Traumatic Stress

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To Amelia and the people of Cupo whose homes were destroyed

and to the Youth of Fabriano and Marche

With thanks to the many young people who participated in our questionnaire , their families and teachers

At the beginning of ‘Gioventu` Duemila` conference each person chose a stone and we all participated in the following exercise ....

Now we will do a little exercise.

Please get out your stone. Close your eyes for a few moments …

Hold your stone .. feel how it fits nicely in your hand and takes the shape of your palm …. Feel the surface, the smoothness

It is your piece of security

During the conference we will be tacking difficult issues - when you feel it hard, hold your stone and turn it over in your fingers.

Write your name on it - make it your own.

Contents

Gioventu` Duemila

Opening remarks for the conference -

This is a stone, in fact a rock, it signifies stability it makes us feel secure and we hope that, at least during this conference, it will not move.

I was born in London but I have my roots in Fabriano. For me Italian is my mother tongue and in the true sense of the word because Italian was the language which my mother spoke to me when I was a child. And it was not only Italian but Fabrianese. So my roots are here.

In these last few days I have been walking in the countryside and I thought about other walks that I have had on these same paths in the mountains. With my grandmother, now dead, with parents, with children now grown, with husbands now divorced and now on my own. People change but these paths are the same, the rocks are the same ones and the mountains do not change.

And I thought of what a fundamental thing it would be if the rocks, the earth, the mountains were not stable, were not unchanging - for in fact that is what happened in the earthquake … and that is what moved us all.

* * * * *

Prologue

Our involvement in earthquake and disaster work began on 26th September 1997 - my mother's birthday - when a sizeable shock hit Fabriano our family home town.

We initiated an appeal, an earthquake relief fund and, based on the principles of Youth Support, concentrated our efforts on the children, young people and their families who had lost homes and been traumatised by the experience. Money was raised and distributed amongst the worst hit families. Support came from unexpected sources - not from big Italian businesses or expatriate Italians - but from 'senior citizens' who had enjoyed holidays in the area and from the veteran British soldiers who, like my father, had been sheltered by the people of Fabriano during the second world war.

È in atto nella capitale britannica una raccolta di fondi pro-terremotati promossa da una fabrianese

Quanti amici a Londra!

Non lo sapevamo, ma Fabriano a Londra ha tanti amici che ne conservano bei ricordi e che in questa nostra triste emergenza dimostrano la loro amicizia in modo tangibile e generoso: è in atto nella capitale britannica una raccolta di fondi per i nostri terremotati che sta dando buoni risultati.

"La città medievale di Fabriano e il suo circondario sono stati gravemente colpiti da un terremoto il 26 settembre. Villaggi come Cupo nascosti negli Appennini sono stati ridotti a cumuli di macerie. La loro popolazione che valorosamente ha servito la patria nell'ultima guerra e ha accolto le truppe alleate e gli sfollati, ora affronta un duro inverno sotto le tende. Ora ha bisogno del nostro aiuto". Così, tradotto naturalmente dall'inglese, inizia un appello che è stato diffuso soprattutto tra gli italiani d'Inghilterra anche tramite l'Ambasciata d'Italia e la chiesa italiana di St.Peter a Londra.

E' ammirevole questa solidarietà che fiorisce oltre la Manica per i terremotati dell'Umbria e delle Marche: ma come mai a Londra hanno a cuore proprio le sorti di noi fabrianesi e addirittura un'attenzione particolarissima va a un paesino come Cupo? Già sorprende che a Londra conoscano la piccola Fabriano; è strabiliante che sappiano anche dell'esistenza di una manciata di case che si chiama Cupo e che, per giunta, di questo villaggio si dica "nestling in the Appennines", cioè nascosto, accoccolato, annidato tra i monti, che cioè si usi un termine che significa anche uccellino implume, che non verrebbe usato se non ci fosse una diretta conoscenza di questo villaggio ed anzi un rapporto affettivo con esso.

Come mai? Perché a Londra vive la fabrianese Laura Busini, figlia della maestra del Cupo, Settimia Cola. La signora Laura è una "sposa di guerra" avendo sposato il Maggiore Robert Birch che a Fabriano era arrivato con le truppe alleate liberatrici e che nella nostra città aveva sostato per tutto il 1944 e oltre, con il suo 56° di Reggimento di Artiglieria Pesante di Sua Maestà Britannica.

Fabrianese verace (e sempre sentimentalmente legata alla sua città natale) Laura; per metà fabrianesi, diritto di sangue, le sue due figlie; un po' fabrianese, per ragioni di cuore, il magg. Birch; amici di Fabriano poi i non pochi soldati inglesi che nella nostra città hanno conosciuto la dolcezza della pace, dopo le tribolazioni, le durezze e i pericoli mortali della guerra. Essi di Fabriano conservano un ricordo, bellissimo come la loro giovinezza, come la felicità raggiunta con la fine della guerra, un ricordo che la loro amicizia con i coniugi Birch non ha fatto appassire.

Ma c'è dell'altro da dire. La raccolta di fondi per i terremotati fabrianesi si è potuta organizzare su vasto raggio perché ci si poteva avvalere di un'organizzazione efficiente come la Youth Support (Sostegno Giovani), che è una "charity" fondata e diretta da una delle due figlie di Mrs. Laura Birch, la dottoressa Diana Birch. Quella che gli inglesi chiamano "charity" (opera di carità), da noi si potrebbe definire un'organizzazione non lucrativa di utilità sociale (Onlus). La benemerita Youth Support aiuta i giovani in difficoltà o a rischio di devianza, come per esempio figli di genitori drogati o alcoolisti. Non è una piccola istituzione di gente solo volenterosa; si pensi che conta una sessantina di collaboratori fissi, dotati delle necessarie competenze, più una schiera di volontari con funzioni di supporto. Gestisce una grande casa di accoglienza e svolge attività commerciali e artigianali per l'inserimento lavorativo dei giovani che chiedono il suo aiuto.

Si tratta di un'esperienza interessantissima, dalla quale anche noi sicuramente avremmo molto da apprendere. (Un'idea: perché non invitare un giorno a Fabriano per una conferenza la dr. Diana Birch, che parla benissimo l'italiano, addirittura con un certo accento fabrianese?). A.C.

Il Tower Bridge, uno dei simboli della capitale londinese

How Many Friends in London!

Very little publicity had been given to the quake and foreign media had concentrated on the damage to the church in Assisi - a famous tourist attraction. But what of the people? My family spent night after night sleeping out in cars to escape the nocturnal threat of being crushed by fresh quakes - what was the psychological toll?

We decided to conduct a survey in the local schools to gauge the reaction of young people to the traumatic experiences and the results of that study were presented at a conference held in Fabriano in April 2000. This conference was attended by a large contingent of local youth including teenagers who had responded to the questionnaire. Thus youth had a direct voice in our deliberations.

Traumatic Stress - An Overview

Almost by definition trauma creates stress.

Understanding the stress reaction -

The natural physiological reaction of the body to an adverse stimulus is for the sympathetic nervous system to prepare the individual for a ‘fight’ or ‘flight’ response. This includes increased pulse rate, increased blood pressure …

Then as stress levels increase, the parasympathetic system takes over causing us to freeze with fear or become incapacitated by our situation.

Such a reaction can be see in the rabbit paralysed before the stoat and unable to flee to safety. And of course the abused child who becomes the passive recipient of further abuse in a detached state almost watching himself or herself being harmed.

This is normal, it provides us with a coping mechanism to overcome adversity and to learn appropriate response patterns. We all know how we feel before an exam, before an important competition perhaps or before a event which needs our concentration. We need the ‘stress’ reaction, the adrenalin rush, blood flow being diverted away from vegetative functions such as digestion towards say muscle power.

Problematic Stress -

So at what level does ‘stress’ become a problem ? - when does it stop being a physiological coping response and become an anxiety state - how do we draw the line between positive and negative outcome.

The answer lies in considering the following factors - intensity, timing and duration.

- Intensity - a degree of stress response is helpful but taken to extreme it feels uncomfortable - heart racing, blood pressure pounding in our heads.

- Timing - an immediate stress response is appropriate but if it recurs at times when the stress stimulus is no longer present, the result can be unpleasant and be felt as a panic attack.

- Duration - again if the response is unduly prolonged or continues after the stimulus has ceased, this is perceived as anxiety.

Causes of stress -

Stress reactions which produce harmful or problematic response patterns can be referred to as ‘traumatic stress’. Traumatic stress can be engendered by a variety of stimuli - personal traumas, injury, bereavement, or loss; abuse in it’s various forms ; disasters - personal such as fire etc or general - floods, earthquake etc ; man made disasters such as war, genocide and refugee state.

World War I – a lost generation

In World War II – The average age of the combat soldier was 26 – In Vietnam he was 19

Two Syndromes

Two main syndromes are recognised.

Acute Stress Disorder and
Post Traumatic Stress Disorder PTSD

Post traumatic stress disorder came to the fore following the Vietnam war and was described in returning war veterans. The debilitating symptoms were all the more important because of the age of the troops affected (average age 19) and the high proportion of population affected.

Previously World War I troops had suffered similar symptoms but had been diagnosed as suffering ‘shell shock’.

According to the American Psychiatric association – Post traumatic stress disorder (PTSD)—once called shell shock or battle fatigue affects hundreds of thousands of people who have survived earthquakes, airplane crashes, terrorist bombings, inner-city violence, domestic abuse, rape, war, genocide, and other disasters, both natural and human made.

It has often been misunderstood or misdiagnosed, even though the disorder has very specific symptoms. Ten percent of the population has been affected at some point by clinically diagnosable PTSD. Still more show some symptoms of the disorder. Although it was once thought to be mostly a disorder of war veterans who had been involved in heavy combat, researchers now know that PTSD is by no means limited to the military but also affects both female and male civilians, and that it strikes more females than males.

Post traumatic stress reactions can affect any of us, at any age, and in any walk of life - in fact - *The risk of exposure to trauma has been a part of the human condition since we have evolved*

as a species. Attacks by sabre tooth tigers or twentieth century terrorists have probably produced similar psychological sequelae in the survivors of such violence. Shakespeare's Henry IV appears to have met many, if not all, of the diagnostic criteria for post-traumatic stress disorder (PTSD), as have other heroes and heroines throughout the world's literature (quote from Matthew Friedman, Executive Director of the National Center for PTSD and Professor of Psychiatry and Pharmacology, Dartmouth Medical School)

Disasters

The word disaster implies an irremediable catastrophe - a traumatic event from which recovery is nigh on impossible. Thus an implication of hopelessness and it is this very hopelessness that fosters the traumatic stress response.

It is generally held that events associated with ‘disaster’ are capable of causing traumatic stress if they cause or threaten death, serious injury or physical integrity of individuals, however the threat to the psychic emotional integrity of the individual is the crucial factor in the ability of that individual to ‘weather the storm’ .

Disasters can take place suddenly and be over in a very short period for example a sudden explosion or earthquake may last mere seconds but recovery from the effects can take years.

One moment a mother can be happily going about her housework having dropped her child off at school and the next moment hear screaming in the street and run out to find a mudslide engulfing the school removing a generation of children from a small community. Such a scenario happened in the sixties in Aberfan in Wales and the community still mourns.

The effects of disaster are not merely felt directly on the personal or emotional level but may be wide reaching in terms of destruction of the substructure of society - buildings, utilities and the means of everyday life may be destroyed and take a long time to rebuild. A person caught in a sudden traumatic event such as an earthquake does not only have to survive the tremor. Imagine the baby pulled out from the rubble of the Mexico City earthquake. We all watched with baited breath as the newborn was eased out of an air-pocket under the collapsed maternity hospital - every moment filmed by CNN and beamed throughout the world - a child surviving against the odds - but that was where the problems began.

A child born into a world of orphan-hood, poverty and hardship. And what of the baby born in a tree in the Mozambique floods - where is the shelter, food for that child? Where is the education, health service, nurturing and support? The aftermath of a disaster will have financial / psychological / sociological / cultural / political implications which will be felt at both the individual and group level.

In emotional and psychological terms the aftermath of destruction and loss may be harder to bear than the initial trauma. Sudden unexpected trauma can be dealt with on a ‘survival’ level more or less ‘automatically’ or reflexly whereas the long grind to re-establish ‘normal life’ may provide a serious drain on personal resources both practically and psychologically. Coupled to that we have the gradual realisation of the degree of loss both personal and societal or cultural which may not be evident in the early post disaster period particularly if communications are poor and the individual cannot obtain information about the survival of loved ones. The early ‘survival’ stage may also encompass a degree of heroism in terms of self preservation and help to others which can be tied up with a good helping of ‘manic denial’. As the dust settles and ‘heroic’ action is less appropriate the denial will

crumble away and reality set in. Fear, anxiety and loss replacing adrenalin driven heroic activity.

An example -

The Turkey Earthquake - Cynthia Long - American Red Cross -

At 3:02 a.m. August 17, 1999, Winnie Balikci awoke to the clamor of what she thought was a plane crashing. But the thunderous boom was followed by roaring vibrations and the guttural rumble of cement, brick, and glass crumbling around her. As she was thrown from her bed, Winnie knew a plane hadn't crashed at the nearby naval base. With the floor undulating beneath her, she was keenly aware that a powerful earthquake was rocking Degirmendere, her small town in northwestern Turkey.

There are few things more terrifying than experiencing a violent earthquake and, for those who survive, the trauma from the event is acute and long lasting. Surrounded by death and destruction, emotions range from panic, horror, and disbelief to rage, disorientation, and despair. According to an Israeli military doctor who treated Turkey's disaster victims, it takes a while for the reality to sink in, but before long "people will come to recognize the situation . . . that within a second all they had is just gone."

The numbers of people affected world wide by trauma and disaster are impossible to gauge. It has been estimated that 17 million people in North America alone are exposed annually to trauma and disaster (Meichenbaum 1995). And numbers in Asia and Africa are of course much higher.

Surveys have shown that between a quarter and a third of individuals exposed to catastrophic trauma for example unusually traumatic events such as disasters combat violence

and accidents develop chronic PTSD or other psychiatric conditions (Yehuda et al 1994)

Early Responses

The early response of rescue services will naturally focus on the essentials for survival. Hence following on a disaster, emergency services will begin by making sure that the needs of everyday living are provided - establishing an adequate food supply, basic utilities such as water and electricity, waste management, communication and transportation services, social amenities and educational services. But an essential part of an effective emergency response and something which is often forgotten or neglected is that it must include a mental health input. This was found to be an essential factor in dealing with the Turkey Earthquake

Quote - **Before Rebuilding Can Begin, Disaster Survivors Must Sift Through Emotional Aftermath** *Cynthia Long* American Red Cross –

Every day, Bahar Gaylayan, a young psychologist in a Turkish state hospital, listens to shocking stories from earthquake survivors still trying to cope with the trauma of the event. It's been more than two months since the second of two deadly quakes rocked northwestern Turkey, but aftershocks continue to rumble through the region and tension is high.

Thousands lost their homes and are living in crowded tent cities, but even those with intact homes have had their lives disrupted. Afraid strong aftershocks will crumble flimsy buildings, many people are still sleeping in tents set up outside of their houses and apartment buildings. Even in Istanbul, more than 60 miles from the disaster zone, residents report sleeping under sturdy steel canopies, some wearing helmets.

Most people living in or near the disaster zone are experiencing post-traumatic stress, the long term effects of which can be psychologically debilitating, according to mental health professionals.

The nature and timing of such a disaster mental health input is crucial. Excessive emphasis on mental health issues at too early a stage or at a inappropriate phase may be disempowering and be rejected by the individuals to which such a service is directed. This can leave them unable to approach services at a time when they may need to do so.

This is particularly important when dealing with those in the 'front line' so to speak or the helping professions. A healthy measure of denial is a very necessary coping mechanism in the moment of crisis or danger. One does not want to examine one's feelings with regard to such trauma while dealing with the immediacy of one's situation - it is after the crisis has passed that one can be allowed the indulgence of self exploration and a 'debriefing' of feelings and reactions to the stresses and traumas.

Why do some people develop stress disorders?

Reaction to trauma of whatever nature depends on many factors, the nature of the trauma, the personality and prior history of the individual and the way that the two interact and are handled or influenced by outside agencies or other factors.

For the most part in disaster management we are looking at normal people responding to an abnormal situation but we must also bear in mind that other factors are involved. For example some of the people involved may be people with mental illness or disorder whose condition may be exacerbated by their experiences. Underlying mental health issues or other problems may also modify the response to trauma. Post traumatic stress

disorder is notably influenced by the coexistence of depression or alcohol or substance abuse.

Values and attitudes.

Individual and group values also play a role particularly with regard to the effects of disaster and violence. The value placed on human life - the respect for the individual provide important slants and influences on the effect caused by traumatic experiences.

Detachment from the fact or possibility of death and serious harm are important issues - like a child believing in the cartoon characters who can get up and carry on after being killed, squashed, pushed off cliffs etc.

This theme is continued in video and arcade games, in media and films. Desensitising from death, from violence and from act of killing and firing at people. These techniques are actually used by military groups in training of troops with video games - so our youth are being 'trained to be capable of killing' . Whether they kill or not is due to other factors - but ability to kill is being fostered.

This detachment from the harmful nature of trauma and violence is responsible for the common observation in the USA that kids who are shot complain that they did not realise it would hurt. They are detached from the reality of being shot.

Part of this detachment is possible by blocking off feelings about the victim . In warfare the way to do this is to see them as all bad or incapable of feelings themselves. An unredeemable foe such as the 'bugs' in the film 'Starship Trooper' are an extreme but good example.

Lack of empathy with the victim can thus result from depersonalising the victim or opponent but can also be an inherent nature of the individual. For example some individuals may have a personality disorder and psychopathic tendencies which would emphasise this point. A study in the USA showed that - 98% of young soldiers showed signs of stress disorder if exposed to 60 days continuous combat - and those who did not show such a reaction were of course psychopathic.

Intervention

Providing help on a psychological level involves a number of issues. The help must be provided in a manner which is acceptable to the individuals and must recognise the possibility that the individual may not want help.

There should be a supportive environment which is accepting of the individual's circumstances, which is empowering and supportive and gives positive feedback. The key is empathy and 'value' imparting self worth - not 'sympathy' implying a victim position. This could be seen in the accepted description of what 'therapy' should be which involves empathy, acceptance and genuine positive regard.

In the disaster situation the ability to be a good listener and hear what the patient is telling of their experiences is generally more useful than being able to 'interpret' - in the acute phase particularly the individual will need to 'unload' the power of the experiences and visions they have stored up.

The manner in which they do this will be influenced not only by their past experiences but also by their cultural norms and an understanding and acceptance of the culture is essential.

Each individual experiencing a traumatic or ‘disaster’ situation constitutes a unique set of circumstances. There is a uniqueness and individuality of disaster and response - a ‘soil and seed’ concept which is also influenced by prior experience. For example someone who has been through other disasters has the advantage perhaps of knowing what to expect and maybe has developed some survival mechanisms - but this individual has also been emotionally or mentally scarred by the traumas he or she has experienced and thus may be more vulnerable to emotional or psychological harm engendered by the experience.

Stress reactions to disaster

Numerous symptoms may be caused by disaster situations and the resultant stress can be manifested in a variety of ways including symptoms in the individual and in their social interactions.

The following information is taken from the National (USA) Centre for PTSD data (ref Young, Ford Ruzek et al) Most people recover fully from moderate stress within 6 to 16 months but symptoms when present include the following list –

a) emotional effects

- shock
- anger
- despair
- emotional numbing
- terror
- guilt
- grief or sadness
- irritability
- helplessness
- loss of pleasure from activities
- dissociation (dream like)

A whole gamut of emotional reactions can afffect the individual often passing from one mood to another in a confusing succession .

b) physical effects

- fatigue
- insomnia
- sleep disturbance
- hyperarousal
- somatic complaints
- impaired immune response
- headaches
- gastrointestinal problems
- decreased appetite
- decreased libido
- startle response

Physical effects alter in nature and intensity as the phases of traumatic response are traversed (see below).

c) cognitive effects

- impaired concentration
- impaired decision making
- memory impairment
- disbelief
- confusion
- distortion
- decreased self esteem
- decreased self efficacy
- self blame
- intrusive thoughts and memories
- worry

Cognitive effects, disordered thinking and reasoning can be long standing and can impair the individual's ability to process the experiences.

d) interpersonal effects

- alienation
- social withdrawal
- increased conflict within relationships
- school impairment

Interpersonal effects should be interpreted carefully and taken into account in the post trauma phase. Children particularly may be seriously affected in social and behavioural terms.

