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THE TRAUMA WORKSHOP:  
WHAT IS IT?  
HOW DOES IT AFFECT US?  
WHAT DO WE DO ABOUT IT?

July 20<sup>th</sup>, 2000  
Robert S. Wright, RSW

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Trauma ..... a definition.

Trauma is defined as physical or psychological injury or the event causing same. Psychological trauma is typified by an emotional shock that makes a lasting impression on the subconscious mind. Understanding this definition of trauma as effect is important.

Trauma ..... is subjective.

The degree to which a tragic event effects us differs from person to person. It is likely that biological, psychological and environmental factors determine the degree to which we are effected. (Consider the studies of resiliency and Darlene Kordich Hall's differentiation between "victimized" children and "traumatized" children)

Trauma ..... How it works.

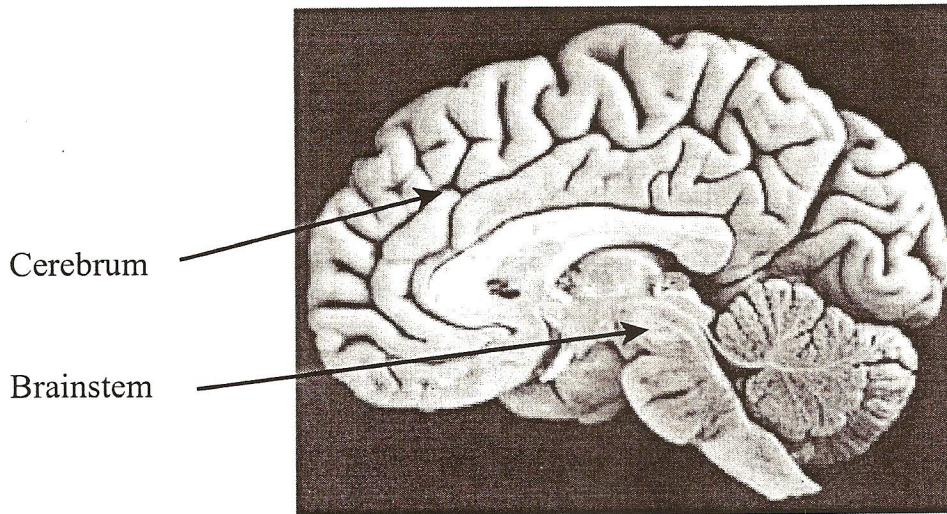
To better understand resiliency to trauma and to more effectively recognize and treat it, I'd like us to consider 2 models for understanding the mechanics of Trauma.

The Neurological Model

In the articles available on David Baldwin's Trauma Information Pages ([www.trauma-pages.com](http://www.trauma-pages.com)), B.D. Perry describes in detail the differing functions of the brain and how they are affected by trauma. Simply put, Perry describes that certain parts of the brain are designed for higher order functions like thinking, while others are dedicated to more primitive functions like reflexes. In the healthy, well developed brain the thinking part of the brain is in a balanced relationship with the reflex center; the thinking center maintaining some resemblance of control.

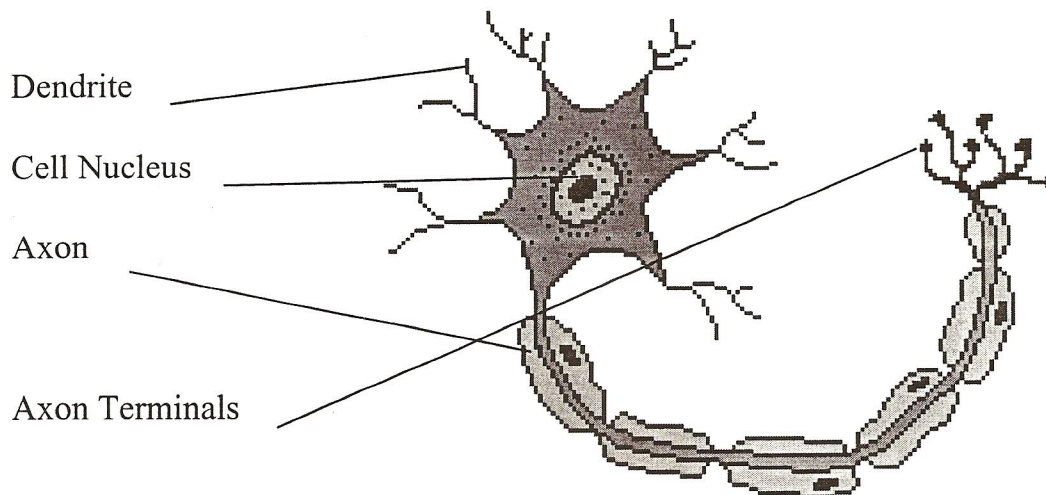
Perry points out that the brain's structure can be effected by environmental stimuli. Like muscles, the areas of the brain that are stimulated grow, change, become stronger. The areas that are less used can weaken and lose their effectiveness. Potentially traumatic events have the effect of stimulating the reflex area of the brain (the fight or flight center) causing this center to become unduly exercised.

