceives as life threatening (Osofsky, 2004). These events provoke feelings of helplessness, fear, or horror. But, how an adult expresses these feelings is distinct from how a young child will express them. Further, when children experience traumatic events normal development is delayed and if the trauma is so severe normal development may be derailed (Osofsky, 1997a; 1997b, Pynoos, 1990).

Types of Traumatic Events

The types of trauma that are experienced are either acute, single episodes or more chronic, long term exposure. Also, the traumatic event or condition may be proximal and involve the child directly, or it may be distal and not directly impact the child personally. When children live in lower social economic conditions in violent urban neighborhoods the various types of traumatic stressors converge.

The type of trauma most often studied is acute trauma. Acute trauma is a single event or an episode of short duration that is not repeated. This type of trauma is either perpetrated upon the child directly or may be witnessed by the child, distally. Acute proximal trauma includes single episodes of sexual, physical, or emotional abuse (Cichetti & Toth, 1995; Helfer, Kempe, & Krugman, 1999). Acute distal trauma includes natural disasters such as earthquakes, floods, or fires; or national tragedies such as war, the political terrorism of September 11, 2001 or the Oklahoma City Bombing; and tragedies such as the school shooting at Columbine. Other types of acute distal trauma are social in nature such as riots or time limited community violence.

More damaging and pervasive is when trauma is chronic (Bernstein & Borschardt, 1991). This is trauma that occurs over a longer period of time or with repeated events. Proximal chronic trauma can take the form of long term sexual, physical abuse or long term neglect. An example

of a chronic proximal trauma is when a child is neglected due to maternal depression. If this occurs in the child's first months of life neuro-affective regulation is compromised. In studies of child incest victims most of the children did not meet criteria for PTSD (Sirles, Smith, and Kisana, 1989). Subtler still, is distal chronic trauma. This type of trauma is easily overlooked when therapist treat children exhibiting symptoms of traumatic exposure. Examples of distal chronic trauma include witnessing domestic abuse (Edleson, 1999; Groves, 2002; Kitzmann, Gaylord, Hold, & Kenny, 2003) or witnessing community violence.

In pediatric settings the most likely types of trauma to be seen are child sexual and physical abuse, adult domestic violence, exposure to community violence, immigrant and refugee trauma, and increasingly exposure to war (Groves & Augustyn, 2004). In New Orleans, 90% of elementary school-age children had witnessed violence in the home or community (Osofsky, Wewers, Hann, & Fink, 1993). In Baltimore, 54% of 6 year olds witnessed some form of violence either in the home or in the community (Schuler & Nair, 2001).

According to the National Child Abuse and Neglect Data System (2000) child victimization rates decline as age increases and 40% of all child abuse victims are under the age of 6 (Children's Defense Fund, 2000). Children under 6 years of age account for 85% of all child fatalities and children under 1 year account for 44% of all child fatalities (National Clearinghouse on Child Abuse and Neglect Information, 2002). In a private pediatric setting 14.7% of mothers reported domestic violence in a past relationship and 2.5% reported domestic violence in their current relationship (Parkinson, Adams, & Emerling, 2001). In a screening done in a suburban hospital 31% of women reported domestic abuse at some point in their life and 17% reported domestic abuse in the past 2 years (Siegel, Hill, Henderson, Ernst, & Boat, 1999).

Children who live in urban areas with high crime rates are at greater risk for exposure to violence in the community. Taylor, et al. (1994) reported 10% of children under the age of 6 from low income urban settings witnessed a knifing or shooting and 18% witnessed pushing, kicking, hitting or shoving. In a Pennsylvanian suburban middle school, 57% of sixth graders had witnessed a robbing, beating, stabbing, shooting, or murder (Cambell & Schwarz, 1996). In Los Angeles, children witnessed 60-80% of homicides (Pynoos & Etho, 1985).

Psychological and Physical Effect of Traumatic Exposure

Under normal circumstances infants and toddlers will learn to trust parents and caregivers. For the most part they will find parents and caregivers available, reliable, consistent, and protective (Bowlby, 1988). In early childhood children generally develop a sense of safety and security and experience normal neurological development. When a child experiences trauma any or all of these systems are negatively impacted.

When there is trauma parents may also be affected. When parents exhibit symptoms this can lead to changes in parenting such as disruption of attachment. Also, research has demonstrated that when parents are affected by trauma they may become over-protective. Research has shown that a preschoolers symptoms can be predicted by their mothers' psychological functioning (Laor, Wolmer, & Cohn, 2001; Linares et al., 2001; Lieberman, Van Horn, & Ozer, 2003).

Everyone is affected when exposed to violence and trauma and much is known about the effect of trauma upon older children and adolescence. Little is known about how young children, children under the age of 5 years old, are effected by trauma. Early research and theory postulated that young children were not affected by trauma at all. It was believed that young children did not have the cognitive capabilities to be affected by trauma. More recent research

has demonstrated that young children are affected by trauma and express their distress not only cognitively (Beehgly & Cicchetti, 1987, 1994), but also neurologically, behaviorally (Marans & Adelman, 1997), emotionally (Erickson, Egeland & Pinata, 1989; Main & George, 1985), and somatically as well.

How symptoms of trauma are expressed will vary by the age of the child and the child's cognitive capacities as well as by their neuro-affective development (Davis et al., 2000; Green et al., 1991). For example, toddlers may feel directly responsible for the tragic event or situation. This is due to toddlers' sense of omnipotence and centrality in the world. Further, toddlers' reactions and behaviors will mirror that of their caregivers. Trauma will impact early brain development and the development of the central nervous system (Perry, 1997).

More recent research has shown a clear relationship between preschool age children's exposure to violence and trauma and subsequent emotional and behavioral problems (Drell et al., 1999; Osofsky, 1995; Osofsky, Cohen, & Drell, 1995). Symptoms include: increased irritability, temper tantrums, sleep disturbances, crying and other emotional distress, fears of being alone, physical complaints, immature behavior, and the loss of acquired skills such as regression in toilet training, and language usage. When young children are severely traumatized they will exhibit symptoms of posttraumatic stress that are similar to adults but distinct from (Drell et al., 1999; Osofsky, 1995; Osofsky, Cohen, & Drell, 1995). These symptoms include the DSM hallmarks of re-experiencing the traumatic event, avoiding people and places that remind the child of the event, increased arousal, numbing of responsiveness and blunted emotions, and nightmares. Young children will also develop new fears, express fear of going near the scene of the violent event, be afraid to go to sleep, show little enthusiasm or fun in play, and children exposed to severely traumatizing events will often seem serious or spacey. The younger a child is

the more disorganized their PTSD or trauma symptoms will be (Green et al., 1991).

To date, there has been no research on the effects of violent urban neighborhoods upon children under 6 years old. Research among children 6 to 15 years of age has demonstrated how the combination of lower-socioeconomic class and violent urban neighborhoods places children at risk for anxiety disorders, depressive symptoms and aggressive behaviors and behavioral problems (Gorman-Smith & Tolan, 1998; Cooley-Quille, Turner, & Beidel, 1995; Schwab-Stone et al., 1995). It is anticipated that young children will also be at risk for behavioral problems and other age appropriate symptoms of trauma when exposed to violent urban neighborhoods. The present study seeks to broaden our understanding of therapeutic treatment for young children exposed to traumatic events such as violent urban neighborhoods.

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