Response to Disaster

Much has been written and theorised regarding the individual's reaction to disaster. The main accepted theoretical base is described below, but it is also important to bear in mind that the response to trauma in an individual is much the same whether the traumatic event is a personal trauma or an overwhelming disaster. The major differences are of course in the societal response, in the fact that a group of individuals are similarly affected simultaneously and in the concomitant difficulties caused by lack of basic amenities and deprivation coming in the wake of a disaster which may not be present in terms of a personal tragedy.

The general response to trauma involves impact, recovery and adjustment - (This has been described in simple terms in 'The Child that Rocks the Cradle' where trauma response and recovery has been paralleled with the response to an untoward event such as an unwanted pregnancy or traumatic childbirth)

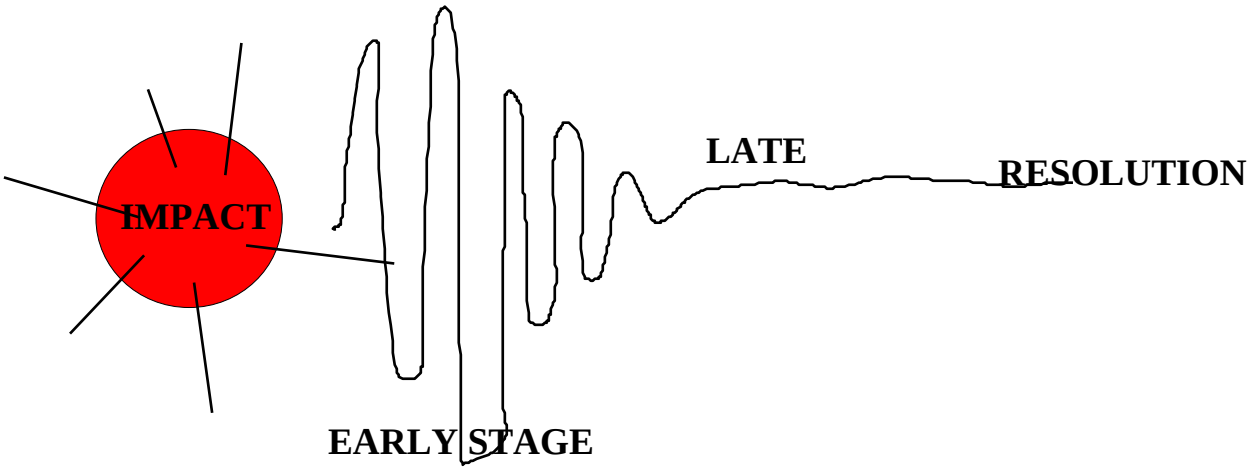
To quote –

Let us consider what happens after a traumatic event.

The pattern of reaction to a trauma has been looked at by psychologists and psychiatrists most particularly in relation to post traumatic stress.

In general terms we have a situation where an initial 'impact' is followed by a strong reaction ... which gradually dampens with the passage of time and settles in resolution. In general terms that initial impact could be an assault, an abuse, an accident, a death etc. etc. In the present circumstances with regard to our

young mothers, it could be considered to be a conception, a pregnancy , a childbirth, or a partner leaving for example.



Another way of looking at it is in terms of the stages of ‘recovery’ from such a ‘trauma’. A traumatic event is followed by a strong reaction - the ‘outcry’ - which is often followed by a period of denial when we don’t really want to deal with the situation and we would rather it ‘went away’.

As the denial period progresses, the ‘victim’ is confronted by reminders which nudge reality back into the scene ... intrusive thoughts and memories of what has really happened stop us from continuing in the denial process.

Constant reminders and confrontation of denial allow a period of ‘working through’ when we can come to terms with what has happened and this results in completion and acceptance of our situation. It is only by working through all these stages and arriving at understanding, accepting and fully realising the situation we are in that we can stop it happening again.

Progression of Recovery Process after Traumatic Event

EVENT ->
OUTCRY ->
DENIAL ->
INTRUSION ->
WORKING THROUGH->
COMPLETION.

Phases of disaster response

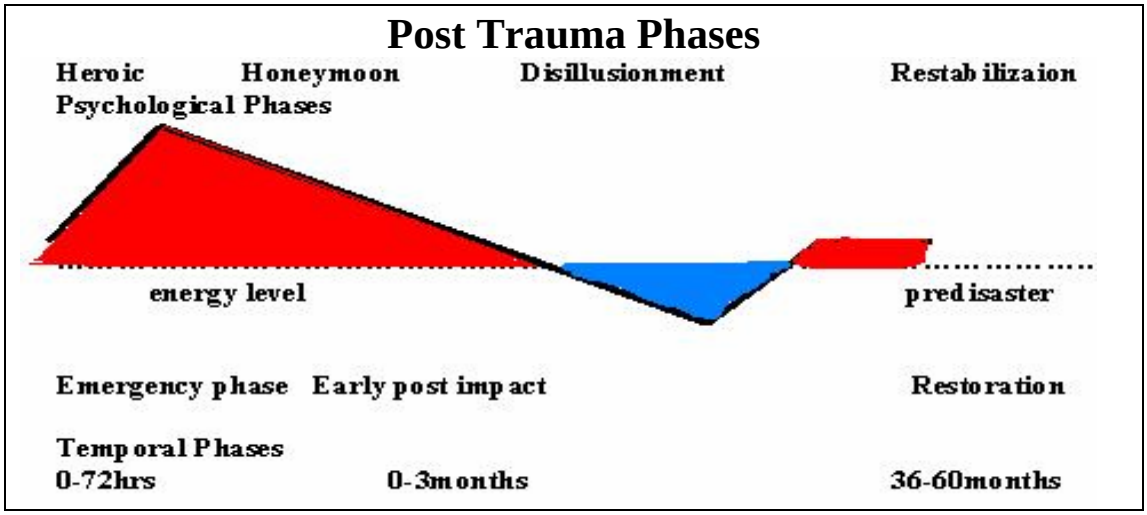
US sources describe three main phases of disaster response -

- Emergency phase
- Early post impact phase
- Restoration phase.

And in terms of recovery - the following phases are recognised -

Recovery - normal phases -

- heroic energy towards rescue etc
- honeymoon community and survivor optimism - media attention VIPs - ends with fatigue setting in
- disillusionment - fatigue irritating experience - not enough compensation etc betrayal abandonment injustice
- restabilization 6 - 36 months feel appreciative of life
- anniversary reactions



{reference Young Ford Ruzek Friedman and Gusman National Centre for PTSD }

The phases are described and delineated slightly differently by different sources but the following is a good description quoted from the American Red cross.

Five Stages of Recovery

Every community that suffers a disaster goes through the same five stages of rehabilitation, according to Hoffman.

First is the **"heroic"** stage, which occurs immediately after the disaster when adrenaline is pumping and everyone is helping everyone else. Miraculous rescues occur during this stage, but it can't be maintained for more than 48 to 72 hours. After so long, energy and adrenaline stores expire and people collapse from exhaustion.

Next comes the **"honeymoon"** stage when search and rescue teams, media and relief agencies rush to the scene. News crews are everywhere reporting live from the disaster zone, bringing images of devastation to the world, and creating an outpouring of sympathy and donations.

Volunteers from countries around the globe arrive to help the victims and there is a general feeling of goodwill despite the tragic surroundings. Dozens of cliched "triumph of the human spirit" media reports are produced during this stage.

But then the media leaves to cover a breaking story elsewhere on the globe. Volunteers pack up to go home to their families and return to their jobs. As the rest of the world moves on, the community is left with the destruction and the monumental task of cleaning up and rebuilding. The **"disillusionment"** stage sets in when people are frustrated and angry as they realize the assistance they were promised will be a long time coming, if at all. They are surrounded by ruin and are, in many cases, out of work and homeless. They quickly become depressed or enraged. In families with no history of violence, spousal and child abuse appears. Suicide attempts are made, and strangers lash out at each other on the street.

Reconstruction and recovery - Eventually the community will rise from the disillusionment stage and enter the **"reconstruction"** phase as cities, towns, and villages are slowly rebuilt, creating a sense of rebirth.

"People begin to realize that nothing will ever be the same, that their homes and cultural centers will never be the way they were before the disaster, but they accept that a new community will emerge from the destruction," Hoffman said. "People are adaptable and they will find new ways of doing things, different ways of living in their new environment."

And then they are ready to enter the final stage--**"recovery."** Life has returned to a state of normalcy, people are out of temporary housing and are back to work and school, and the troubling symptoms of disillusionment are gone. Once in the recovery stage, people draw strength from the fact they survived and were able to mend their lives. They draw strength from the resources they summoned to survive and use them to carry on.

We will later look at how the above phases related to the Italian earthquake experience. Our research with young people centred on the restoration / disillusionment phases in the transition towards normality.

Long term effects of disaster

Little is known of the long term effetcs. Psychologically we have studies of PTSD which has centred on long term symptoms in veterans and clearly emotional problems can be very long lasting.

Physically there would also appear to be long term effects - an example from Armenia -

Armenia ten years later

The Dec. 7, 1988, earthquake in the northern part of the Armenian Republic registered 6.9 on the Richter scale. Half a million to 700,000 persons were made homeless, with deaths estimated at 25,000. More than 21,000 residences were destroyed and the city of Yerevan was all ut raised to the ground. A large epidemiological study investigating the long-term effects of the catastrophic Armenian earthquake found that the more personal and material losses sustained by individuals in that earthquake, the more illness those individuals would report in years to come. The researchers studied employees of the Armenian Ministry of Health and their immediate families (a total of 35,043 subjects) who had been living in the earthquake region on the day preceding the earthquake. Also, 705 new employees who had started working at the Ministry of Health after the earthquake were interviewed. Haroutune K. Armenian, professor, Epidemiology, School of Public Health, said, ‘Our findings support the hypothesis that longer-term increased rates of hypertension, heart disease, arthritis and

diabetes following an earthquake may be related to the intensity of exposure to disaster-related damage and losses' (The Johns Hopkins Gazette: December 7, 1998)

Syndromes Associated with Disorders of Stress

For the individual, child or family caught up in a major disaster or affected by stress reactions the nature and duration of their symptoms are an individual reaction characterised and influenced by their personal psychological make up, their coping skills, their previous experience and history. (see also the workbook for young people - 'A Young Persons Guide to Crisis Intervention')

> ***Crisis Intervention*** *- All of us have been in some sort of crisis at some time in our lives. But what seems like a crisis to one person might not seem so drastic to another. We all have different things that can stress us most and we all have different levels of tolerance of stress.*
>
> ***So what is a crisis?*** *We could say that a crisis is a situation that causes stresses to a person or group of people that is so severe or so sudden that they are unable to cope and need outside help. A problem overwhelms their coping abilities.*

In terms of management , support and treatment it really does not matter if we diagnose acute stress reaction, post traumatic stress or look at individual symptoms. In fact the diagnoses, being temporally defined, must to an extent be made in retrospect and with the knowledge of hindsight. It is important however to realise how long symptoms can last and that treatment for sufferers of post traumatic stress may in effect be lifelong.

The following descriptions of anxiety disorders are medical / psychiatric definitions as set out in the accepted American (USA) and European (WHO) standards. An individual patient may of course suffer trauma or stress while not fulfilling the diagnostic criteria and this does not mean that they are any less in need of help and support.

Symptoms

Broadly speaking symptoms can be divided into three categories and the degree, intensity and duration of these symptoms vary between the various forms of the stress disorders.

Put simply the symptoms can be described as –

- Intrusion
- Avoidance
- Hyperarousal

Intrusion

Intrusion implies the fact that the problem won't go away – memories flood into every day life and sudden flashes of memory can be so intense that the memory feels 'real' as if they are reliving rather than just remembering. Intrusion can also take the form of nightmares.

Avoidance

Avoidance takes the form of avoiding social situations and relationships. Closeness is perceived as threatening and emotions are numbed. The individual functions on auto pilot without an emotional investment in what is going on and is then suddenly overwhelmed with feelings when reminders and triggers come up. Others people can provoke re-experiencing of

emotions and so closeness is also avoided for this reason too. This avoidance also means that the feelings actually related to the event are not felt and worked with positively and thus cause added psychological damage and symptoms like depression. There is no ‘catharsis’ of their pain.

Hyperarousal

Hyperarousal makes us jumpy, on guard sensitive to every little sound, sensation and clue that more trouble is on it’s way. A constant feeling of threat and dread. Sufferers are impulsive and take precipitous actions without thinking them through.

Irritability, being snappy argumentative and frankly violent may be present. This is made worse by lack of sleep tiredness, exhaustion and the nightmares that disturb their nights plus the memories that interfere with their days. Coupled with the poor impulse control, violence or self harm and even suicide are risks.

Sleeping tablets, medication and drug use can be resorted to in an attempt to deaden this pain and in itself brings added problems.

Acute Stress Disorder

Anxiety stress disorder is defined as a disorder involving anxiety and dissociation and the symptoms described below occurring within one month of acute stress trauma exposure.

The disorder lasts for a minimum of 2 days to a maximum of 4 weeks has at least 3 dissociative symptoms and one form of other symptom (DSMIV)

1 dissociation emotional numbing
2 re-experiencing
3 behavioural avoidance
4 psychological arousal
5 significant social or occupational impairment

The following are the characteristics described in DSM IV -

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 persons response involved intense fears 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 (being in a daze)

3. Derealisation

4. Depersonalisation

5. Dissociative amnesia (inability to recall an important aspect of the trauma)

C The traumatic event is persistently re-experienced 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 aspects of functioning or impairs the individuals ability to pursue some necessary task such as obtaining necessary assistance or mobilising 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 four 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 or medication) or a general medical condition, is not better accounted for by brief Psychotic Disorder and is not merely an exacerbation of pre-existing Axis I or Axis II disorder.

Post Traumatic Stress Disorder

This disorder is a more long term illness. It should include at least one symptomatic form of re-experiencing and a minimum of three symptoms of persistent avoidance ; a minimum of two

persistent symptoms of increased arousal and it should last at least a month and with more impairment of social and occupational factors than is seen in acute stress disorder.

The US DSMIV describes it in the following manner -

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 persons response involved intense fears helplessness or horror

B The traumatic event is persistently re-experienced in at least one of the following ways -

1. Recurrent and intrusive recollections of the event including images, thoughts or perceptions. In young children this may involve repetitive play.

2. Recurrent distressing dreams - in children dreams generally frightening without specific content .

3. Acting as if the traumatic event were recurring (sense of reliving the experience) illusions, hallucinations, dissociative flashback episodes including those on waking or when intoxicated - in children trauma specific re enactment may occur.

4. Intense psychological stress at exposure to internal or external clues that sybolize or resemble an aspect of the traumatic event.

C Persistent avoidance of stimuli associated with the trauma - 3 or more of -

1. Avoidance of thoughts feelings conversations, activities places people.

2. Inability to recall important aspects.

3. Marked diminished interest or participation in significant activities

4. Feeling of detachment and estrangement from others.

5. Restricted range of affect - unable to show loving feelings.

6. Sense of a foreshortened future does not expect to have a career, marriage or children or a normal life span.

D Persistent symptoms of increased arousal (not present before the trauma) - at least 2 of the following

1. Difficulty sleeping or staying asleep.

2. Irritability and outbursts of anger.

3. Poor concentration.

4. Hyper-vigilance.

5. Exaggerated startle response.

E. The disturbance i.e. symptoms described above - lasts for a minimum of one month.

F The disturbance causes clinically significant distress or impairment in social occupational or other important aspects of functioning.

European model

The European Description of PTSD as per the ICD-10 Classification of Mental and Behavioural Disorders produced by the World Health Organization, Geneva, 1992 is slightly different from the American DSM IV which is the more commonly quoted source.

F43.1 Post-Traumatic Stress Disorder

This arises as a delayed and/or protracted response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime).

Predisposing factors such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence.

Typical symptoms include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks") or dreams, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma.

Commonly there is fear and avoidance of cues that remind the

sufferer of the original trauma. Rarely, there may be dramatic, acute bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction to it.

There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive use of alcohol or drugs may be a complicating factor.

The onset follows the trauma with a latency period which may range from a few weeks to months (but rarely exceeds 6 months). The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of patients the condition may show a chronic course over many years and a transition to an enduring personality change.

Diagnostic Guidelines

This disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A "probable" diagnosis might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive-compulsive disorder or depressive episode) is plausible. In addition to evidence of trauma, there must be a repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams. Conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are often present but are not essential for the diagnosis. The autonomic disturbances, mood disorder, and behavioural abnormalities all contribute to the diagnosis but are not of prime importance. The late chronic sequelae of devastating stress, i.e. those manifest decades after the stressful experience, should be classified under F62.0.

Levels of risk - Who are at high risk of symptoms?

So given the high number of people affected by trauma and disaster, how can we concentrate our support and treatment efforts? How do we know which people to watch more closely? Which individuals are most at risk of developing symptoms of stress reactions and particularly of PTSD - long term post traumatic stress?

It would appear that the following list of factors increase risk of developing post traumatic stress.

- Those individuals experiencing early stress reactions
- Survivors of mass destruction (witnesses)
- Those with unresolved bereavement
- Individuals experiencing loss of home or community
- Prior exposure to trauma
- Associated major life stressors (divorce etc)
- Survivors of toxic contamination
- Those with low levels of emotional support or high levels social demand
- Individuals who appear to use avoidance self blame or rumination as a coping mechanism
- Coping via substance abuse -which is also an avoidance.
- Serving as an emergency worker which can also lead to avoidance of personal issues in an attempt to focus on those of others.

It is important to remember the role of the rescue worker who buries or submerges his own feelings under the guise of helping others. The adage ‘Physician heal thyself’ applies to firemen, relief workers, rescue services and particularly those working far from their homes in a different culture, who are probably doing such work to escape from unresolved conflicts or emotional problems back home - in addition to being exposed to traumatic experiences ‘on site’.

Types of disaster -

The prevalence of PTSD varies following different types of disasters - The data in the following graph is gleaned from a number of sources that are not strictly comparable having varying criteria - however it is interesting to note what a high level of disorder is caused by earthquake trauma.

Disaster	Adults	Children
Mt St Helens Volcano	4%	
Other Volcanoes	37%	
Buffalo creek flash flood	25%	35%
Tornado	21%	
Blizzard and flood		60%
Bushfire	16%	33%
Earthquake	60%	95%

It is of note that when separate rates are quoted for children their rates are always higher than adults and the highest value in reported studies thus far would seem to be for children in earthquakes - over 95%

In man made disasters – the most significant stressor has been shown to be fire with the highest levels of PTSD - 100% in burned survivors of fire disaster.

We have said that one of the salient features of PTSD is the recall, reliving of the event and flashbacks. It therefore makes sense that external events that enhance the ‘recall’ will tend to amplify the PTSD response. Continuing aftershocks for example will reinforce the emotional stress response for example as will sensory stimuli which allow reminiscence and identification with the initial adverse stimulus. A good example is quoted following the Turkey 1999 quake.

Another quote from the American Red Cross following the Turkey disaster - Perceptual Cues Delay Emotional Recovery

Treating the psychological wounds of survivors is as important as treating the physical injuries, according to Jill Hoffman, an American Red Cross mental health counselor. She emphasizes that the longer the delay in psychological counseling of survivors, the longer the recovery from the disaster.

The emotional strain of losing family members is debilitating, but the stress is compounded by loss of one's home, place of business worship and community, according to trauma counselors

Added to that are what Hoffman calls constant "auditory and visual cues" of the traumatic event--scenes of devastation, frequent and terrifying aftershocks, and the anguished expressions of survivors, many of them living in makeshift tents or shacks

After August 17's earthquake, and the hundreds of subsequent aftershocks, the region was rocked by two more powerful temblors: a 5.8 magnitude aftershock on September 19 and a massive 7.2 magnitude earthquake on November 12. Thousands more were killed, more communities were destroyed, and survivors were thrown into a state of constant anxiety, afraid that every passing truck was another deadly rumbling of the earth.