## The Thinking Center (Cerebrum) and the Reflex Center (Brain Stem)



More information on the brain and its functioning can be found at the following web sites:  
Traumatic Brain Injury Resource Guide: <http://www.neuroskills.com/index.html?main=tbi/brain.html>  
Virtual Hospital: <http://www.vh.org/Providers/Textbooks/BrainAnatomy/BrainAnatomy.html>

## How Brain Cells Change

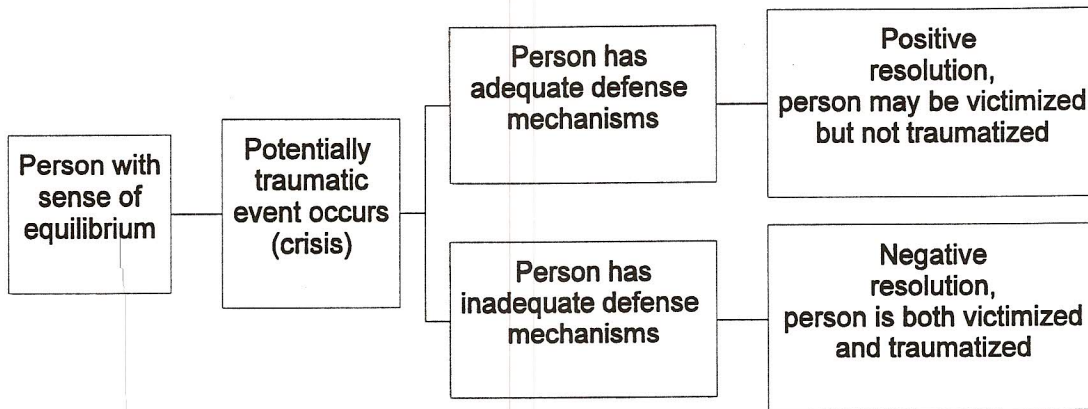


1. increase number of dendrites
2. change in structure of axon
3. increase number of axon terminals
4. increase amount and perhaps type of neurotransmitters
5. increase efficiency in reclaiming spent neurotransmitters (re-loading)

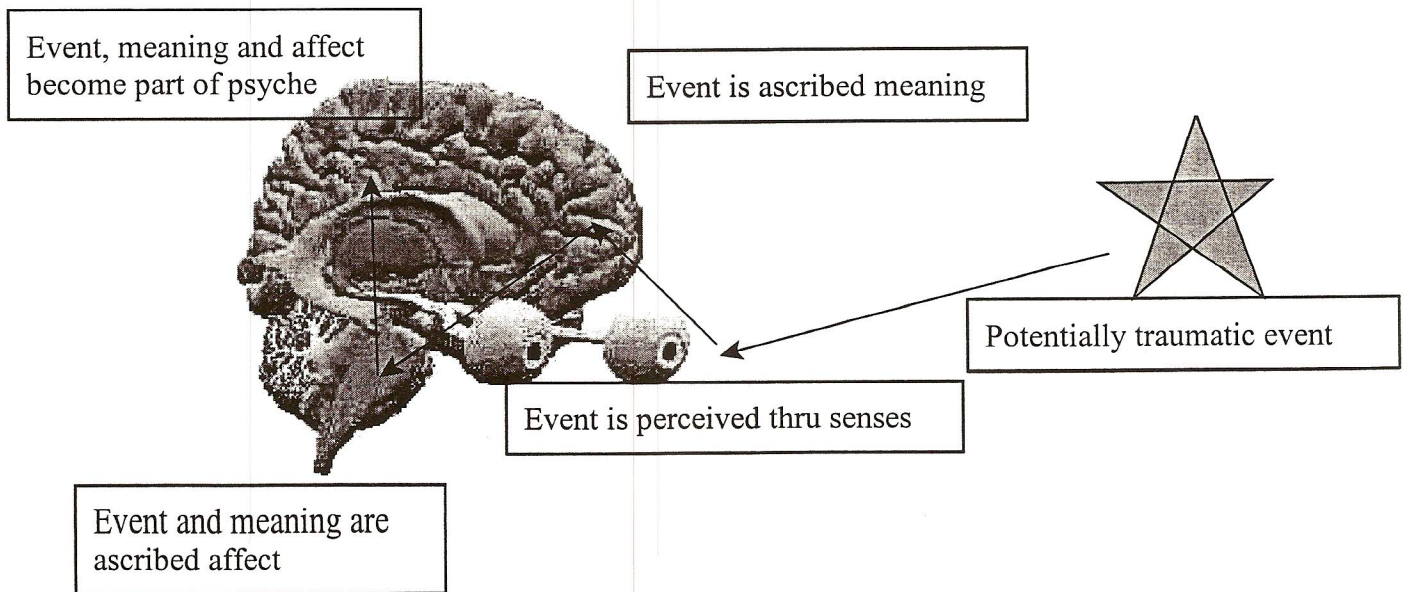
## The Psychological Model

To understand the psychological model we must consider 2 concepts; defense mechanisms and the crisis construct. Defense mechanisms (or coping styles) are automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors (DSM-IV pg. 751). These defense mechanisms are organized into 7 categories ranging from highly adaptive methods to extremely maladaptive methods. These defense mechanisms control how we perceive and respond to events. I often describe this complex process with the following simple diagrams.

### The Crisis Construct



### The Thinking/Feeling Dialogue



## The Stress Disorders

Regardless of which model we use to understand the trauma process the behavioral and emotional consequences are the same. Prolonged or severe exposure to a traumatic event can have long term behavioural and /or psychological consequences. These consequences are well described in the list of symptoms attributed to Post Traumatic Stress and Acute Stress Disorders in the DSM-IV. These pages are included below. The major differing characteristics between the two disorders is the onset and duration of the symptoms. In children it is not uncommon that participation in post traumatic play is a prominent re-experiencing symptom. This is well described in Darlene Kordich Hall's manual on Assessing Child Trauma. These pages are also included below.

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Specify if:

**With Poor Insight:** if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

## ■ 309.81 Posttraumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
  - (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
  - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
  - (3) inability to recall an important aspect of the trauma
  - (4) markedly diminished interest or participation in significant activities
  - (5) feeling of detachment or estrangement from others
  - (6) restricted range of affect (e.g., unable to have loving feelings)
  - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
  - (2) irritability or outbursts of anger
  - (3) difficulty concentrating
  - (4) hypervigilance
  - (5) exaggerated startle response

- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**Acute:** if duration of symptoms is less than 3 months

**Chronic:** if duration of symptoms is 3 months or more

*Specify if:*

**With Delayed Onset:** if onset of symptoms is at least 6 months after the stressor

### ■ 308.3 Acute Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - (2) the person's response involved intense fear, helplessness, or horror
- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
- (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
  - (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
  - (3) derealization
  - (4) depersonalization

- (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)
- C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.
- D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- E. Marked symptoms of anxiety or increased arousal (e.g.,
  - difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
- G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
- H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

## Post-traumatic play (intrusive recollections)

Post-traumatic play is frequently the manner in which young children demonstrate their recurrent and distressing recollection of negative events. (In contrast to young children, older children may process this area more like an adult and describe themselves as having disturbing thoughts or images of the traumatic events.)