Helping survivors - Treatment issues.

How can we support survivors of trauma so that PTSD does not become a major influence in their lives and how do we plan treatment?

Disaster workers identify the need to :-

- **Protect** - from further danger
- **Direct –** people to safety
- **Connect –** Survivors to society and their families

- **Defusing and debriefing –** is also important

An example from Turkey –

Telling the Earthquake "Story" Hastens Recovery
To help people cope with their anxiety, the government, relief organizations, and hospital psychiatry departments, like the one where Gaylayan works, have established counseling programs that allow people to tell their frightening earthquake stories as a means of discharging their fear. The need is so widespread that the Bakirkoy State Hospital in Izmit has established a special unit for earthquake survivors.

"The most important thing is for people to tell their story," said Jill Hoffman, an American Red Cross mental health counselor. "Each time they tell their story it's less charged."

Talking about the symptoms of their fears also helps release the strain and people tell Gaylayan about their nightmares, short tempers, and unshakable anxiety. The men seem to display more severe symptoms, according to Gaylayan, and she listens to their accounts of unpredictable panic attacks, feelings of hopelessness, and depression.

"Males cannot express themselves as easily as women, they're supposed to be strong and unafraid," Gaylayan said. "If the man is perceived as being unafraid, his wife and children will be less frightened. Plus, men think of themselves as the providers for the family and feel frustrated by relying on aid

from outsiders after losing their homes and possessions to the earthquake. The stress is tremendous."

But counselors like Gaylayan try to assure survivors that it's normal to be afraid after a terrifying earthquake, that fear and anxiety are "normal reactions to an abnormal event." After talking about the effects of their fears, counselors urge people to remember the abnormal event and recount what happened when the earthquake struck. For some, especially those who watched loved ones die, the memory is acutely painful and prolonged counseling is necessary. For others, the memory is terrifying but becomes manageable when confronted.

For everybody, recalling the horrifying moments when the earth shook is a harrowing experience--even for trained psychologists. Although Gaylayan listens to earthquake stories every day, upon recalling her own experience when she was trapped for hours with her husband and child under mountains of shifting rubble, tears rolled down her face.

And perhaps we do not need to make heroic gestures and look at high tech solutions. Perhaps a helping hand and the companionship of a peer could be as important as professional intervention - The American Psychiatric Association states that *In some cases the symptoms of PTSD disappear with time, whereas in others they persist for many years*. PTSD when longstanding can lead to other psychiatric illnesses, such as depression. But - *Everyone who experiences trauma does not require treatment; some recover with the help of family, friends, or clergy. But many do need professional treatment to recover from the psychological damage that can result from experiencing, witnessing, or participating in an overwhelmingly traumatic event.*

Support groups and help from the community are important – plus an overall feeling of working together for future gain - a

sense of purpose and goals - Two examples are of interest here -

First let us consider the problems in war zones and refugee status. In the face of the dual problems of depersonalisation and dispossession we have the protective factors of hope and survival. Lack of identity and lack of connectedness can lead to a negative prognosis but surprising counter influences exist. In the middle east for example a report of dual problems which point a clue to one aspect of protective factors.

The Israeli army who have recruits as young as 17, have a very high suicide rate particularly among these youth. In contrast Palestinian youth have been raised over past decades to have no real citizenship, no security in possessions, no sense of belonging. They were unable to attend school at times and education went underground.

A paradox arose in terms of schooling being forbidden hence going underground and becoming acceptable and something sought after by youth - rather than perhaps the high truancy rates we have in some urban areas in Europe and USA. Education became a way of 'winning' and of keeping ahead. Thus there has been no increase in suicides among Palestinian youth because they are fighting for survival and this involves surviving as a race. Thus different coping mechanisms have been adopted by Israeli and Palestinian youth although both are involved in a violent conflict with all the resultant traumatic stress.
[1]

A second example of working together for a future goal - Again from the Turkey experience –

Support Groups Allow Survivors to Talk About Experiences
Understanding the need to tell their own earthquake stories, survivors living in tent cities, often with the help of

[1] (Ref. Defence of Children International)

organizations like the Turkish Psychological Association, have established different support groups.

The "Women's Association," for example, has its own tent in a Turkish Red Crescent camp in Adapazari. It's a spacious tent, and sewing machines are scattered about. The floor is covered with colorful Turkish rugs and gas lanterns cast a warm glow in which the women gather to sew, drink tea, and chat. While discussions aren't limited to the disaster, conversations often lead to the earthquake and the daily struggles of living in a tent city.

Not only are the women able to relieve stress by expressing their fears and concerns, they are also actively participating in the recovery of their community. While chatting and sipping tea, the women sew quilts, embroider pillow and cushion covers, and create finger puppets, scarves, and hats.

After they have a vast assortment, they sell their hand-sewn creations at a Women's Association Bazaar, the proceeds of which go directly to earthquake reconstruction programs.

"They are actively improving their own circumstances and contributing to the improvement of the community, which empowers them," said Jill Hoffman, American Red Cross mental health counselor. "The more people get involved with their own recovery and the more active they are, the less apt they are to get depressed and feel hopeless."

So there we have it – the most important factor in my view – relief from the feeling of helplessness and hopelessness. The victims need to be empowered to face their traumas and overcome their fears.

* * * * *

A Survey of the Psychological and Emotional Consequences of Earthquakes

The Italian Earthquake study – Youth Support Italia

Part One - The Survey and Results

{ This section of the paper was first presented by Sonia Lucia in our preliminary presentation at our European meeting at the Royal College of Physicians London October 1999 }

What was the outcome of the earthquake which struck the Apennine region of Umbria / Marche in September 1997**.**

We were moved by the words of a young school child from Gualdo who said 'We are shaking in our dreams' Lisa (not really her name) felt the earth move beneath her night after night as a series of earthquakes destroyed her home.

What is the psychological effect of feeling the earth move in that way and of realising that it is not perhaps the stable bedrock that we believed and hoped it to be.?

How do young people and children respond to the trauma and stress of such events?

The Earthquake began suddenly on 26th September 1997 and there were repeated smaller quakes and aftershocks from September 97 until the new year 1998. This is an important point – the quake was not of great intensity or severity measured on a global scale or against say the Turkey or Greek quakes but it was long drawn out and as we will see this is a significant point in psychological terms.

The survey in the schools took place in the first week of June 1999 – so 18 months after the first quake.

The epicentre of the quake was near Fabriano – although here in fact the worst damage was in Cupo and that was where YSI centred it's relief work.

We used two schools in our study group. Liceo classico Stelluti and liceo scientifico Volterra both local secondary schools. The liceo classico had been destroyed in the quake and the pupils had been moved to another building. So we should note here that these pupils had been directly affected in school even if they were not physically affected at home.

The control group was supplied by pupils in equivalent schools in Ancona and Falconara. Two pupils from Ancona had moved there from Fabriano after their houses were destroyed in the quake - so they were transferred to the study group.

Study method

The study method was a self administered questionnaire[2] which was given to the young people in class groups in their schools. An explanation by their teachers or by one of us preceded the questionnaire. They were encouraged to be frank in their responses. The questionnaire was confidential but they were asked to give their names if they wished and were offered feedback if they wanted it.

The questionnaire was divided into three main areas. Feelings and thoughts about the actual quake. Long term reactions and feelings after the quake and a self esteem questionnaire.

[2] See appendix

The questionnaire dealt with whether they were affected personally, materially and what problems they experienced at three stages – at the time of the quake; since the quake; and at the present time.

The self esteem questionnaire is a multi cultural instrument based on the Canadian 'Battle self esteem inventory' which has been widely used in all youth support research and is thus tried and tested and gives good levels of comparison to control groups and other populations. One useful part of this is a 'lie' and defensiveness scale. This was useful in deciding whether 'untrue' responses were false, deliberate sabotage or mistakes.

The average age of the pupils in the study was 16.75 years with a range of 14 to 18 years. The average age of youth with problems was 16.5 – slightly lower – this was not significant. Controls and study group had the same average age and characteristics. This means that they were just over 14 on average at the time of the quake.

Sample Size					
Fabriano	Female	305	Male	196	total 501
Control	Female	130	Male	46	total 176
Spoiled				42	**total 719**

The sample size was 501 in the study group which were 305 girls and 196 boys. The controls were 176 which were also more girls – 130 – than boys – 46. We do wonder about this figure and perhaps some of the audience will be able to expand on the gender ratio in local schools.

42 papers were spoiled – and we have some comments about that. In total 719 pupils were involved in the study.

Spoiled Papers				
		Mistakes	Smart Arse	All
Controls		4	8	12
Study	Stelluti	5	5	10
	Volterra	8	12	20
Total study		13	17	30
Total		**17**	**25**	**42**

Analysis of the spoiled papers revealed some interesting features. From a statistician's point of view spoiled papers are a nuisance. Papers that have to be discarded and which reduce your final numbers. From a psychotherapists view point however they were also quite revealing.

In all there were 42 spoiled papers which gave an overall percentage of 5.8% there was not much difference between controls and study group in this respect. The controls had 6.8% spoiled of which 33% were mistakes and 66% deliberate spoiling. The study group had an overall level of 6% with 43% mistakes and 57% deliberate spoiling.

In summary a slightly higher rate in the control group which could easily be explained by the fact that having not been directly affected by the earthquake, they did not take the survey so seriously.

If we look a bit more closely at these figures we can see that most of the deliberate spoiling – which we have referred to as 'Smart Arse' remarks – are coming from the boys. In Fact nearly 8% incidence in boys and only 0.66% in females – more than a hundred-fold in males.

This of course reflects the nature of young men – however the exact content of the response was also interesting. We will return to that later.

The study sample divided up into young people who had not been directly influenced by the quake in that they had not sustained personal injury or loss of property but were nevertheless affected indirectly – these numbered 300 of whom only 39 did not have an emotional problem in consequence of the quake.

A group of 125 had mild damage to their homes; 39 had severe damage and only 7 sustained injury. Thus 171 were directly affected by the quake. Controls and study sample showed similar gender differences.

	Stelluti		Volterra		Totals
	male	female	male	female	
no problems	3	5	27	4	39
probs no dam	10	119	66	66	261
damage mild	8	41	42	34	125
damage severe	1	10	16	12	39
injury	0	3	1	3	7
spoiled mistake	3	2	4	4	13
spoiled smart A	3	2	12	0	17
totals	28	182	168	123	501

As we have seen, 164 students had their houses damaged of which 39 suffered severe damage. Housing consisted of staying with family 60%; friends 25%, a second (holiday) home 20%, containers 2% , Caravans 3%. The numbers add up to more than 100% because there were several moves – which of course were also disruptive and destabilizing for an already traumatized group.

Only 7% suffered any physical injury and this was generally mild.

A 17 year old girl

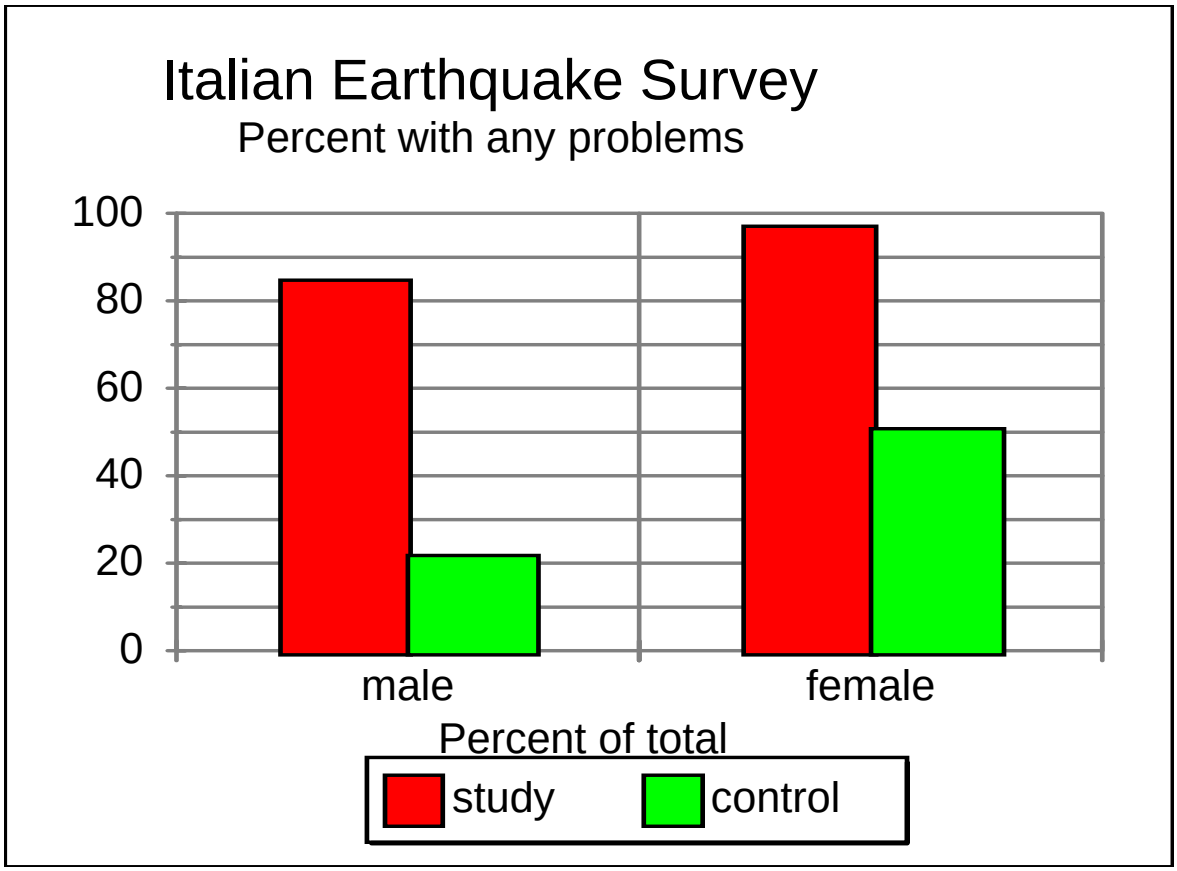
When the earthquake started we had to run out of the house. In the morning when the shocks became more intense, shortly afterwards I returned home. It was a complete mess. The church bell tower was almost falling down and everyone at Borgo were scared to go home. I had never been through such an experience but I count myself lucky to have found another house. It worried me to think that others might find themselves in difficulty and I was anxious because of the number of times we had to go out in the open as the house was crumbling.

Let us now go on to look at the responses. I must remind you that we are looking at the individuals own perceived problems. In the study group 296 girls – that is 97% felt that they had problems resulting from the earthquake. In contrast only 166 boys which is 85% of males felt they had problems.

Percentages	study		control		total
	M	F	M	F	
no problems	15	3	78	48	100 (139)
problems	85	97	22	51	100 (538)
total	100	100	100	100	100 (677)

Note also that quite a high number of controls also had problems - however it should be stated that there were no cases in the study group who had been directly affected by the quake who did not report problems - not even the boys!

The percentages show that 51% of control females and only 22% of control males also reported problems.



This shows well in the graph. There is as you see an enormous gender difference.

Looking at the number of problems experienced. Some experienced a high number of problems but as would be expected the number decreased with time.

The same pattern is followed by males and females although the males experience fewer problems.

The average number of problems experienced by girls were 3.6 at the time of the quake, falling to 2.7 afterwards and 0.3 at the time of the survey – ie 18 months duration.

For males the comparable figures were 2.2 ; 1.2 and 0.1.

Self esteem was not a significant factor in distinguishing between the various age or gender groups or between schools etc. However the self esteem measure was lower in those with multiple problems and particularly when problems were long standing.

Here we have an example of low self esteem in a girl who lost her home.

Girl 18 years old Low self worth

The earthquake influenced my life a great deal because my house was badly damaged and so I was out of home for a year. Apart from the fear of the earthquake I suffered a lot of problems because my routine was completely turned upside down. I was afraid of being injured and of not knowing what had happened to other family members. Seeing the way objects shook made me anxious.

The main problems at the time of the quake were – insomnia in a fifth of pupils; tiredness in a quarter, weakness 11%, Anxiety in a third, fear in over half (59%) palpitations in 13% and fear of being alone at home again in nearly half (46%).

Main Problems – at time of Quake

- Insomnia 20%
- Tiredness 24%
- Weakness 11%
- Anxiety 33%
- Fear 59%
- Palpitations 13%
- Fear of being in home alone 46%

Of course a lot of these problems relate directly to the physical conditions that the young people found themselves in. It was

difficult to sleep and many were scared of being at home when there were aftershocks.

After the quake the problems remained to some degree but lessened in frequency.

It should be stated here that it was hard to define the cut off point between ‘at time of quake’ and ‘after quake’ when there were so many after shocks and this was a drawn out event. However we decided to count symptoms occurring in the first week as ‘at the time’

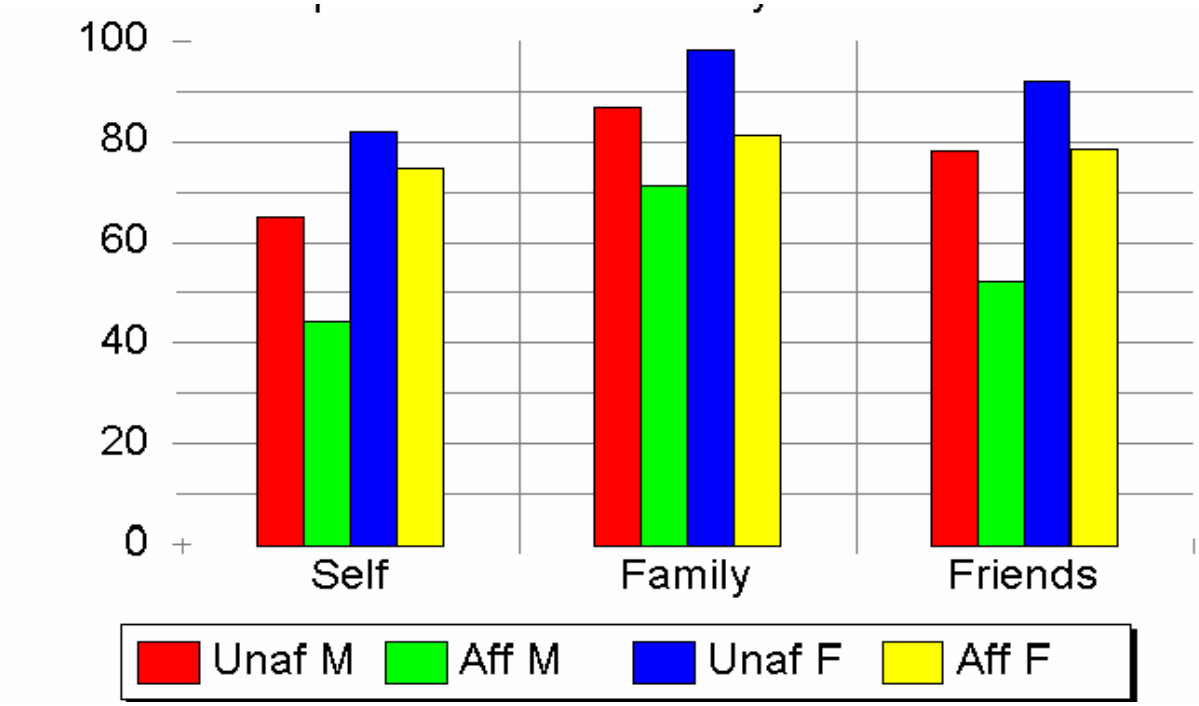
The important thing to note here is the emergence of new symptoms as the pattern shifts into a chronic situation. We thus see that 13% now have difficulty concentrating.

Main Problems – After Quake

- Insomnia 19%
- Tiredness 15%
- Difficulty concentrating 13%
- Anxiety 24%
- Fear 47%
- Palpitations 9%
- Fear of being in home alone 39%

We asked the pupils if they were worried about themselves, their friends and their families. As one might expect, the girls worried more than the boys. Interestingly the pupils who were not directly affected – ie had not had their houses damaged or experienced injury, worried more than those who had been directly affected. This was most noticeable with regard to worry about oneself. In fact affected males worried least about themselves 40% at the time of the quake.