Post-traumatic play is often most problematic for both caretakers and clinicians to identify. Caretakers have a difficult time understanding how this type of play is different from a child's "normal" play. We have had some success in describing this type of play in the following manner. Post-traumatic play is the child's attempt to recreate the negative experience in a controlled way so that he/she can try to understand and master the experience. Normally the child won't make a carbon copy of his experience, but instead chooses to use symbols to represent aspects of his/her experience. However, some children will actually enact elaborate, and virtual "re-creations" of their experience within the limits of their developmental understanding and physical abilities.

In addition, we speak to caretakers about specific behaviours which they may have observed and highlight for them the areas of difference between post-traumatic play and the child's usual play:

- (1) In this play, themes are often persistently catastrophic, violent, bizarre or highly unusual, and/or sexualized.
- (2) This play often does not have a happy ending or resolution which allows the child to be the "master" of it (as would be the case in normal play).
- (3) This type of play has a "driven" quality which is unlike the "light-hearted" play normally seen in children. The child doesn't "enjoy" this play and in fact the child may show a tremendous sense of seriousness and absorption in this activity. Post-traumatic play usually excludes others. In many cases the child simply appears to be in his/her "own world" and may even be unaware that others are present. In some children post-traumatic play is accompanied by the child's entry into a dissociative state.
- (4) The emotions shown are very intense and may re-create those the child experienced during the traumatizing event(s). These emotions are often so vivid that observers speak of being emotionally affected by the play and may describe feeling frightened or victimized themselves if the child includes them in their play. We often tell trainees that if they feel like they have been victimized and are experiencing a sense of exhaustion after this play, then they were probably witness to post-traumatic play. Because of the intensity and disturbing themes of this play, when other children who were not part of the original trauma are enlisted in this play, they may experience "vicarious victimization" and sometimes even become symptomatic for short periods of time. They may become anxious or fearful, have nightmares, show increased aggression, and participate in secrecy and/or trickery as well.
- (5) The play normally has elements of "secrecy" in it as the child may only engage in this activity when he is alone and not around others. Caretakers often report that they only know the child is engaging in this type of play because they can hear the child in another room screaming and speaking harshly to his toys and knocking them about. Other caretakers tell us that they never see this play but find evidence of it. For example, in one case the parent continually found the child's dolls with all of their heads and extremities removed and having had red marks coloured on them as if to signify blood.
- (6) This play is highly repetitive with the same themes reoccurring usually without resolution. In some cases parents report children obsessed with this play, preferring to engage in it above all else. When changes are seen it is usually an addition of more specificity and elaboration on the same basic themes, as if the child were now remembering more details.

The assessor will often need to encourage caretakers to listen more carefully to the **content** of their child's play. They should be asked to document the themes of any repetitive play and to try to tune into the child's "alone" play. As well, they should be asked to note any unusual play which makes the caretaker feel uncomfortable, confused, or which seems out of the range of most children's play or is different than their child's normal play activity. Finally, caretakers (and professionals) need to be especially attuned to their own emotional reactions in any play that the child initiates with them, i.e. are they feeling:

- (1) uncomfortable?
- (2) physically intruded upon?
- (3) sexually uncomfortable or invaded?
- (4) angry?
- (5) abused or exploited?
- (6) tricked or lied to?
- (7) a little scared or worried about what the child might do (to them) next?

These feelings are often reported by caretakers and professionals who have played with children engaged in post-traumatic play. They are often the first indication one has that this play is not developmentally appropriate and should be "tracked" further and assessed.

### **Intense emotional distress at similar events**

Another reaction frequently seen in traumatized children is the exaggerated and frequently "unusual" responses children have when "triggered" by something in the environment which reminds them of some element(s) of the negative events. Children under these circumstances may become terrified, profoundly agitated and hyperactive, and/or immobilized in response to these stimuli. Caretakers often describe scenes in which "out-of-the-blue" the child screams, clings to them, starts crying, shakes like a leaf, vomits and/or has diarrhea. In extreme cases children may even become feverish and physically ill. Parents have talked about responses such as these going on for several minutes and lasting upwards to an hour or even more. Children may always have the same reaction to just one stimulus, or they may have a range of responses to a variety of "triggers." These responses may seemingly come and go or change in characteristics (both "trigger" and response) over a lengthy period of time. Some adult trauma survivors speak about life-long terror responses to certain types of objects or events, while others describe rather long "dormant" periods and then the sudden re-emergence of severe reactions to groups of related stimuli.