Worry about Self and Others – Immediate
Pupils unaffected : Directly affected



Looking at the same factors in the period after the quake. The effect is even more marked. Only 25% of affected males worry about themselves as opposed to 55% of unaffected males. The highest rate of worry is in unaffected girls who worry most about their family – over 80%.

I was worried for my mother and for her state of mind

At the time of the survey a significant number of pupils were affected by long lasting symptoms. These included depression – with lasting symptoms in 5% of those with mild damage to their homes. Also 44% felt sadness for others and anxiety was persistent in 5% of those with damage to their houses.

Girl of 18

The earthquake of 26th September 97 affected my life a great deal and that of my family. Having lost overnight my home and all my possessions now I am harder with the realities around me. It is true that suffering makes you grow up.

That fear which never leaves us ...

I giovani e il terremoto: i risultati di una ricerca su un gruppo di fabrianesi

Quell'ansia che non ci lascia più

Un momento del convegno (Foto Ferretti)

«La paura più frequente riscontrata tra i ragazzi è quella di rimanere da soli nella propria casa»

dal Vietnam alla Turchia, dal Galles ai paesi asiatici e africani. «Non è possibile stimare ogni volta il numero di persone colpite da trauma e dallo stress che esso produce», ha detto la dottoressa Birch, «tuttavia si può dire con certezza che chi viene colpito da tali tragedie ne risente sul piano mentale, fisico e delle reazioni interpersonali». Dopo il terremoto che nel settembre del 1997 colpì Marche e Umbria, Youth Support intervenne in vari modi per aiutare la popolazione fabrianese rimasta senza casa. Più di un anno e mezzo dopo, la prima settimana di giugno 1999, l'associazione promosse una ricerca tra gli studenti della città per capire le conseguenze che il sisma aveva prodotto in loro sia nell'immediato sia nel lungo periodo. Più precisamente, il gruppo studiato comprendeva i ragazzi del liceo classico Stelluti e del liceo scientifico Volterra, ma nel contempo la ricerca interessò anche due licei di Ancona e di Falconara (il gruppo cosiddetto "di controllo", perchè costituito da ragazzi che dal sisma erano stati colpiti molto lievemente). E' stata la dottoressa Kelly Rose ad esporre i dati più salienti. «I problemi più rilevanti nel periodo

Part Two
Comment and Discussion.

This study has shown some significant pathology in teenage school pupils who had experienced a moderately severe earthquake.

This study took place before the Turkey quake and hence the children were not affected by that. One might have expected that identification with the sufferers in that disaster could have caused a reawakening of symptoms. Individual memory and group memory of disaster is important in assessing reactions.

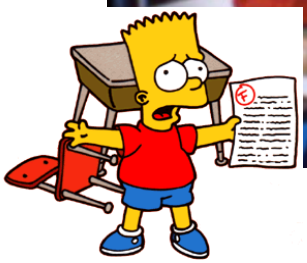
Hence the 'problems' experienced by the control groups. Communities do not live in isolation, there is a movement of people between Fabriano and Ancona for example and relatives may live in both communities. Each have experienced quakes before and the majority of parents and grandparents of Ancona and Falconara pupils will have experienced quakes and talked to their families about them. Hearing of earthquakes in the region will have awakened fears in the pupils.

We did also wonder if the control group may have been affected by the on going war in Yugoslavia just across the water - but the results do not seem to indicate this as a factor.

So now let us consider the spoiled papers, the smart replies – the smart-arse comments. An inappropriate response like laughing at a funeral can indicate embarrassment or inability to cope with the flood of mixed emotions. This is more than that. The sort of forced bravado which results in this sense of joking in the face of danger , making light of pain and problems, and pretending not to care is a form of 'manic defence'. It can appear as a driven form of escapism.

It may begin as a smoke screen diverting others from seeing our real feelings and weaknesses - but the pernicious nature of such a defence is that it then hides our true feelings from ourselves. It may help troubled youth to cope with emotions but is a flawed coping mechanism which brings it's own problems in its wake.

So we had our characters to hide behind … what alter egos did we find? Well we had God … Bart Simpson – who would have got an F for his contribution!



Two Homers - notably Homer Simpson the cartoon buffoon and not the classic Homer which I noticed the pupils were learning about when I visited the school. Obviously the Liceo Classico (High School) has a new syllabus - A sign of the times! Perhaps Homer Simpson is the psychologist of our new age – a hope for the new millennium.! Then there was Elvis – it's nice to know that the mystery is over and we know Elvis is enrolled in the Liceo in Fabriano!

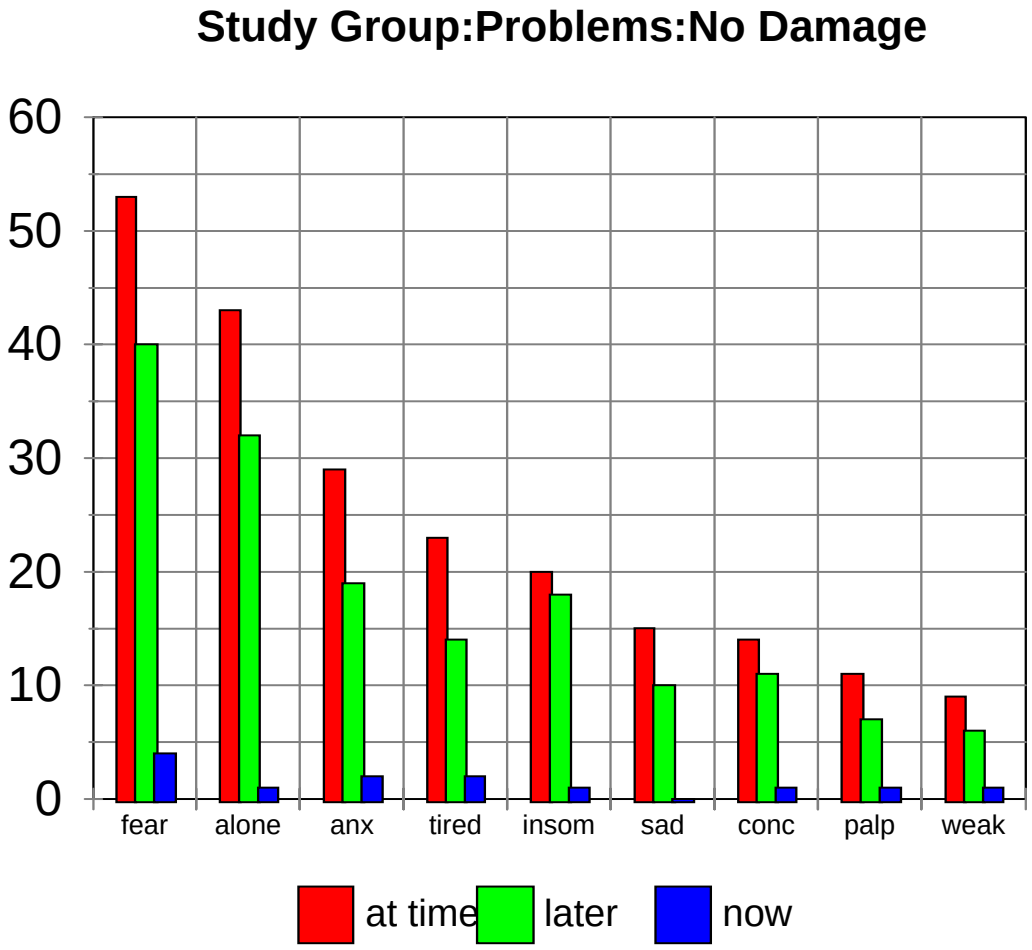
We have a good example of a manic defense in the words of one of the girls

Example of manic defence in 15 year old girl whose self esteem score was 24 (max 25 average 20)

'The period of the earthquake was really amusing apart from the fact that my house had been declared condemned and I have been forced to sleep at my grandparents house. I spent the days in the company of my parents and friends enjoying myself a lot. In my family, I've been the one less worried about the shocks. I didn't let myself be conditioned by the events and I tended to have a good time during those unusual days. This event also had a positive side, it forged solidarity between people and it made us reflect on our life. Most likely if my house had not been destroyed I could have said that the earthquake was a completely positive experience. Now that the house is 'destroyed' I have to say that I would not mind feeling some more little shocks.'

Another aspect of the emotional defence also lies in the gender difference - males reporting fewer problems - for all the usual 'macho' reasons. Latin races are supposed to show 'machismo' anglo saxons the 'stiff upper lip' but whatever you call it the adolescent years - which are what we are looking at here - are the time when the gender difference is at it's most intense, when boys are developing into young men and have not yet acquired the confidence to be able to show their emotional weaknesses. So fewer males completing the questionnaire, fewer reporting problems and more making a joke of it. A highly defended group.

Looking a little more closely at some of the problems.



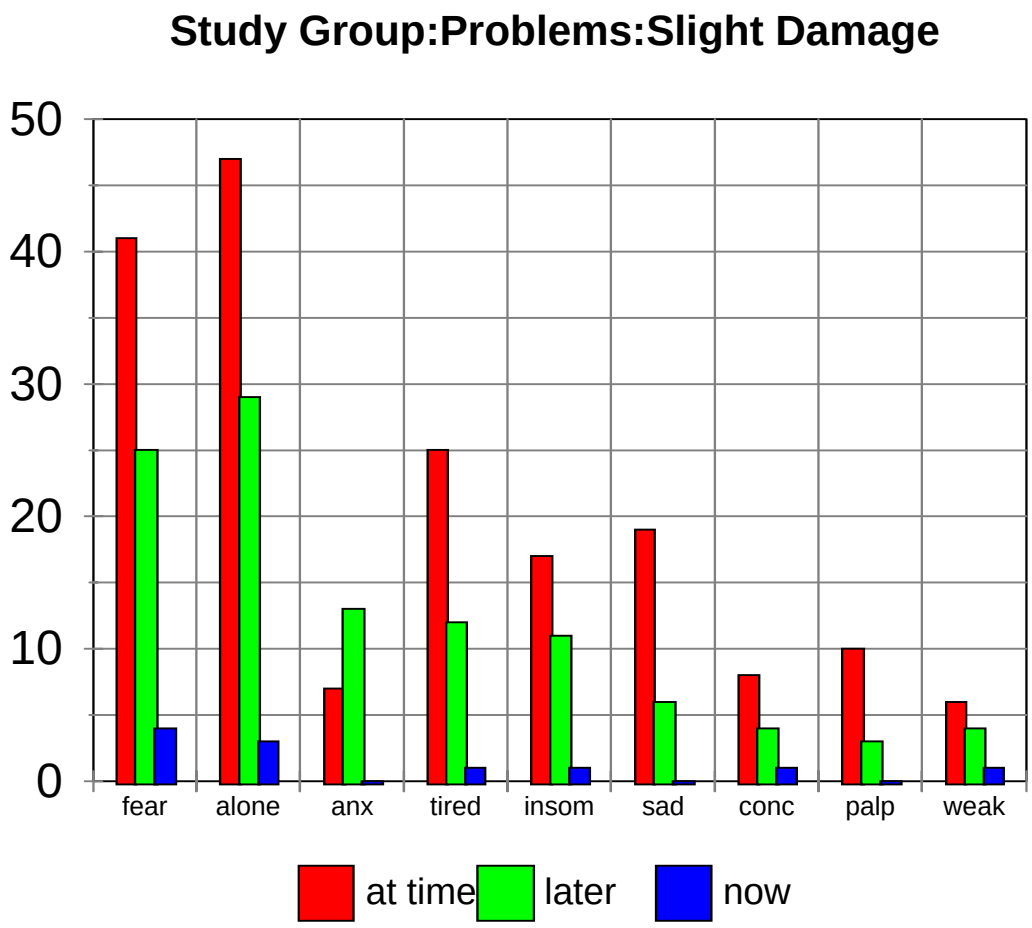
The graph shows problems for the group with no damage to their homes. The symptoms are shown in the order of incidence as at the time of the quake. The highest incidence is for fear, fear of being alone, anxiety, tiredness and insomnia.

Looking the at the rates after the quake we see that the order has changed. Insomnia and lack of concentration becoming more prominent. And as time goes on some of the symptoms disappear altogether for this group. The top five remain although lack of concentration, palpitations, weakness and fear of the dark also persist.

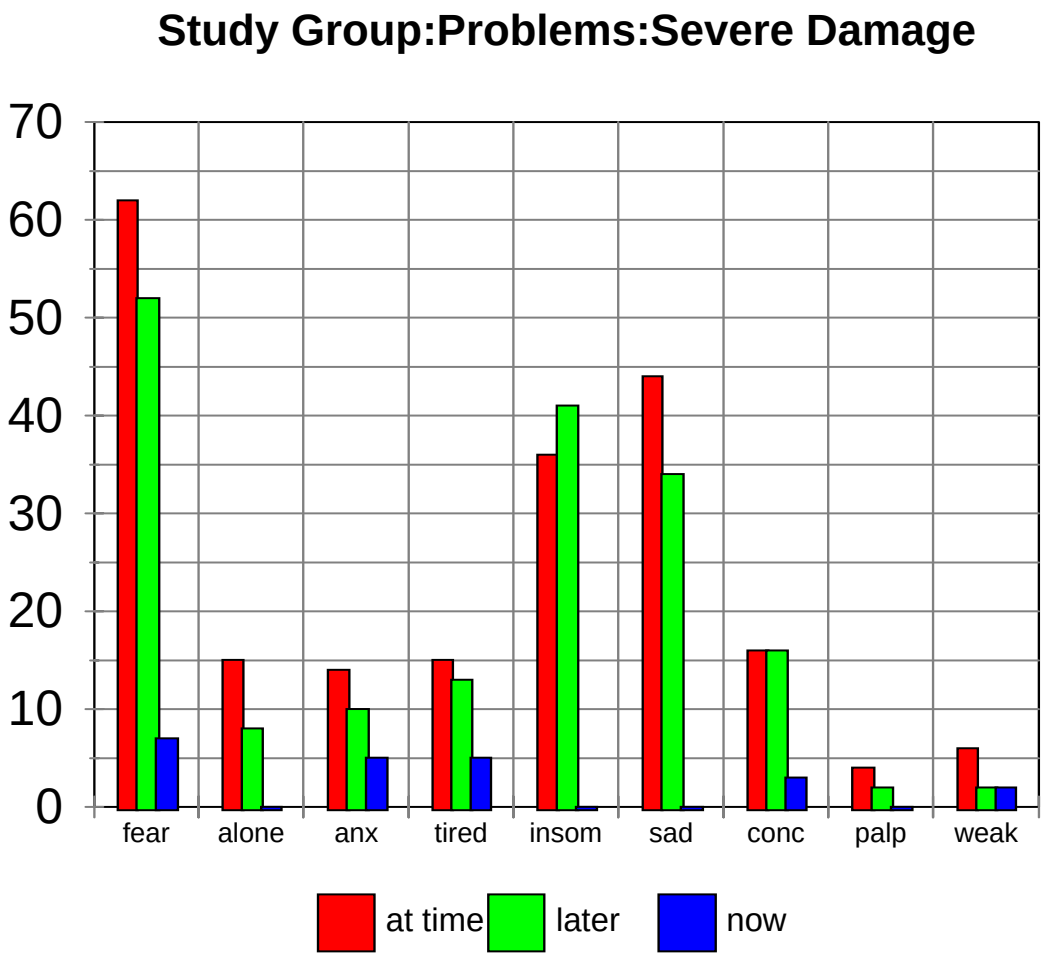
A 16 year old male

It was a terrible experience. Every day I lived with the fear of seeing my house crumble and of losing myself or my friends fortunately this dreadful experience is now over.

The same graph for the cases with slight damage to their homes shows a different pattern. The top two symptoms are the same as for those without damage – fear and fear of being alone at home. But of the top six symptoms anxiety is very much lower. Only 7% as opposed to 29%.



In the case of the group with severe damage – the pattern is different. They are fearful, can't sleep, are sad, school problems are a major feature coupled with lack of concentration. Weight loss , poor appetite and headaches – somatic symptoms come to notice. However note again how anxiety is less of a feature than for those without material loss.



Concentrating on the timing shows how the different levels of direct damage influence the responses. Note lower anxiety again in those directly affected with severe damage. This relates to the feeling of once the worst has happened you don't have to fear it any more.

After the quake those without damage have a high level of anxiety related problems while in general insomnia, sadness and problems with concentration are prominent particularly for the group with damage.

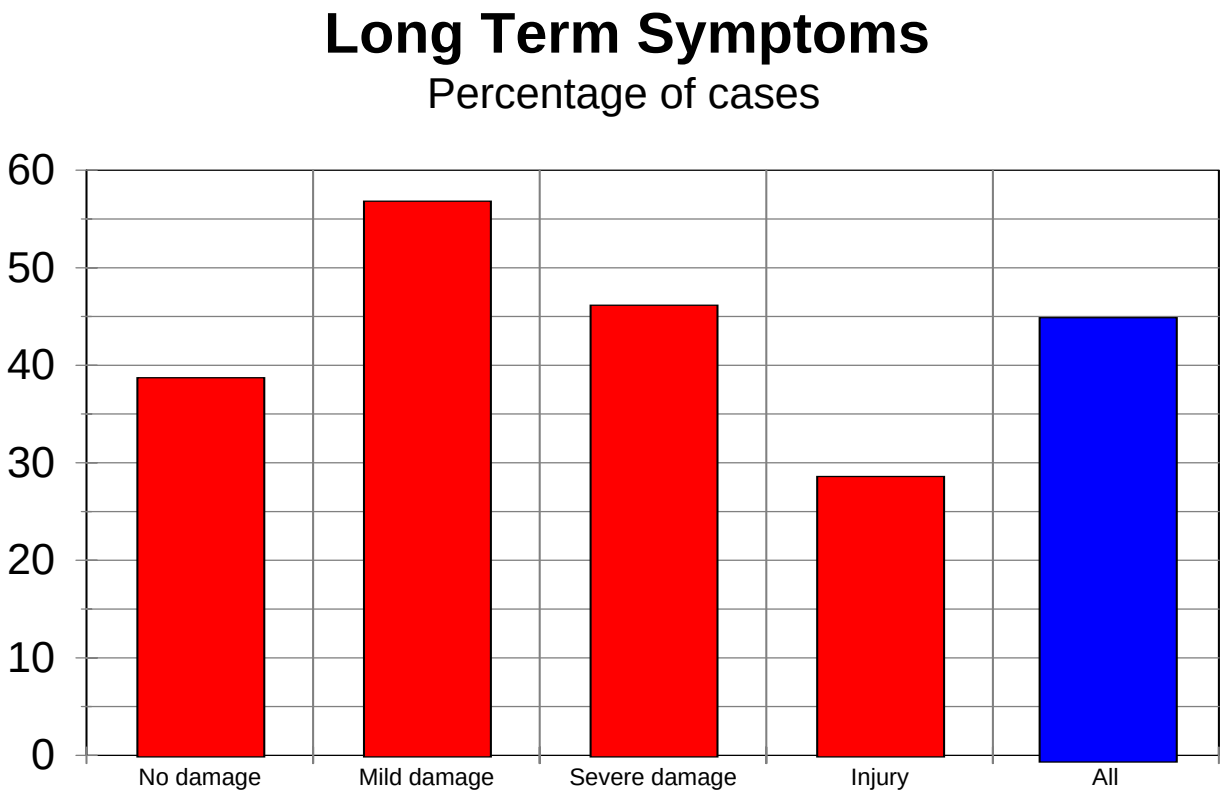
In fact the students responses echoed this feeling that waiting for something that might happen caused more anxiety – Several remarked that gaps between the tremors were more scary because you were waiting for the next one and that the longer gaps were more difficult to cope with because you then knew another one was imminent.

I was worried by long periods without shakes.

Girl aged 16

The earthquake marks your life and your existence because every time that there is even a small shock you are traumatised and start yelling. Even if I have not suffered any damage either to my house or to my person the fear is there and it is powerful, even now (18 months later).

In the long term (this is eighteen months later) these are the symptoms which persist. Fear, anxiety, tiredness, insomnia, poor concentration.



The duration of symptoms is also important to note. 40% of all students had some long standing symptoms and 12% still experienced at least one symptom after 18 months.