When children show strong distress responses to certain stimuli they are probably demonstrating emotions felt during the original trauma. At first, caretakers often are unable to identify the stimulus and only after repeated occurrences are they sometimes able to sort out possible "triggers" which cause such a reaction. Caretakers have described these behaviours to us as a response to many types of stimuli. Adverse responses to the dark, water, toileting, certain types of people, and enclosure in small spaces are among the most common "triggers" we have encountered. Other more unusual stimuli have been snakes, lit cigarettes, mops, wooden chairs, pictures in magazines of children lying down on a bed, people counting, certain colors and/or smells, and farm landscapes to mention just a few. Virtually anything can be a trigger if the child associates it with the original trauma.

Caretakers need to be reassured that the practitioner will not think them foolish (or crazy) if they describe to the assessor their child's seemingly incomprehensible reactions, nor will the professional censure their educated guesses as to what might be causing these reactions. Parents and other caretakers should be instructed to record any of the child's unusual distress responses. They should note what occurred just before, what happened during the child's distress response, and what was said or done after the response was over. All of this information will be essential to the assessment and later treatment of the traumatized child.

## Intervening in the Trauma Process

Once we understand the trauma process it is easier to see how one can intervene to minimize the impact of potentially traumatic events on us.

Potentially traumatic event	Prevent traumatic events (prevention)
Event is perceived through the senses	Shield innocents from exposure to traumatic events when they occur
Event is ascribed meaning Event and meaning are ascribed affect	Support healthy development such that individuals have resilience to trauma (healthy brain development, healthy psychological development)  *Employ methods in crisis situations that support the client in using adaptive defense mechanisms  *Implement CISD methods or TED methods before new equilibrium is established
Event, meaning and affect become integrated into the psyche	Various therapies are used to assist clients to reorganize the meaning of trauma in their lives (CBT, psychoanalysis, REMD) or to mask and control the symptoms of the trauma (various pharmaceuticals)

Of these methods of intervention listed above, I would like to present outlines for intervening in the middle of a crisis, and in the hours within 72 hours of the event. We may refer to these two methods of intervention as Crisis Intervention and Crisis Debriefing.

### Crisis Intervention (When You are on the Scene)

Five Reasons Why Coping Mechanisms Fail:

1. Event is too traumatic or over whelming
2. Event has special significance to person
3. Event occurs at a time of special vulnerability

4. Event occurs when coping mechanisms are blocked
5. Event is new and specific coping mechanisms do not exist

#### Three Views of Hazardous Events

1. Threat (accompanying emotion = fear)
2. Loss (accompanying emotion = deprivation)
3. Challenge (accompanying emotion = painful, anxious expectation)

#### Emotions as a Tool in Crisis Work

1. Pain is a significant mobilizer for clients in crisis. Do not stifle it prematurely. The presence of pain is evidence that defence mechanisms like denial and disassociation have not fully been manifested.
2. Anger is also useful and should be allowed to be vented safely. Verbal hostility can be appropriate if the client has the perception that someone else is to blame. It gives the sense that one is doing something about the event.

#### Eight Action Principles of Crisis Intervention

1. Immediate Intervention: Do something immediately that is demonstrable and accessible even if the action seems purely symbolic
2. Action: Focus the client on action by developing an Action Plan, even if actions are purely symbolic
3. Limited goal: Establish very limited goal of re-establishing equilibrium. Now is not the time for counselling and psychotherapy
4. Hope and Expectation: Re-establish a glimmer of hope by pointing the client beyond the current crisis
5. Support: Be there! Provide sufficient but not excessive support, ensure that client has access to 24hr support (after hours telephone number, help line, neighbor)
6. Focused problem solving:
7. Identify the most critical problems and issues for both you and the client
  - a. Identify alternative courses of action
  - b. Weigh costs & benefits of each alternative
  - c. Choose a course of action
  - d. Act with a step by step plan
  - e. Evaluate effectiveness within 24 hrs
8. Self-image: Efforts must be made to identify the impact of the event on client's self-image

9. Self-reliance: Promote self-reliance, though client may need significant direction, the goal is the promotion of self reliance. The client should be actively doing things to resolve the crisis.