The incidence and average duration of the most common long term symptoms – fear 4% with average of 5.5 months chronic tiredness 2% on average for 6 months and anxiety 2% lasting nearly 4 months - show that although the incidence of each symptom might be low – the actual impact on the community and the individual is significant.

16 year old female

Fortunately in my village the effects of the earthquake were not very destructive and my house was not damaged Therefore the various consequences that it brought were fear, anxiety and agitation for a long period of time. I was anxious over the thought that these events are unpredictable and can happen at any moment. I was afraid of the destruction of the earthquake and of losing those I loved.

The phases of disaster impact can be seen in the progression of quotes from the students – first the survival and heroic camaraderie stage –

Fifteen year old girl

In my block during the days of the quake there was a great communication even among those popele who are usually terse and don't talk at all with anyone. They stopped under our house and talked about everything (including the earthquake). But the bad thing was that only during those days of was there a communal rapport between the inhabitants of the same building. During the shocks some people were so scared that they came out of their homes without being fully dressed!

I saw windows burst and houses crumble.

School was closed for a month

This phase gave way to a pervading sense of hoplessness and helplessness in the face of danger which was a theme in many of the students comments.

Female aged 15

At that time I was in terror specially when night came and I would have had little chance of escaping if there had been shocks.

Female aged 15

I was really worried when the walls moved back and forth. I went and slept in the car during the shocks.

Female aged 19

I'll always remember the earthquake because for me and my family it was a long period of continuous chaos, of great fear and of little achievement both at school and on the work front. It is only when you are in the face of it (the earthquake) that you really understand that in the face of nature you cant do a thing, you can only hope that it will not play any 'nasty tricks'.

At the time of our survey of the Fabriano quake the young people were one could say, in the restoration / disillusionment phases in the transition towards normality. The drama of the initial event had passed and they were beginning to face up to the long term reality of what had happened.

Initial shock and helplessness had also faded and they had gone through a phase of anger, feeling let down and this was expressed both directly and indirectly.

Girl of 16 (SEI 10) with an anxiety state and a low self worth.

The thing that worried me most about this quake was that the shocks were so frequent. My nerves were in pieces and I was in a dreadful rage. I also had a great uncertainty about tomorrow because I did not know if I would have a tomorrow.

They were also angry with the authorities –

'they know it's a seismic zone' why were they not prepared. When the school building collapsed the teachers did not help the pupils during the evacuation.

16 year old boy angry with the authorities

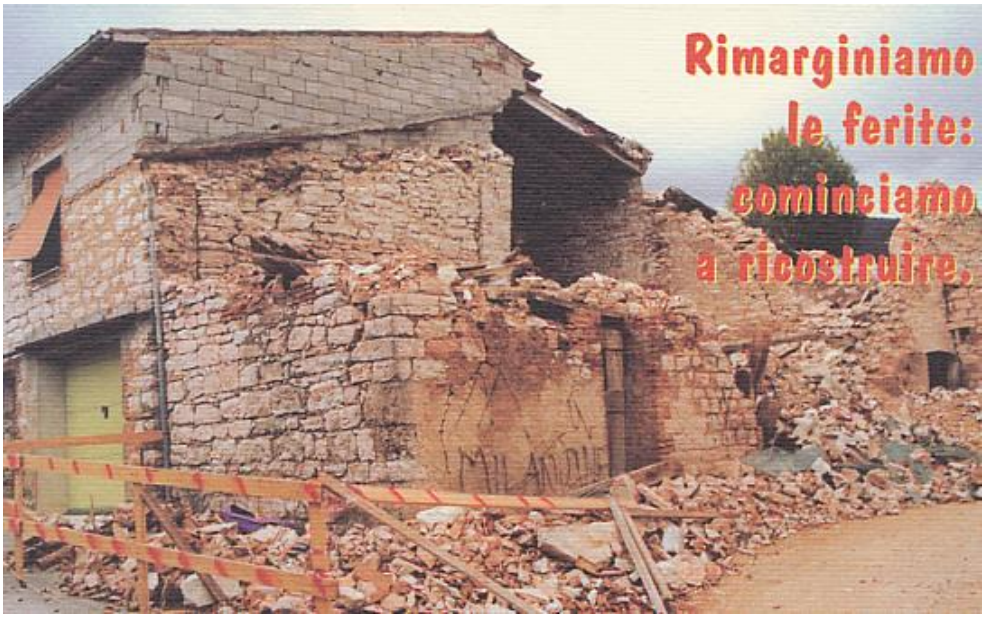
I'm afraid of Italian Beurocracy because the rebuild times are so long and my house is left just exactly as it was on that day.

The earthquake has been a real problem for me and my family. Of course life goes on but I feel better out side than indoors. It is as if when I go inside the house, which since the earthquake I share with my parents, grandparents and my brother, I feel much too sad because I remember how good it was before alone and in peace in my condemned house. However I get along very well with my parents and especially with my brother apart from the inevitable family squabbles.

Anger could well up against the family when they were cramped together – while in other families stronger bonds were forged.

Girl 19 years used voluntary work to avoid her sense of helplessness – family issues.

After the earthquake I made closer ties with my family and my parents. During the earthquake I did voluntary work with the scouts in the 'caravan city'
I am scared of the earthquake coming back and of being alone in the house. I'm afraid of a nocturnal quake. What worries me most is not to be able to do anything about it.



This slide is apt – the time had come to heal the wounds. Communities want to move on and it is laudable that people do not wish to dwell on the past but move forward positively to a new future. However we must remember that the emotional scars of such experiences are forever part of us and though diminished by time can for the more vulnerable of our society prove to be a real obstacle to a healthy and happy life. So we do need to provide support services and help for young people who are caught up in such traumatic situations and take note of their emotional needs.

Our estimate is that in this event approximately 3% of school pupils suffered from a significant degree of long term post traumatic stress. Fabriano was not the only town affected – Umbrian towns sustained heavy damage. We only examined a small proportion of the school children. 3% over the whole area is a lot of children. The effects on younger children may also have been more pernicious.

This is a seismic zone and there will be more quakes. A continuing program of education coupled with a dialogue with youth to air the problems and fears is just as important as building anti-seismic houses. What we need is ‘anti-seismic’ minds.

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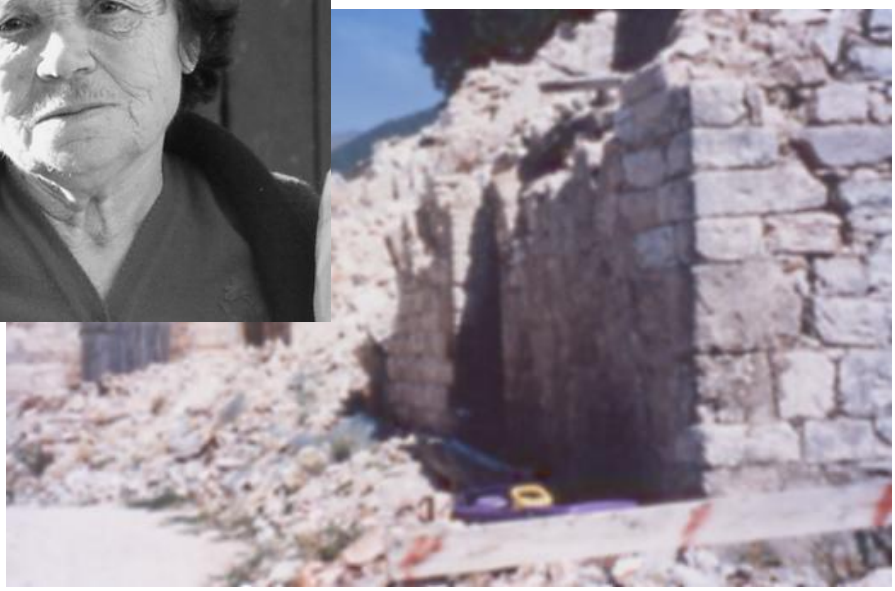


A developmental view of stress and the reaction to violence

{The original presentation was preceded by a sound track based on Pink Floyd ‘The Wall’ blended with the words of ‘Hush now baby’ see below in both languages}

The effects of traumatic events and violence - be it abuse, aggression or indirect violence may be seen in adolescence while having origins at an earlier stage of development.

Infancy -

The baby/ infant may be subjected to anger, rejection and be the focus of negative emotions which will impact on emotional development of the individual. It is here that object relations, the basis of all future relationship with the outside world and other living beings, are formed.

To outline rather simplistically the concept of object relations the following quote from ‘Inner Worlds’ [3]is appropriate –

“The baby asks for attention by crying, smiling, coughing and later vocalising. A fortunate child will receive an appropriate response which makes sense and thus aids his understanding of the world, whereas the unfortunate baby will receive the 'wrong' response or no response, leaving him confused and disturbed. We all receive some inappropriate responses since mothers are not perfect and the needs of a child can be easily misunderstood. A child's demands must also to an extent be frustrated if he is not to continue as a demanding omnipotent tyrant.

[3] Inner Worlds – YS Publications

The mother will be seen by the child as being good, nurturing , provider of all nourishment, when she is meeting the baby's needs at times such as feeding. In Kleinian terms, she is then seen as the 'good breast'. When she is withholding, frustrating the child and not fulfilling his needs, she is seen as the 'bad breast'.

When mother is doing something good, she is good, and when someone is doing something good to you, you feel good, you become good. Hence the good part of mother becomes part of the inner world of the baby. The same happens when mother is being 'bad'. Hence good and bad sides of mother represent 'internal objects' for the child.

At first the child cannot integrate these together. A young baby can adore the 'good mother' and then murderously hate the 'bad mother' without being able to see that both are parts of the same person. Later he may fear that he has harmed or destroyed the good while attacking the bad or that he may have exhausted or consumed the good breast by his greedy demands. Keeping these opposites apart is useful in avoiding the conflict inherent in integration but stops the child from developing a well functioning inner self."

Some of us never quite manage the integration of good and bad elements or we may use the split to cope with stressful situations, disowning the parts that do not fit with the currently felt emotion. If you are feeling anger or hatred for your mother, something taboo in 'nice' society, it is convenient to see her as totally wicked and neglectful, to completely disregard the loving, caring side which does not accord to your present view. You can't hate her if she's good, but you have permission to hate her if she's evil. This conflict – particularly if fuelled by abuse and violence during childhood is a breeding ground for personality disorders and behavioural problems which we then see emerging in adolescence and adulthood.

Developmental	Object Relations	How to deal with emotions How to relate to others
	Patterns of Behaviour	Patterns of feeling

The relationship between the individual and the mother figure / parent figure is central to all future emotional development and particularly the way that negative emotions are dealt with.

The mother is the container of positive and negative emotions for the developing baby and provides a ‘buffer’ zone, tempering the effects of negative feelings and reflecting them onto her child in an attenuated and thus manageable form. If the mother is unable to fulfil this function for her child - by virtue of being emotionally unavailable, distant, depressed, mentally ill or rejecting of the child - the baby will feel the full brunt of negative emotions at a stage when these may be too powerful to deal with - emotional damage - emotional abuse will thus occur.

To Quote again from ‘Inner Worlds’ –

“… we know ourselves by virtue of the reflected aspects of ourselves which we receive from other people. Winnicott beautifully described the mother as the mirror for the infant. He spoke of a mutual adoration between mother and baby whereby the child was able to express his feelings towards his mother who reflected them back in a way that could be incorporated into the child's developing self.

If the mother acted as a faithful mirror accurately reflecting the child's feelings and relating to him as a new unique individual whom she loved, then his true nature would flourish, he would develop as his 'true self'.

However if the mirror was flawed and instead of reflecting feelings, projected something different, the mother's fears, mother's worries, mother's hope that the child would somehow conform to, a mould of her making for him to fit into rather than his own space to grow in. If such a false image was projected back to the child, then he would forsake his 'true self' which was being rejected by his mother and instead, develop a 'false self' which his mother might love."

The true self becomes locked away, walled up -

- in the words of Roger Waters -

"... Mother's gonna make all your nightmares come true,
Mamma's gonna put all of her fears into you,
Mamma's gonna keep you right here,
Under her wing
She won't let you fly but she might let you sing
Mamma will keep baby cosy and warm,

Ooooh Babe, Ooooh Babe, Ooooh Babe

Of course Mam'll help build the wall ...."

Lack of mirroring and lack of responses - i.e. being ignored is more harmful than being the recipient of negative feelings - i.e. negative responses are better than no response. No response means you are valueless. If you don't value yourself you cannot value others and hence we have lack of empathy , lack of appreciation of harm delivered to others - this thus fostering the ability to inflict abuse and trauma on others.

If professionals detach too far from youth and fail to give youth a nurturing or ‘parental’ figure they can also echo the lack of mirroring - the youth can become depersonalised therefore by professionals and by institutions. ‘It doesn’t really matter what I do - because I don’t matter.’

Case History - .

Sarah *had been* s*exually abused by her grandfather since the age of 4 or 5. In common with many victims of sexual abuse, she was unable to 'disclose' what was happening. She at the same time could not believe that people - her mother, her aunt and her grandmother could not 'see' her distress and acted as if they did not know*

She began to act out the anger and frustration she felt in delinquent activity - smashing windows on her estate and minor acts of vandalism. This did not get her into trouble, people did not seem to notice. There was no consequence to her behaviour - just as there appeared to be no consequence to her grandfather's behaviour.

Later, as an adolescent, Sarah's rages became more intense. She walked a long distance with a knife in her hands , wanting to kill her grandfather. When she arrived she saw her grandmother and could not commit the deed. She thus went home, smashed the family home and was committed to a mental institution. She calmed down and was released. Another example of missed communication.

Later during therapy she went into an 'uncontrollable rage' one night and smashed windows in the treatment unit. The following day she doggedly refuted that there was any possible consequence to her behaviour. A breakthrough in therapy occurred when she was faced with possible consequences and a code of 'acceptable behaviour' was laid down. It was as if at last 'it mattered' what she did and therefore 'she mattered'.

In the extreme situation the mother may actually be abusive to the infant - and this abuse may actually begin in utero (eg effects of drugs, lack of antenatal care, hitting mother in the stomach etc) and continue into infancy and beyond. The developing psyche of the child may traverse many avenues of abuse prior to the effects coming to the fore in adolescence.

Security of attachment and it's opposite pole – separation anxiety are developed in infancy and play a continuing part as we progress through life –

A quote from 'Inner Worlds'

For a teenager, life can be an insecure tightrope walk between the dependant need to seek approval and maintain the goodwill of parents and the need to break free and establish oneself as an independent person.

The infant learns of this dilemma in his earliest days - as he crawls off mother's lap to retrieve a lost toy - as he takes his first faltering steps away, always looking behind to make sure she is still there, and later, as he develops the confidence to wander briefly out of the security of her gaze.

John Bowlby saw child development and attachment in terms of exploration from a secure base. In many ways all life is an exploration, a venturing forth from a secure base. Every time we move into new areas of life, into new jobs, new relationships we are re-enacting this same first dilemma, calling on the same inner reserves of strength and emotional security to carry us through.

Those of us fortunate enough to carry within ourselves the security which we acquired at our mother's knee will grow in self confidence with each encounter. But suppose we have no inner security, no safe place to be? Each experience, each

relationship provides not only a new opportunity for acquisition of approval and self worth but also an increasingly desperate search for that loving 'holding' safety which was lacking at an earlier time.

Childhood

Traumatic events and violence occurring in childhood profoundly affects the adolescent whether it be violence perpetrated on the individual or witnessed violence within the family or society. Family structure and family behavioural patterns lay down ‘blueprints’ for behaviour, values and emotional functioning. These can be looked at from various perspectives – for example the concept of ‘life scripts’ – dysfunctional patterns and boundary issues all play a part.

How do we understand the effects of violence? The dynamics of the situation could be see thus - an initial act of aggression or violence perpetrated on the child will produce feelings which may or may no be openly evident. Some feelings may be covert and gradually build up to produce inner tensions and conflicts. The overt and expressed feeling may be that which is acceptable within the society or family grouping of the individual - that will accord with the current expressed behaviour patterns of the child. For example the child may feel fear and act timid, retiring or wet the bed or the child may be angry and jealous and destroy a siblings toys.

Initial Act			**Resultant Act**
Agression	**Feeling →**	**Shown**	**Current behaviour**
	→	**Covert**	**Future behaviour**

The covert feelings which may be unacceptable in the family are those which may surface later in adolescence and can be the source of more extreme and perhaps harmful behaviour patterns and psychological pathology.

The following model is useful in discussing the effects of physical violence on a child.

Stimulus	**Feeling**	**Result/ Role**	**Flexibility/ Resilience**
Violence →	**Hurt Betrayal**	**Cry Pain**	**High**
	Confusion	**Attempt at reason**	
	Anger Unfair	**Strike out Revenge**	
	Guilt Worthlessness	**Scapegoat**	
	Bad	**Passive**	
	Deserving punishment	**Victim**	**Low**

The lower the ‘energy level’ ie less able to adapt, lower resilience and flexibility - the higher the passivity with more internalisation of feelings - anger hatred, lower self worth, lower coping skills and thus the more likelihood of self hatred, self harming behaviours.

As abuse / experience of violence becomes more frequent and more commonplace the individual may become more hardened and ‘acculturated’ to the experience and thus more fixed in the adopted role or behaviour pattern of behaviour and feeling.

In terms of the ‘cycle of abuse’ - The adolescent is at a pivotal point between violence received as a child and violence given to (own child) others.

Violence received ← Adolescent → Violence given

as a child to own child

Violence within the child's environment can take several forms all of which impact on future well being. Direct violence to the child (abuse); other forms of abuse (emotional etc) ; violence between family members; violence witnessed outside the home; 'Covert' violence eg rough play.

Types of Violence	
Direct Violence	- Direct violence to the child (abuse) - other forms of abuse (emotional etc)
Witnessed Violence	- violence between family members - violence witnessed outside the home - Media violence
'Covert' violence	- rough play - made to do things don't like?

In play a child can be learning about how to handle violence and aggression. We see animals, puppies for example play fighting and learning how to cope with conflict. Children do the same and adolescents also test out boundaries and 'play fight' certain situations in the safe environs of the family and friends.

When these limits are extended and breached however, problems arise. The fight that gets too serious, the rough play that ceases to be fun and causes tears. The tumble on the carpet that stops being a lesson in physical closeness and becomes a sexual grope. The game that is no longer mildly competitive and becomes dominance with submission.

Advantages				Problems
Social	←	Rough Play	→	Bullying
Grouping	←	needs boundaries	→	Domination
Learning skills	←	protection	→	Submission
Fun (for all)	←	'rules' of game	→	Boundaries breached

When dominance becomes a factor – then cruelty and bullying creep in. How do we tell when this boundary is breached? If the behaviour is for the satisfaction or gratification of one to the exclusion of the other, if one has to be 'put down' – then this is bullying – there needs to be equality in play and maintenance of boundaries. Otherwise there is a point where the acquisition of positive skills is replaced by learning negative behaviours.

+ve skills ← → -ve behaviours

Another example is in the learning of social groupings – a positive learning experience can be replaced by the negative modelling on gangs.

Learning abusive patterns – copying with family violence.

Violence in the family has a very high level of persistence from one generation to another. Maltreatment of children has been shown to increase levels of violent crime perpetrated by adolescents by 24% ; violence between parents was a factor in the history of 70% of violent adolescents and those exposed to multiple forms of violence – ie within family members and to self – had double the rate of violent crime (at 75%) than a control group in the Rochester (USA) youth development study. Similar trends – although with lower overall rates – have been experienced in other countries.

However ‘ the number of potential psychological casualties of violence far outnumbers the physically wounded seen in emergency rooms’ Here lies a source of adolescent disturbance and behavioural problems. Social factors such as family poverty, stress, overcrowding and homelessness also play their part here.

Abuse in childhood also increases the risk of drug and alcohol abuse – an article in the International Journal of addiction (Vol 29 1994) on ‘Childhood victimisation and the risk of alcohol and drug arrests’ (Ireland and Widom) concluded that childhood maltreatment is a significant predictor of adult arrests for alcohol and drug offences and there was a 39% increase in juvenile crime in this group.