### Principles of Traumatic Event Debriefing (Conducted between 24 and 72hrs after the Event)

#### Resolution/Reorganization is the Goal

1. Trauma will be resolved. Resolution will occur.
2. Resolution will take longer than we think. Like a recovery process it goes on indefinitely.
3. Resolution does not go away. Resolution is integration, it becomes a part of who we are.
4. Resolution can be hindered slowed or otherwise affected by external circumstances.

#### Goal of Resolution is to Organize

The re-organized self is slightly different than the self before. Belief systems, leisure activities, may be different

#### Mourning/Grieving

Grief is a part of the process. When we change, we lose who we were and must mourn that passing before we can move on to become who we are going to be

#### Words

Language that is accurate in describing the event and emotion of the client is critical. Words can be used to literally organize the patchwork of ideas that the client shares.

#### Acceptance

One part of mourning is acceptance. Acceptance is also becoming aware of the new reality.

#### Empowerment

It is important throughout the process that clients are given the sense that they are in control of the resolution/reorganization process.

#### Positive Outcomes of Trauma

1. I have lost but I am. I have not been destroyed

2. Re-evaluation of goals and values, Opens up the possibility of lifestyle enrichment
3. Promotion of compassion, an awareness of one's own vulnerability and one's need of others
4. Social Action: often directed toward prevention of future trauma
5. Permanent change: trauma will leave you a different person

### The Steps in the Debriefing Process

Debriefing is usually a group process from 3 to 20 persons, though the techniques and methods can be used for debriefing individuals. It is critical to use this method between 24 and 72 hours after the event. Earlier and you are really doing crisis intervention and the techniques are different. Later and you're really doing trauma treatment work, again the techniques are different. Participants must be comfortable in a relaxed and less than formal atmosphere. Rules are observed: Confidentiality, speak only for yourself not others, no interruptions of the process are allowed, mutuality and equality are important, consultation after debriefing must be available.

1. Fact Phase: focus on the details of the event. What actually happened? Create a graphic picture of the event from each persons perspective. Clarity is more important than accuracy
2. Feelings Phase: focus on the physiological and emotional feelings experienced during the event
3. Thoughts Phase: what or who did you think about as the event was occurring
4. Reaction Phase: after the event, what images linger (a good question or phrase is "though the event happened yesterday, I can still see . . . , I can still hear . . . , I can still feel . . . ,)
5. Symptom Phase: question specifically about lingering physiological and emotional symptoms
6. Teaching Phase: educate about the healing stages, reorganization as a lifetime process, stress management, available counselling resources, etc.
7. Re-entry Phase: spend last few moments with a normalizing event like talking over refreshments. Don't let client leave with defense mechanisms down and emotions raw.

When Do We Use These Techniques?

1. When we are with clients who are in crisis
2. When we are precipitating crisis during an apprehension or severe intervention
3. With our co-workers when they come back from a potentially traumatic intervention
4. With foster parents after major incident with children in care
5. When participating in crisis response teams at schools and hospitals
6. With ourselves when we need to reframe an event.

The following is an appendix to B.D. Perry's excellent article on how trauma effects the brain of children. He makes several clearly understood statements about the brain, its development and function here, that I couldn't resist thduplicating the appendix here. The full article can be found at [www.trauma-pages.com/perry96.htm](http://www.trauma-pages.com/perry96.htm).

## APPENDIX 1

### KEY POINTS: BRAIN ORGANIZATION AND FUNCTION

The brain is not a 'single' system. It is many interacting and interconnected system organized in a specific hierarchy -- with the most complex (cortex) on the top and the least complex (brainstem) on the bottom.

Different parts of the brain -- different 'systems' in the brain' -- mediate differed functions (e.g., the cortex mediates thinking, the brainstem/midbrain mediate state of arousal).

All systems in the brain are comprised of networks of nerve cells (neurons). These neurons are continuously 'changing' (in chemical and structural ways) in response to 'signals' from other parts of the brain, the body or the environment (e.g., light, sound taste, smell).

The 'changes' in neurons allow the storage of 'information'. This storage of information is the basis for 'memory' -- memory of all types -- motor, sensory, cognitive and affective.