Case History –

Ingrid *lived in a very violent household. Mother and father frequently fought and her older brothers were all violent. Her father and brother were alcoholics. Ingrid was abused physically and sexually. She was placed in children’s homes at various stages in her childhood where she was also abused. Ingrid became a mother herself at the age of 14 and had another child two years later. She was by that stage earning her living in prostitution. She moved around the country with her two boys avoiding the authorities and progressing from one violent pimp to another. She abused alcohol and drugs. The boys were cared for erratically, they were not deliberately abused but did suffer neglect and had various ‘accidental’ injuries.*

Ingrid decided to try to change her lifestyle after a close friend was murdered by her customer. She acknowledged that she had often placed herself at risk of severe injury and she was afraid she would die.

When the boys were taken into care of social services their behaviour echoed their mother's obsession with images of violence. They fought other children, destroyed property and in play therapy when given a doll the six year old boy tortured the female image and then ended the play by crushing her head in.

A sad example of patterning on family disturbance and childhood violence. Several years later the family are still functioning in the same disturbed manner and the boys are sociopaths.

Summary

To summarise therefore - we have three basic important concepts -

1. **Object relations** which give us a blueprint of how to relate to others and to understand the 'good' and 'bad' aspects in each and every one of us.

2. The Winnicottian concept of **mirroring** - unpleasant feelings in the infant being mirrored by the 'mother' figure and reflected back to the baby in a way that can be coped with. The concept of false mirroring and lack of mirroring both producing potentially pathological scenarios with children developing into youth who are unable to cope with their angry and aggressive feelings.

3. Bowlby's concept of the **safe base** from which we explore our environment which gives us the basis upon which to develop relationships with others.

The degree to which these three concepts are developed and fully integrated into our personalities will govern the way in which we develop resilience and coping strategies and thus how we confront and overcome adversity and traumatic events.

* * * * *

The Response of Children to Traumatic Stress

He was half asleep lying in darkness. It was warm and he felt safe and content. Muffled sounds reached his ears but he felt calmed by them. It was a comfortable sound with a familiar rhythm. He pulled his knees up to his chest and curled up, fell asleep.

Suddenly he was woken by an unfamiliar noise. Voices were getting closer he could hear his heart beating faster …. louder … and resounding in his head. He felt afraid.

Now he realised he was being crushed. He felt pressure on his head, his chest was compressed and he could not move.

What was happening?

The pressure increased until he felt himself slipping into unconsciousness as his blood oxygen level fell and his brain became starved.

Just as the pressure on his chest became unbearable, he felt himself grabbed.

A voice yelled 'I can see him …. Yes take it easy … I've got his head … It's Ok … not long now and we will have him out!'

He felt himself suffocating, unable to breathe.

Strong arms took hold of his chest and pulled him free. Someone was trying to put something in his mouth and yelling …

the noise was deafening all around him. He tried to open his eyes but the light dazzled him.

'Breathe .. breathe!' someone yelled again

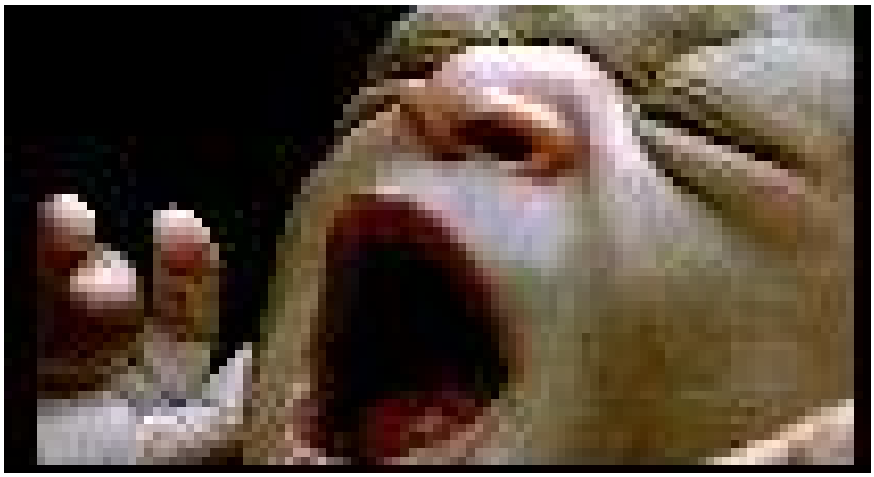
He choked and coughed up some fluid …

This was all too awful!

He let out a cry!

* * * * *

Was this child pulled out from the rubble of an earthquake? Was this boy buried while lying asleep in his bed? The description would have fitted these scenarios. ….. But NO. This was something which we have all experienced. This was the moment of birth!



First Cry!

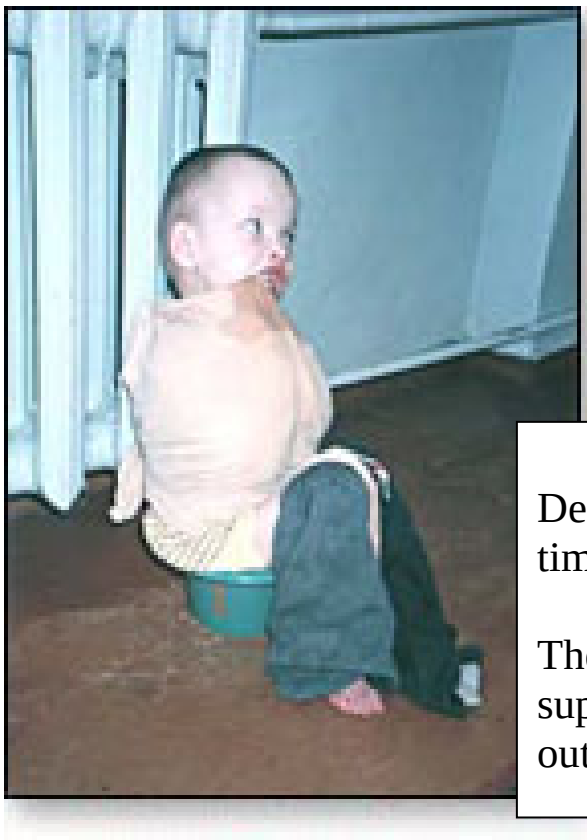
Children are exposed to traumatic events from the moment of conception.

Growth and development followed by the violent expulsion from the womb; every organ squeezed as the foetus is pushed towards the outside world , evicted from it's first place of safety from a dark reasonably quiet world into a glaringly bright and harshly noisy environment. This is something we all go through. One of our first moments of trauma.

And there are those who firmly believe that birth experiences and even pre-birth experiences do constitute a significant factor in shaping our psyche and that this first traumatic stress can and does cause damage which requires therapeutic intervention. For example re-birthing therapy, Arthur Janovs writings e.g. 'The Primal Scream' and other allied works focus very much on this approach but most therapists would attribute at least some effects to the birth and possibly intrauterine stage. It is for this reason that exponents of natural birthing such as Le Boyer in France focussed on the birth environment allowing the child to be born into dark quiet environments rather than the harsh labour ward and others have tried birth under water so that the baby is expelled into warm water feeling like the amniotic fluid.

Early life can be traumatic as we learn to handle the frustrations of life of needing to get fed changed and looked after. Then we have to share our world with others , learn how to relate to them and also start to learn how to cope as maybe new siblings come into the family, new situations present themselves. Learning to walk, talk, sleeping in our own bed … going to school … these are all hurdles that we all have to pass even in an ordinary caring nurturing environment - so just imagine what will happen if we add traumatic events such as sickness, rejection, abuse, abandonment. Or maybe a natural disaster starvation, injury, loss of loved ones …

Effects of trauma



Depend on the frequency and timing of traumatic events

The manner in which the child is supported by the family and the outside environment

A child starts life with an inherent degree of flexibility and resilience to deal with traumas but the degree to which this coping ability is strengthened or weakened by events depends on the inherent personality of the child and the way the psyche develops (which we will discuss further); it depends on the frequency and timing of traumatic events occurring in the child's life; and it depends on the manner in which that child is supported by the family and the outside environment.

Sources of Traumatic Stress

Children can be subjected to traumatic stress by a number of different factors.

Children often are exposed to trauma as a result of the following kinds of events:

- actual emotional, physical or sexual abuse
- witnessing domestic violence or being in an abusive environment
- Being directly involved in a disaster or accident (including war)
- witnessing the effects on others of a disaster or accident
- Being ill
- Family member being ill (e.g. mother unable to care)
- Bereavement and severe loss (could be family member or pet)
- Family breakdown or divorce
- School -academic stress - exam stress

There are of course others but these are the main factors. Depending on the individual child, the family social and cultural variations different factors will assume a greater or lesser importance for each individual child.

Some of these factors are more important in children than adults. For example a loss of a pet can be a greater bereavement than the death of say a grandparent.

The very concept of death has a different meaning too for a child. A child with a developmental age under five does not understand the permanency of death and thus cannot handle bereavement in the same way as an adult. Coupled to this we have the patterning of our society which fosters the idea in children that cartoon cat Tom can be flattened by a bulldozer, dumped off a cliff and swallow dynamite and still come back and bother 'Jerry' the cartoon mouse.

Another factor to consider is loss and how that occurs. A family break up and losing a parent by divorce for example is more damaging to a child than loss of the parent by death - given that they are old enough to understand death. A definable end point is an important thing for a child. Worry about loss is more damaging than the actual loss in most cases and children are dreadful worriers.

Hence most cases of school phobia relate to worrying about what will happen at home or what will happen to mum while the child is out of the house.

Imagination

Children have a very active imagination - this is how they learn and develop. They visualise a situation, practice it in play and thus prepare themselves for the time when this will really happen. They also dream about events and rehearse them in their dreams.

- **Learning via imagination**

- Children have active imaginations
- visualise a situation
- practice it in play
- prepare themselves actual event
- dream about events
- rehearse them in their dreams.

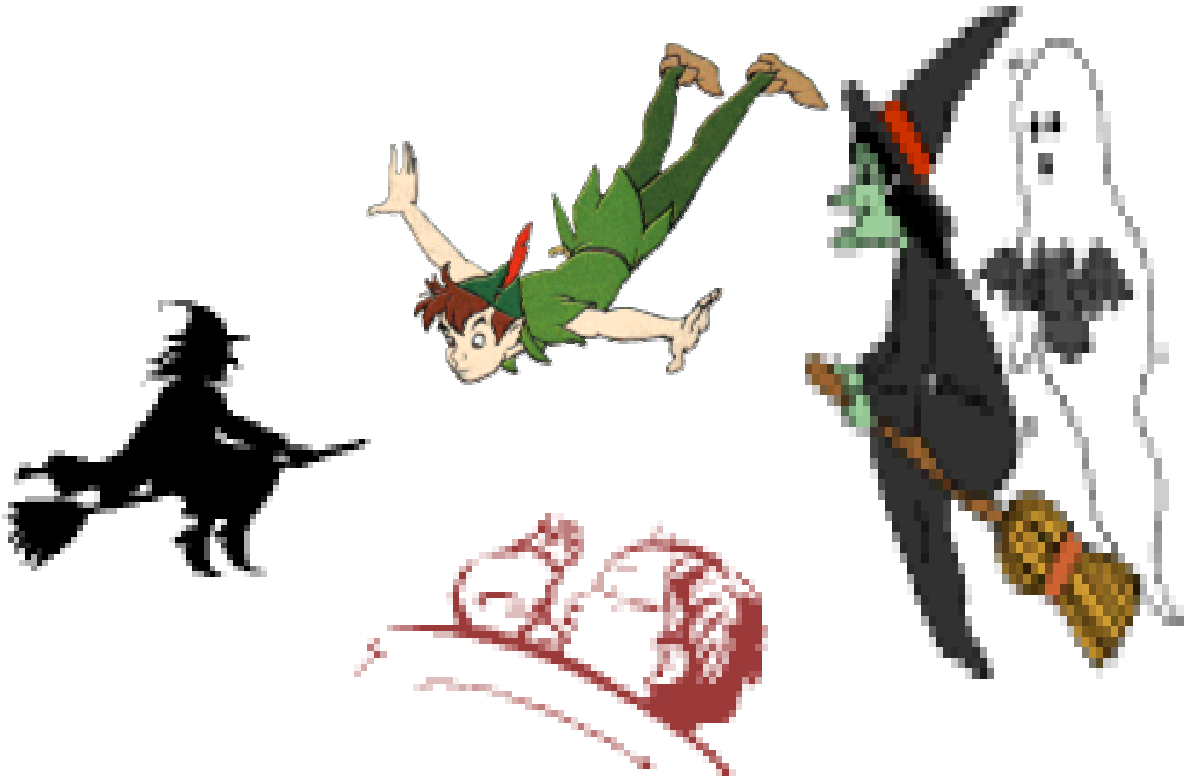
As adults we have to an extent lost the ability to do this naturally and that is why we have therapies which focus on visualisation, on learning how to play and we visit analysts to hear interpretations of our dreams.

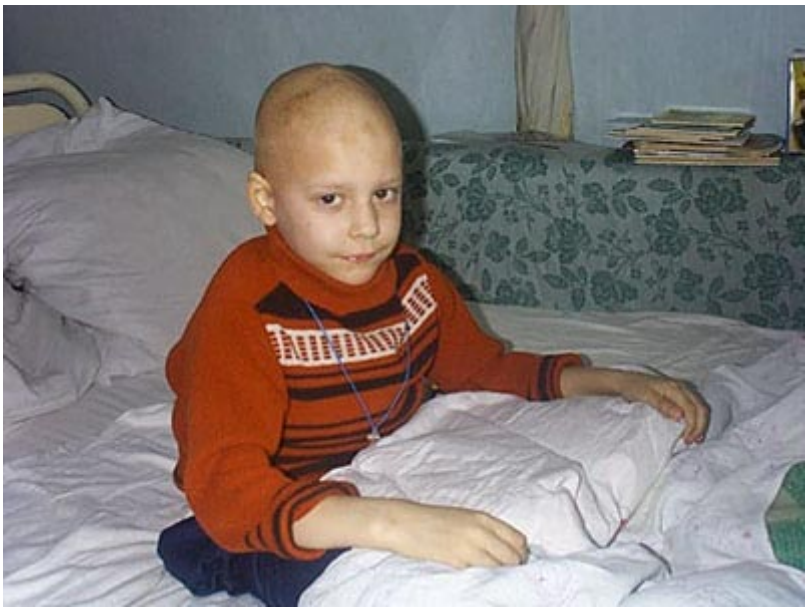
This is all very well when life is good, when we are cared for and when our dreams are filled with happy children, on the yellow brick road to Oz or flying with peter pan in never never land. Its a different matter when they are invaded by the Wicked witch of the west or Captain Hook

So while an active imagination is a plus for children - it also becomes a factor in governing how children react when traumatic events unfold. Imagination becomes worry and fear; dreams become nightmares and play becomes re-enactment of troubling and terrifying events.

Frightened children can resort to repetitive behaviour and clutching at lucky charms and amulets in seeking protection. They believe in magic and fantasy and will take on any 'helpful' belief to protect them from danger. So they confuse religion, magic superstition. Walking without stepping on cracks like (Jack Nicholson in 'As good as it gets') , using ritual and every conceivable charm as the little boy treated by psychologist Bruce Willis in 'Sixth Sense'. This is the sort of behaviour which we also see of course in adult OCD Obsessive compulsive disorder.

Dreams become nightmares





Chernobyl

Reactions

Not surprisingly, just as in the case of adults - many studies have shown that there is a connection between children's exposure to traumatic events and psychological problems. Children do develop post traumatic stress just as adults do and there are also problems which are more specific to the child's developmental stage and to their environments and the particular activities which children are involved in as opposed to adults.

Hence while adults have difficulties in social and work settings - children have problems making friends, may be bullied and assume a victim position at school, have problems with school work and can be viewed as withdrawn and uncommunicative by teachers.

Their emotional problems and lack of concentration can also be misinterpreted as low intelligence or refusal to work and study - thus landing them in further trouble at school. They are then likely to become resentful, angry maybe and feel let down by the authorities. This in turn can lead to acting out, aggression and bitterness.

Effects may be seen as -

- Anxiety states and PTSD, fear, anger depression.
- emotional difficulties and developmental problems
- poor relationships with friends and family
- low self-esteem - guilt and blame - worthless - ashamed
- school problems and poor concentration
- delinquent or difficult behaviour - anger
- Troubled play - including sexualised play (CSA)
- General health problems and substance abuse (teens)

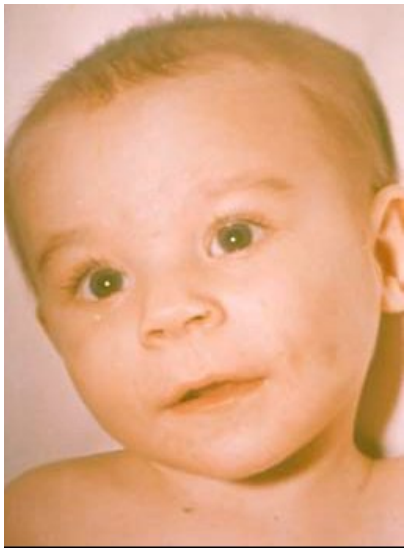
The symptoms of full blown traumatic stress PTSD in children are similar to the adults with the exceptions descried above. The developmental stage is important and the way a child

communicates his or her problems to the outside world is the limiting factor.

As an example of the different communication levels and the way in which we as adults need to be vigilant and aware of these alternative ways of communicating let us consider how a small baby communicates this pain and how an abused infant can also suffer from PTSD.

Two very important signs exist. Firstly a frequently abused child will not show the normal pain associated with physical injury - this is the case at first and then they learn that crying and showing distress can bring further abuse. So they start off fretful, uncomfortable and difficult to feed - so perhaps hyperactive and then become withdrawn, unresponsive and not feeding for that reason - hypo active.

The hypervigilance which we see in older children and adults - waiting for the next assault - becomes a condition known as ‘frozen awareness’ A wide eyed worried look - almost an ‘old’ look. This child has experienced too much pain and suffering in its short life.



The PTSD association lists the following signs -

- disturbing memories or flashbacks
- repeated nightmares and dreams of death
- belief in omens and prediction of disastrous future events
- pessimism about the future and expectation of early death
- avoiding reminders of traumatic experiences
- fear of re-experiencing traumatic anxiety
- behavioural re-enactment (expressed as repetitive play)
- emotional numbness (seeming to have no feelings, except perhaps anger)
- diminished interest in significant activities
- physical symptoms, such as stomach-aches and headaches
- feeling constantly on guard, or nervous and jumpy

The traumas suffered or witnessed by the child will also influence other childhood emotional and psychological disorders and play a part in their development. It is a matter for discussion to what extent traumatic stress alone is responsible for their aetiology.

These disorders are listed by north American sources - definitions vary cross culturally. -

- attention-deficit hyperactivity disorder
- dissociative disorders
- eating disorders
- major depression
- oppositional defiant disorder
- panic disorder
- phobias
- separation anxiety disorder

Children and families -

Children do not exist in a vacuum, they are generally part of a family. Winnicott said that 'There is no such thing as a child' meaning in this case that there is only a diad - mother and child (parent and child) it is the reaction and dialogue between individuals and not the individual alone, which is of primary importance.

Children are obviously very influenced by their families and how families deal with stress. Some families are calm, reasonably unemotional and do not show feeling readily - this may be helpful in traumatic situations but may also block the ability to deal with and process emotions.

Others may appear to be noisy - over emotional and dramatic in their responses. They may however be able to cope with stress well by expressing their pain and supporting each other through it.

Yet other families may deal with stress badly. For example an anxious parent or a depressed parent will transmit these feelings and poor coping strategies to their child. So children are very much affected by the reactions and behaviour of the people around them as they grow up - whether these be their natural family, a foster environment or professional carers and teachers.

In summary this can be put as - if you see a dog for the first time - you don't know what it is, you don't know if it is hostile or friendly. The natural reaction is to be inquisitive. A family could foster this approach - a sense of exploration and acquisition of knowledge. So you walk up to the dog and grab it's fur. The odds are that the dog, sensing that you are not afraid and thus not a threat will react in a friendly manner. Perhaps lick you .. this will tickle .. you will laugh.

But if your mother is afraid of dogs - she may yell - you will sense the dog is something to be scared of - the dog will sense

that you are something to be scared of. You jerk your hand away - the dog is jumpy and may bite - Mothers fears are realised and reinforced - you have her fears instilled in you.

A confident parent can instil confidence and lack of fear in a child. This is beautifully depicted by Roberto Benigni in 'La vita e` Bella' where a father refuses to be afraid in a concentration camp and prevents his son from being fearful.

La Vita e` Bella

We have seen children adopt the behaviour and reactions of their disturbed parents with respect to depression, anxiety states, hysteria, violence, and all manner of personality disorder.

To quote the PTSD Association - *Children whose parents are persistently psychologically impaired have a poor prognosis for their own psychological reaction and children whose parents suffer significant peritraumatic distress have a higher rate of emotional damage and poorer outcome. In families - there is a reciprocal effect by means of which each individual's stress*

amplifies the stress of the other family members. Placing both child and adult at risk of long term symptoms

So what is being done to help children in disaster areas?

A quote from the Turkish quake (American Red Cross)

The Turkish Psychological Association has established a program for children in the Adapazari tent city. In the children's tent, volunteer psychologists encourage the young people to express themselves through art. Most of them long to return to a normal home life, and their pictures and Play-Doh and Leggo sculptures are often of big, beautiful houses the children would like to someday live in, according to volunteers.

Many psychological organizations specifically target children in their programs. The Duzce Education Group, for example, provides education and game facilities for children living in tent cities. Initiated by students of Istanbul's Bosphorus University, the organization's mission is to provide a "nurturing place where children can play and learn."

"After the November 12 earthquake that was centered in the city of Duzce, several students from our university worked as translators at hospitals set up by the Egyptian and Israeli governments," said Kirsten Sadler, a professor of molecular biology and genetics at Bosphorus University. "They were particularly struck by the terrible conditions of the children there--many of them had lost friends, family, or even parents. Even though the life toll from this earthquake was not even close to the big one last summer, the psychological damage is enormous. The psychology of the whole country was severely damaged after last summer, many people still live in fear that everything they have could be wiped out in a matter of seconds. The entire city of Duzce moved literally into the streets. Thousands of them are still living there, and it is very hard on

the children. Our students wanted to create a safe and educational place for the kids to come."

Child earthquake survivors are at a particular psychological risk because of their difficulty in understanding what happened, according to Sadler. Added to that are the stresses of being part of a displaced population. "The caretakers themselves have suffered incredible losses, and the entire population is living in tents. Therefore it is virtually impossible to create an environment for the children which allows them to feel safe," Sadler said. "In addition, the hardships of the life there--outdoor toilets, public baths, no cooking facilities, and crowded tents sometimes occupied by more than one family--make it nearly impossible for the children to play or to gain some sense of normalcy in their lives.

"Formal counseling services for the children in this setting is not a realistic option, since the government simply does not have the trained staff or resources to organize such an effort. Therefore, we are trying to provide a place where the children can be children--playing and learning--and where they can have an opportunity to work out some of their issues through play, physical activity, and creative expression."

And educational programs are also important so that children know what to expect -

Earthquake Preparedness Education Eases Anxiety

Just like adult earthquake survivors, children experience a loss of control and a sense of vulnerability after the disaster. Mental health professionals tackle these problems through education and raising awareness about earthquakes. "You can't control earthquakes, you can't control the shaking, but you can be prepared for the next disaster," said Jill Hoffman of the American Red Cross. School programs teach children to duck under desks if sirens blare during the day, or to curl up in the

fetal position with a pillow over their heads if a quake strikes while they are at home. Teachers urge their students' parents to move heavy furniture away from doorways and beds and to develop a safety and evacuation plan. Parents and kids are also encouraged to pack an emergency bag filled with water, a change of clothes, flashlights, and items that make them feel safe, such as a favorite teddy bear. The bags, they are told, should be kept by the door so they can be easily grabbed if the family needs to evacuate. "Families need to develop an internal frame from which they feel safe," Hoffman said. "No one is ever prepared, physically or emotionally, for everything falling down around you, but you can minimize the risk and, therefore, minimize the anxiety."

The Kobe Earthquake

{The following was presented at our European Conference at the 'Royal College of Physicians' in London by Dr Yuka Okada }

Let us look now at a study of children's experiences after the Kobe quake - the work of Dr. Yuka Okada - Associate Professor in the Faculty of Human Development at Kobe University and a practising paediatrician.

Effects of the Kobe Earthquake on young children –

Kobe is working area of Japan near Kyoto and Osaka. It is about 100 km distance from Tokyo.

In Japan the number of children who have psychosomatic diseases, behavioural problems and developmental problems has been increasing recently. We started at the developmental behavioural paediatric clinic to treat the children from physical aspects, but also from psychological and social aspects in 1990. Developmental behavioural paediatrics means paediatrics where

patients are treated from biological, psychological, sociological, ecological and cultural aspects. We are working in collaboration with child psychiatrists.

The study addresses the psychological aspect of the Kobe earthquake. The people of Greece, Turkey and China have suffered recently from earthquake disaster.

Just before the dawn of January 17th in 1995 the Kobe area was hit by the extremely strong earthquake. Over 6000 people including over 40 children died in the few seconds. More than 500 children lost their parents. In addition one fifth of citizens lost their houses and more than 250 thousand people were evacuated and lived in shelters. Many school buildings were used as shelters.

As paediatricians and child psychiatrists we made manuals in order to educate health, medical and educational professionals

and we consulted the children who showed emotional symptoms. Through these activities we found that the parents found children's behaviour changed, worsened. As a part of these activities we started the project to follow up the children in order to know the psychological effect of this serious disaster for young children and to seek a proper supportive approach.

We planned interventions with 240 children from 3 kindergartens in Kobe. We started the interventions one month after the earthquake. The first focussed on teachers. We started our activities of mental health care by sending questionnaire about how the tragedy affected children's behaviour. We did this survey with teachers and we discussed the children's problems and how to deal with problems properly.

The second phase was a direct service for mothers and children We saw a group a group of parents to hold a question-answer meeting on mental health of children after disaster. I personally met them, heard of their terrible experience and gave advice to those who needed help from us.

The results of our questionnaire at one and a half months after the earthquake were compared with those of the children in Miki city, which is next to Kobe city, and was not so severely damaged. In Kobe city one child died and 12% of children had completely destroyed houses.

Fifteen of 65 items from the questionnaire showed a significant difference between the groups. Common characteristic of the behavioural changes at this age are agitation and irritation, separation anxiety and other aggressive behaviours. Physical symptoms: general anxiety, post-traumatic stress disorder related symptoms. We experienced a higher level of hyperarousal and activity which was commonly noticed, but avoiding and numbing symptoms are not a common thing at this age.

The children who stayed at shelters seem more agitated and irritated to the point of becoming explosive. They seem to have more serious problems than others.

We did another survey for paediatricians in the damaged area for children below 6 years old. Regressive behaviours were the most common problems in the group of the children under 6 years old, they could find all types of problems. For example, sleep problems, restlessness, recurrent abdominal pain and depressive symptoms. Paediatricians directed the mothers not to worry about it and to hold the children and to take much time to stay with them. Many children needed the feeling of safety and being held. For the young children it was the most important treatment to make sure of their emotional security base.

A 5-year old boy who lost his mother and the baby, whispered to his teacher several hours after the earthquake, “I’ll tell you a secret - My mum and the baby were dead. Now only my daddy and I are left”. He asked the teacher never to tell of this to anybody. It’s secret. The fact which was of course absolutely clear for adults, but it was important that it should be kept a secret for the young boy. We should keep in mind, each child has an individual developmental character of perception, of recognition and expression.

The results of a questionnaire for their parents at 5 months and at 14 months after the earthquake showed that the avoidance level had increased and their experience of events were common regarding avoiding and numbing behaviours, although many of them tended to take a pessimistic view of the future, most of them realised, family bonding had become tighter and that they had learned a lot about life. Four years later over 90% of them thought the same.

Though our work we came to believe that certain children had a particularly high risk of developing emotional problems.

- The first high risk group were the children who had any developmental, behavioural or family problems before the earthquake.
- Second, the children who lived separately from their parents and family after the earthquake.
- Third, the children who had lost their parents.

In Japan the care of the children who have lost their parents is not well developed. A boy who lost his father painted a black rainbow. The black rainbow touched the hearts of the people who cared for him. They deeply hoped that this rainbow would become a colourful rainbow.

Then the foster care house for the children who lost their parents named Rainbow House was built and started this year in Kobe with individual donations. Many young people from all over Japan contributed to this charity and collected money for the house. In fact, we experience the conflict between the people who have gradually survived and who have not survived. We think the social healing approach is needed in our society.

We did this project as a collaboration with JSPP and Chaga. JSPP is a small academic association which consists of child psychiatrists and paediatricians. Chaga is the group. It started at the Kobe earthquake as an avenue for specialists in child care to become involved in voluntary activities. The members are medical doctors, psychologists, social workers, teachers, students and journalists. We have learnt key-points of child mental health-care after the Kobe earthquake.

Basically we had to develop a network of child mental health in the community. In the emergency situation the network worked quickly and effectively. The voluntary workers worked in collaboration with community network. We are sure that this is very important from a society and individual point of view and provided a family-centred mental healthcare for young people.

The people in Kobe area faced together the problem of co-operation and collaboration and professionals learned a great deal about the mental welfare and needs of children after the Kobe earthquake. We found that how working with the children encouraged not only their parents, but also the people around them. We would like to emphasise that we realised that children should be the energy for our society.

* * * * *

The description of the Kobe Quake brings up some interesting points - not least of which is the child's 'secret' - the child attempting to understand death and loss of his mother and little brother and 'keeping it secret' from part of himself so that he only need process part of the potentially overwhelming feelings at a time.

One of the points that is echoed in all the descriptions of disaster and traumatic events is the matter of growth and gaining strength through adversity. We are talking about communities and the families being drawn together, because they are facing this difficulty together and although they might have a pessimistic view of the future, they actually are trying to work together though this difficulty and how do we keep that co-operation going when there isn't any more trauma - when the threat has gone?

In discussing resilience and flexibility we can look at this as an attribute of youth, that we can use as a valuable resource. But in fact flexibility and resilience are something that occur in response to some negative occurrence: to abuse or to being frustrated, not having your needs met all the time. So it is a matter of degree how adversity and harm in your surroundings is actually going to be used as a positive influence and how much is going to be negative influence, something harmful.

The children needed to be held and re-establish some feeling of security - somewhere where they could be safe. One comment from a teenager in the Italian study was that the teacher didn't help the children to get out of the school when the earthquake happened, means that they ran out and forgot about the children, so they had not been held and looked after it seems. When they are scared and think about getting out maybe adults don't think enough about calming and holding the children which might be understandable in the height of the crisis. The pupil saw it that at the school the teacher was responsible and she felt let down but also remarked that the teacher seemed to be a bit lost at the time.

Children and War

Turning to another aspect of life which causes traumatic stress for children - Warfare. We have considered to an extent how children feel when they are the recipients of abuse and attack - the victims of warfare, refugees and dispossessed. But children are increasingly used as the fighters in wars. Every day on TV we see youth involved in battles as stone throwing rioters in the middle east or on the streets of Ireland and other embattled areas. We also see children being drilled as full soldiers.

The age of troops in armies drops as the casualties rise - hence the lost generation in the first world war - teenagers falsifying their ages to get in to fight young - and then as we have already discussed, there was the Vietnam war with the average age of the combat troops being 19. The Russian boys in Afghanistan were also very young and many suffered severe post traumatic stress.

But in poorer countries and in states of civil war and disorder and the sort of circumstances which often pertain in long drawn out conflict such as within Africa - troops may be even younger - and are often recruited against their will.

An example from Amnesty International

Today over 300,000 children – some as young as 10 – are fighting adult's wars.

"They forced me to learn how to fight the enemy in a war I didn't understand. We were constantly beaten, just to keep us in a state of terror." So said Emilio, 14, Guatemala

Why do children become soldiers?

- *Army chiefs actively use children because they are small and speedy, easy to intimidate, don't ask for wages and are less likely to rebel.*

- *Most child soldiers are very poor - they come from separated families, or vulnerable groups like street children or refugees. Desperate poverty forces them to join up - it may be their only way to get food and clothes and defend themselves.*

- *Other children are kidnapped and forced to become fighters.*

- *Adults may lure young recruits by glamourising war, and the power that comes with guns and giving orders.*

- *Some children lose their families in war and want to get revenge. The camaraderie of belonging to an army may also appeal to orphans.*

How are children turned into soldiers?

- *They are desensitised to violence by being exposed to it.*

- *They may be beaten, drugged, and made to suffer initiation rites.*

- *Some get combat training. Many others are simply given a gun and sent into battle.*

- *Modern weapons are light enough for a 10-year-old to carry. In some countries, guns are cheaper than books.*

What happens to them?

- *children are emotionally and physically devastated.*

- *many child soldiers witness atrocities, are forced to kill and are themselves killed or injured.*

- *they are often too young to understand the dangers and may be brainwashed into thinking they are invincible.*

- *they lose out on a normal childhood - they are separated from their families; there is no chance to play or go to school.*

- *their health is put at risk - they may be disabled, raped, or exposed to HIV/AIDS.*

What is the answer?

- *The use of child soldiers should be banned and the law enforced. But this will only work if families have enough money to live on and to educate their children, so that joining an army does not seem like the best option*

- *International organisations and governments should try to cut poverty and inequality in vulnerable countries, through long-term development that tackles the root causes of violence and conflict. We must work together to build peace and stability and protect children from being drawn into conflict and violence.*

- *There need to be tighter restrictions on the trade of light weapons, which are light enough for children to carry.*

Traumatic Stress at any age –

So we have seen that age is no barrier to the development of stress reactions. Children suffer from traumatic stress in the same way as adults although they interpret the events in ways they can understand and show their pain in different ways. Adults need to protect, nurture and listen to the varied forms of a child's communication. We need to learn to communicate at a child's level both in hearing their pain and in treating their problems.

* * * * *

Disruption of the Family Life Cycle In Disaster and Trauma

The Family Life Cycle - A System Moving Through Time

{This article was presented by Frank Aust – Psychotherapist Youth Support - at the conference 'Gioventu` Duemila' Fabriano April 2000}

The purpose of this presentation is to refocus on the individual as a member of a family system which this person has been connected to by birth. The idea is to trigger thoughts rather than to give answers how to integrate this aspect in our daily work as professionals dealing with individuals and their families.

It seems useful to present important events in a person's life as linear and unidirectional when describing the path of an individual from birth to death. In contrast, to describe movements in the family system in a similar, linear fashion may not be so effective.

The individual life cycle takes place within the family life cycle, which is the primary context of human development. Relationships with parents, siblings and other family members go through stages as one moves along the life cycle. Naturally there is an intermingling of the generations, and events at one level have a powerful effect on relationships at another level. This does often include the entire emotional system of at least three, and now even four, generations.

Family stresses, which are likely to occur around life cycle transition points, frequently create disruption of the life cycle and produce symptoms and dysfunction in one or more members.

The development of a life cycle perspective for the individual has been greatly facilitated by the creative work of Erik H. Erikson (1950), Levison (1978), Miller (1976), Gilligan (1982), and others in defining the transition of adult life.

The stages of the life cycle are rather arbitrary breakdowns. After all, this is a model and therefore presents a conceptual structure on which there are many variations. Cultural factors play a major role in how families go through the life stages and define the tasks for their members at each stage.

I would like to present Carter and McGoldrick's proposed six-stage model for the family Life-Cycle:

1. Leaving home: Single young adults

The parent offspring separation defines a process that affects both parents and their children. Not only children leave home, but marriages are re-negotiated and careers and lifestyles are re-assessed and revised. Many personal changes that sometimes appear to be dysfunctional can be a part of the family process, a process that fosters differentiation and individualisation of family members in all generations.

2. The joining of families through marriage: The newly married couple

The family has to adjust to a new family system. The marital system has to be formed and relationships with extended families and friends have to be negotiated.

3. The family with very young children.

The marital system has to adjust to make space for children. The couple has to join in childrearing , financial, and household tasks. They have to realign the relationship with the extended family to include parenting and grandparenting roles.

4. The family with adolescents.

The parent child relationship has to shift in order to permit adolescents to move in and out of the system to gain independence and to be able to develop as a person.

The couple can refocus on mid-life, marital and career issues. The shift towards a joint care giving for the older generation might begin. New demands require more flexible boundaries.

5. Launching children and moving on

The couple has to renegotiate the marital system as a dyad. The parents and children develop an adult to adult relationship. In-laws and grandchildren have to be integrated in the family system. The couple is often faced with the disabilities and the death of their parents (grandparents).

6. Families in later life.

The family members have to explore new family and social role options. They have to deal with loss of spouses, siblings and other peers and have to prepare for their own death. Therefore they have to accept the shift of the generational roles.

The family life cycle is not a linear event. It does not begin with a specific stage and does end with the death of members of a particular generation. In fact death is a life change event that occurs within the context of the life cycle and may deeply affect its evolution.

The spiral shows that the family's systems density changes at different times. For example it is compact at the top and spreads out at the bottom. The family appears to change between periods of family closeness, periods of natural and non-pathological enmeshment and periods of family distance.

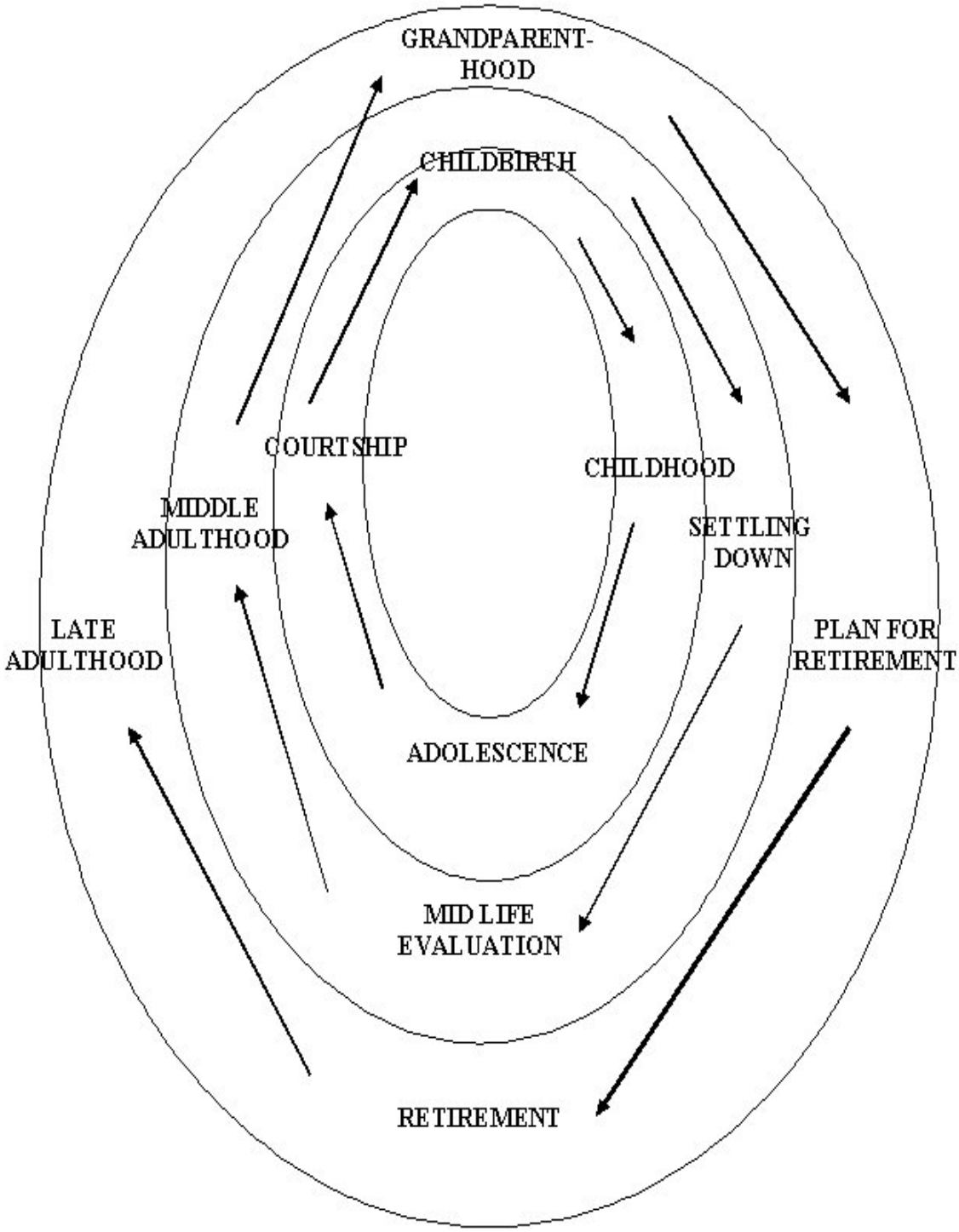
The close periods will indicate the predominance of forces in the family system that hold the family together.
The distant period describes the force that pulls the family system apart and pulls the family members out.