Different parts of the brain -- which mediate different functions -- store information (memory) that is specific to the function of that part of the brain. This allows for different types of 'memory' -- for example, cognitive (names, phone numbers), motor (typing, riding a bicycle), 'affect' (nostalgia).

The brain stores information in a use-dependent fashion. The more a neurobiology system is 'activated' the more that state (and functions associated with that state) will be 'built' in -- for example, practicing the piano, 'memorizing' a poem, or staying in state of fear.

In different 'states' of arousal (e.g., calm, fear, sleep), different neural systems are activated. Because the brain stores information in a use-dependent fashion, the information 'stored' (i.e., the memories) in any given situation depends upon the state of arousal (i.e., the neural systems which are activated). One example of this is 'state-dependent' learning -- another is the hyperarousal symptoms seen in post traumatic stress disorder.

## KEY POINTS: BRAIN DEVELOPMENT

The brain develops in a predictable fashion -- from most primitive to most complex; Ontogeny recapitulates phylogeny.

Normal development of neuronal systems (and functions they mediate) require specific patterns of activity -- specific 'signals' -- at specific times during development.

These critical periods are windows of vulnerability during which the organizing systems are most sensitive to environmental input -- including traumatic experience.

Because the different systems in the brain develop (or mature) at different times in the life of a child, there are different critical periods for different functions (e.g. regulation of anxiety, mood, abstract thought).

Because these brain systems develop in a sequential fashion, from brainstem to cortex, optimal development of more complex systems (e.g., the cortex) require healthy development of less complex systems (e.g., the brainstem and midbrain).

Therefore, if the state-regulating parts of the brain (brainstem and midbrain) develop in a less than optimal fashion (e.g., following excessive traumatic experience) this will impact development of all other regions of the brain.

The brain remains sensitive (plastic) to experience throughout life -- but differed parts of the brain are most plastic (cortex) and others are relatively implastic (brainstem) .

**EXPERIENCE CAN CHANGE THE MATURE BRAIN -- BUT EXPERIENCE DURING THE CRITICAL PERIODS OF EARLY CHILDHOOD ORGANIZES BRAIN SYSTEMS!**

Trauma during infancy and childhood, then, has the potential effect of influencing the permanent organization -- and all future functional capabilities -- of the child.

## KEY POINTS: THE RESPONSE TO TRAUMA

The brain mediates threat with a set of predictable neurobiological, neuroendocrinological and neuropsychological responses.

These responses may include different 'survival' strategies -- ranging from fighting or fleeing to 'giving up' or a 'surrender' reaction.

There are multiple sets of neurobiological and mental responses to stress. These vary with the nature, intensity and frequency of the event. Different individuals may have differing 'response' sets to the same trauma.

Two primary adaptive response patterns in the face of extreme threat are the hyperarousal continuum (defense -- fight or flight) and the dissociation continuum (freeze and surrender response). Each of these response 'sets' activate a unique combination of

neural 'systems'.

These response patterns are somewhat different in infants, children and adults though they share many similarities. Adult males are more likely to use hyperarousal (fight or flight) response -- young children are more likely to use a dissociative pattern (freeze and surrender) response.

As with all experience -- when the brain 'activates' the neurophysiological system associated with alarm or with dissociation, there will be use-dependent neurobiological changes (or in young children, use-dependent organization) which reflects this activation.

It is these use-dependent changes in the brain development and organization which underlie the observed emotional, behavioral, cognitive, social and physiological alterations following childhood trauma.

In general, the predominant adaptive style of an individual in the acute traumatic situation will determine which post-traumatic symptoms will develop -- hyperarousal or dissociative.

#### KEY POINTS: CLINICAL WORK WITH MALTREATED INFANTS

Anything that can decrease the intensity and duration of the acute response (alarm or dissociative) will decrease the probability of persisting neuropsychiatric symptoms!

In general, structure, predictability and nurturance are key elements to a successful early intervention with a traumatized infant.

The primary source of these key elements is the primary caretaker. Therefore, it is critical to help the caretakers understand as much about post-traumatic responses as possible.

If the primary caretakers were impacted by the same trauma, it is imperative that they get treatment which complements the work with the child.

Early assessment and intervention can be prophylactic -- helping prevent prolonged acute neurophysiological, neuroendocrine and neuropsychological trauma response.