Between the two periods there are times to explore one's individual identity and sexual intimacy that may lead to marriage and childbearing. What appears to happen is that these forces of closeness and distance shift. They oscillate as the family evolves to enable different members of the family to go through the different stages. While going through the process of the different stages the family develops a repertoire to differentiate and disengage.

Viewed form the perspective of the family as a system, these changes provide a practising ground for experiencing intimacy and self-actualisation. These experiences are repeated at different levels of maturity and through different tasks as the individual develops in the family.

The task of separation is greater and more difficult to manage successfully when the parental support system is not working or is unavailable to provide assistance. Parents who have not had the opportunity to learn these tasks of separation in their life cycle stage are more likely to become overwhelmed when confronted in a re-occuring situation with their own children. They are more likely to respond either by attempting to control their adolescents arbitrarily or by giving up control completely.

Family spiral



Families that have experienced earlier losses and rejections tend to become overprotective, and parents may try to exert control by reinforcing excessive childlike behaviour. The message given is that separation is dangerous. Often strenuous efforts are made to protect members, especially children form outside threats. These family members meet each others needs but fail to promote growth.

If the family opens up to fast and releases its unprepared members prematurely , the children will finish their relationship training with peers and with other adults. This might result in seeking repeatedly divorce, substance abuse, and job instability.

Traumatic events usually involve a threat to the well being of a person involved. As a consequence, the person experiences emotions like loss of control, helplessness, vulnerability and fear that creates psychological distress. The effects of these traumatic experiences often become impossible to be assessed and verbally processed by the person due to a very high degree of stress and sensory information.

The psychological distress caused and the inability to consciously control these memories often results in avoidance. The trauma remains unprocessed which can cause a vicious circle of traumatic memories.

Some life cycle events in later life have the power to unstable the person to a degree that these memories resurface in often uncontained, distressing and confusing ways . As a consequence it can become impossible to manage to handle the life cycle tasks. The stress of present tasks and past difficulties becomes to much to deal with.

The person becomes stuck.

As the person in his or her capacity as a parent, spouse etc. is part of a family system he or she might therefore make it impossible for other family members to successfully go through their life cycle stage.

The family becomes stuck.

The family system is immortal. The cycle starts over and over again by forming families, bearing children, raising them, coming apart to form new families. The family provides an environment for the crucial processes of negotiating closeness, intimacy , differentiation and individuation. The family members need to have the opportunity to work and rework these tasks at different generational levels in order to learn the process.

To look at a symptomatic family member without looking at the family system might sometimes miss the far reaching consequences of this person's doing. It also might prevent us as professionals to help the person effectively as the source of his or her difficulties remains untreated and therefore continues to have an effect on the person over time.

Abuse as a Source of Traumatic Stress

When I first entered the room I could not see anything. It was dark with the curtains drawn although it was mid afternoon. The noise was dreadful, painfully loud and penetrating, boom boom boom. I knew she was in there somewhere but did not want to frighten her by letting light in too quickly.

I turned off the music and called her name softly but only heard a moan from the corner of the room. The furniture was piled up and the bed leaning upended against the wall. The sound came from behind it. Angela was crouched huddled on the floor shaking and rocking as she moaned. Her head was between her knees and she protected her head with her hands. I tried to talk to her softly and gently stroked her head as I spoke … just so she could hear my voice and establish contact, know there was someone there who cared.

…. But she was in a different world reliving her painful experiences … cutting off from reality and back in her old life of terror. When she eventually raised her eyes it was not me that she saw but a vision of her worst fears.

So what had caused Angela to develop this condition? … The shelling of Kosovo? … Being pulled out from under the rubble of the Turkey earth quake? … No. The reactions might have been the same , but it was none of these general disasters … it was a disaster of her own. She saw and heard her father coming up stairs to her room to continue his long standing abuse.

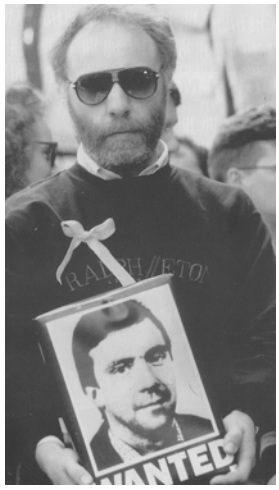
* * * * *

An abusive set of circumstances can traumatise the individual in much the same way as a ‘disaster’ or catastrophic event can

traumatise a community. Serious episodes of abuse can obviously produce physical and emotional damage which can be so severe that an acute stress reaction occurs, perhaps also followed by a chronic pathology. We see this kind of reaction say after a rape or a severe beating or attack.

Lesser acts of abuse can be equally harmful particularly if they are repetitive causing a wearing down of the spirit of the individual. Such traumatic stress reactions can be seen in long standing childhood abuse, in repeated abuse within a relationship or domestic violence and in the relentless breaking down of the personality which occurs in torture.

Abused children : Torture victims



Empathy for the Victims

There are parallels here between the work of such organisations as Amnesty International in attempting to understand and relieve the emotional damage done to prisoners and victims of torture with those of organisations such as ours working with abuse victims. In fact we have received support from John McCarthy the Beirut hostage who likened his fate to that of some of our patients and particularly to a little boy who died at the age of three having been starved, locked in a cupboard and

progressively tortured with cigarette burns and bruises. With John's support we built a garden of peace where our residents could find an island of calm and mourn their losses.

Little Malcolm died and so ended his suffering but most such children survive and carry the emotional burden of their childhood experience into adolescence and adulthood.

Domestic violence and family abuse

Violence may be directed against the child themselves or against another family member and witnessed violence can be as harmful to the developing psyche of the child as direct violence. In many cases the two coincide. Added injury is caused by the feeling of betrayal consequent on not being protected by the family. A beaten and terrorised mother may not be able to protect her children from her abusive partner.

These experiences which may occur within the confines of the child's home - a place which we would normally designate as a 'place of safety' can produce the same psychological and emotional effects as those of warfare in what is traditionally regarded as the most 'unsafe' place - the battlefield.

In fact anyone who has seen the film 'Sleeping with the enemy' will have gained some understanding of the sort of issues we are talking about that face the victim of domestic violence. We have in fact used this film in our group therapy sessions on anger management. In the film Julia Roberts is terrorised by a violent and pathologically jealous husband who all but kills her on many occasions. Films may sometimes seem far fetched and take such issues to extremes but real life is often even more extreme.

In our unit we do see the extreme and some of our case histories seeing what some human beings go through beggars belief. I

shudder to think what four year old Sarah remembers of the night she lay in intensive care recovering from dreadful head injuries and her step father broke into the hospital to smother her. Again a ‘safe place’ violated. It would seem that in this day and age we have lost the basic medioeval principal of ‘sanctuary’. …. Or what six year old Steven remembers of the Saturday morning when his step father tried to saw his mother’s head off with a bread knife. Yes, they are extreme, but they happen.

Case history –

We had our own Julia who is now well and happy living independantly with her four children - but her life was not always so … . Julia came to us from hospital after the birth of her youngest baby. She had recovered from more than childbirth. Some months previously in early pregnancy she had sustained severe injuries including a broken leg. She said she had fallen down stairs - a common excuse. But what was the truth?

Perhaps the truth was harder to believe and certainly harder to talk about. Her partner had subjected her to years of extreme abuse culminating in an incident one night when she was nearly killed.

It had started with him coming home and finding her on the telephone to her mother. He insisted on believing she was talking to another man and blind with rage he smashed the phone across her face and threw the dinner dishes across the room. A long draw out argument ensued during most of which he held her up by her hair and then when he tired of this he turned his attention to the youngest child, a little one year old boy. The child was held upside down and burned with a cigarette and then as Julia begged him to stop and the older children screamed and cried, he placed a noose of wire around the child’s testicles and threatened to amputate them.

Thankfully he was distracted from this task by someone coming to the door and Julia took the chance of running out. He caught up with her in the nearby car park and beat her senseless … she had tried to shelter in a car and he slammed the door on her head, then pushed her out and drove over her leg before leaving her for dead. She amazingly managed to drag herself home where her teenage oldest daughter called an ambulance.

This older girl had been born when Julia was a teenager herself. She was the responsible member of the family and had become a carer before her time. She hid her anger with her mother's partner and her anger with her mother for not protecting them by reversing roles with mum and protecting the younger ones as best she could.

Her ten year old brother was less able to hide his feelings. His anger boiled over at school where he destroyed equipment, tore his books, could not concentrate and believed he was the worst boy in the world. His self esteem was as low as it could be. Why was he so useless that he could not protect his mother and could not protect his brother and sister?

A cycle of abuse

Sadly anger and violence is a inheritance of an abused child who feels impotent weak and can thus use violence to strike back at the world for the pain inflicted on himself and his loved ones. Hence paradoxically the pain of being unable to protect - can become an urge to inflict harm. Thus the victim can identify with the abuser in an attempt to understand his past.

This is described well by a young Jamaican boy who aged 14 attended one of our peer counselling courses. The 'story' told in a workshop is a thinly disguised version of his own childhood.

The Beatings – David's story

David was eight years old. His daily chores after school involved feeding the dogs, washing the dishes, tidying the house and trimming the hedges when they needed it. Too much for and eight year old, right? No Not according to his father David Beating IIIrd.

David's father was 34 and still suffering from the scars of being excessively flogged as a boy. This seemed to be a family tradition. His father , his father's father and the father before that all seemed to believe that a proper 'licking' with a piece of barbed wire was what a boy needed to set him straight.

Each successive parent would transform the pain, frustration and anger inside in to blows fists and lashes of abuse.

At school, David was withdrawn and did not participate much in class and school activities. He was not very bright and so was teased and jeered by most of his classmates. He had very few friends and did not trust or desire the freindship of his male teachers. His many bruises and cuts were either hidden deep under his skin or under his shirt. No one suspected that he was being abused. To them he was an unfriendly or shy child

One day after PE at school David dragged himself home very tired. He raked the yard, tidied the house and washed the dishes. Then he went to bed. When his father came home from work at 8 in the evening he noticed the dishes washed ad the yard raked . He hit David violently in his upper back and surprised the sleeping child.

"Yu Feed the dogs .."

"No Dad .."

Before David could finish his sentence his father used his huge hands to slap him across his face.

“Yu worthless piece of trash you. Yu can’t do notin. Yu are no use to me”

His father marched out of the room and David knew exactly where he was heading. He went to the tool shed and grabbed a piece of barb wire. With years of anger blinding his eyes, he stormed to his son’s room and started to lace the child’s back with the wire.

David pleaded and cried but his father’s ears were deafened by hate and years of degradation. David did not understand why his father would beat him so badly. He could not understand why he was not loved. He thought maybe daddy misses mummy. Maybe daddy had a hard day at work. Then lastly he thought - maybe I am a bad boy and I don’t deserve to be loved. With this thought he went to sleep.

The next day at school was torture. The barb wire had torn bits of the flesh off his back and he couldn’t sit with his back on the chair. At lunch he sat alone as usual.

SMACK! A bully passed and hit him on his back. The hit itself did not cause much pain but it must have tore some loose skin off as it burned him and there was a little blood on his shirt.

After lunch a teacher watched him as he got up and noticed the spot of blood on his clothes. She asked him what was wrong but he refused to tell her.

She brought him to the nurse who asked him to remove his shirt. He reluctantly undid his buttons and took is shirt off. The secret was out.

The nurse was amazed to see the state of his back. Loose skin hung and his flesh was exposed in some parts. The nurse called the police who came and took David to a home. His father was called and questioned.

David stayed in the foster home for three weeks. At the end of the three weeks was a court hearing. The judge recommended that both David and his father get counselling and a decision be made at the end of the sessions.

After months of counselling David's father got over his anger and pain and David at 8 years old decided he would never abuse his children.

It is important to note that in this case 'David' has decided not to follow the family pattern and is set on an alternative path - that of helping others. Abused children do not have to become abusers - there are alternative roles - for example 'the victim' or 'the carer'.

To quote from Inner Worlds[4] –

"…. the child who takes on the blame and responsibility, becomes the victim. The victim who knows that he deserves his fate, that he is bad, and that is why bad things happen.. That victim will continue to take the knocks of life, to progress from abused child to battered wife, to exploited mother .... until she is able to see that it is not her fault, she is not responsible, she did not deserve the pain ... and neither do the children around her

Such a victim may be able to break free of the mould and become a social worker, a nurse, a doctor, someone working with young people, someone who understands and can protect..

[4] Inner Worlds - A Violent Age - Responses to abuse and violence.

So we do not have a predestined path. There are alternative responses to violence.

Violence can be internalised in the compliant victim, or can be aggressively returned. Blame, fear, anxiety, anger interact to produce the response - that person's individual way of coping with the hurt. ...”

Sexuality

I mentioned Julia Roberts. One of her less credible films was not as one might expect, the violent ‘Sleeping with the enemy’ but another more romantic film ‘Pretty Woman’ - which was actually in many ways a reworking of the theme of ‘irma la Douce’ which starred Shirley Maclaine and Jack Lemmon. The theme of rescuing a ‘fallen angel’ by falling in love and all will be well as they fade off together into the sunset is about as far removed from reality as I can imagine.

Prostitution is in no way romantic, amusing or attractive. Girls and boys who become prostitutes have very serious pathology and long standing deep wounds which are impossible to heal. Certainly they can be helped by therapy and by taking on a new life but this is not a complete solution by any means.

Lets look at the ‘real story’ … The odds are that Julia’s character had been sexually abused as a child … probably by a close relative , father or stepfather being the most likely candidates. Her brothers and maybe the odd uncle also used her. She picked up infections and maybe got pregnant - but probably by this stage she had run away from home or had been pushed out as her family followed a common pattern of turning sexual attention to the younger children when the older girl became fertile and capable of child bearing.

So out on the streets and in the wide world - how does she relate to people - in the only way she knows - sexually. She puts herself in danger. She lets others use her ‘as a whore’ because that is what dad did to her. By this time it is likely that she is self harming in other ways too … maybe using drugs or cutting herself.

She needs money and starts ‘survival sex’ - prostituting to feed herself and then the drugs need to be paid for too. She may start out on her own risking violence and infections. She may get a pimp who may also beat her up and he will force her on the street even when she feels ill and weak. She will pick up a pelvic infection and perhaps become infertile … but may give birth to a few children before that. The babies may have crack withdrawal at birth and will be neglected while mum is doing her tricks and eventually they will be taken into care of social services. A great start in life for Richard Gere’s children!

It is also highly likely that she will take little pleasure in the sexual act and will not want relationships with men who will remind her of the abuse she was subjected to in childhood. Her prostitution is an extension of her abuse. She is likely to have any relationships she does engage in with individuals who are less identifiable with these abusive role models. So maybe cross cultural or homosexual or someone less threatening with whom she can feel in control. For example abused white girls often feel safer with black men who are less easily identifiable with their fathers. The majority of severely sexually abused children who end up in prostitution have gay preferences. … So if Julia Robert’s character is a white intelligent LA girl - Richard Gere would be more likely to have been say a black female with a low IQ or a mental health problem. .... I don’t suppose that plot would have gone down well with the romantic movie scene!
By joking about such a non funny situation the intention is not to diminish in any way the pain of the victims but to demonstrate the confusion and mixed messages in a society which fails to protect young people from such abuse.

Abuse – antecedent of prostitution

Sexual abuse → Low self esteem
Self harm ← → Prostitution
Drugs ← → Alcohol ← → Infections

Abuse and Traumatic Stress

Long standing abuse will produce the same degree of traumatic stress as warfare - abused youth will of course show symptoms and signs related to the specific abuse - for example fear of sexual relationships and morbid concentration on somatic symptoms associated with the reproductive organs in those who have been abused, but the basic pattern of response is th esame no matter what the stimulus.

Hence for example if we briefly review the diagnostic criteria of PTSD and the significance of these criteria as applied to abuse we can see that the symptoms noted in abuse victims very much fulfill the diagnosis of PTSD

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 persons response involved intense fears helplessness or horror*

An abused child feels a threat to their physical integrity and is helpless to protect himself.

B The traumatic event is persistently re-experienced in at least one of the following ways -

1. Recurrent and intrusive recollections of the event including images, thoughts or perceptions. In young children this may involve repetitive play.

2. Recurrent distressing dreams - in children dreams generally frightening without specific content .

3. Acting as if the traumatic event were recurring (sense of reliving the experience) illusions, hallucinations, dissociative flashback episodes including those on waking or when intoxicated - in children trauma specific re enactment may occur.

4. Intense psychological stress at exposure to internal or external clues that sybolize or resemble an aspect of the traumatic event.

They relive, experience flash backs and have nightmares.

C Persistent avoidance of stimuli associated with the trauma - 3 or more of -

1. *Avoidance of thoughts feelings conversations, activities places people.*

2. *Inability to recall important aspects.*

3. *Marked diminished interest or participation in significant activities*

4. *Feeling of detachment and estrangement from others.*

5. *Restricted range of affect - unable to show loving feelings.*
6. *Sense of a foreshortened future does not expect to have a career, marriage or children or a normal life span.*

They avoid the people involved, going to places where abuse took place, Block out painful memories, Withdraw from school, activities and friends, do not show feelings and have little sense of a personal future.

D Persistent symptoms of increased arousal (not present before the trauma) - at least 2 of the following

1. *Difficulty sleeping or staying asleep.*

2. *Irritability and outbursts of anger.*

3. *Poor concentration.*

4. *Hyper-vigilance.*

5. *Exaggerated startle response.*

They have sleep problems, angry outbusrts, poor concentration and are on guard the whole time waiting for the next attack.

E. The disturbance i.e. symptoms described above - lasts for a minimum of one month.

It lasts for years. In many cases for the rest of their lives.

F The disturbance causes clinically significant distress or impairment in social occupational or other important aspects of functioning.

These are kids who have great difficulty in pursuing the activities of daily life. They find it difficult to study, to hold down a job, to make relationships, have a family life of their own and without long term help support and therapy are unable to experience and enjoy the myriad of experiences which we take for granted every day of our lives.

* * * * *

Treatment of Post Traumatic Stress

Principles of intervention.

Some principles of intervention have already been discussed -

a) The nature and timing of such a disaster mental health input is crucial. Excessive emphasis on mental health issues at too early a stage or at a inappropriate phase may be disempowering and be rejected by the individuals to which such a service is directed. This can leave them unable to approach services at a time when they may need to do so.

b) The helping professions - The above comment is particularly important when dealing with those in the 'front line' or the helping professions. A healthy measure of denial is a very necessary coping mechanism in the moment of crisis or danger. One does not want to examine one's feelings with regard to such trauma while dealing with the immediacy of one's situation - it is after the crisis has passed that one can be allowed the indulgence of self exploration and a 'debriefing' of feelings and reactions to the stresses and traumas.

c) Providing help on a psychological level involves a number of issues. The help must be provided in a manner which is acceptable to the individuals and must recognise the possibility that the individual may not want help.

d) There should be a supportive environment which is accepting of the individual's circumstances, which is empowering and supportive and gives positive feedback. The key is empathy and 'value' imparting self worth - not 'sympathy' implying a victim position. This could be seen in the accepted description

of what ‘therapy’ should be which involves empathy, acceptance and genuine positive regard.

e) In the disaster situation the ability to be a good listener and hear what the patient is telling of their experiences is generally more useful than being able to ‘interpret’ - in the acute phase particularly the individual will need to ‘unload’ the power of the experiences and visions they have stored up.

f) The manner in which they do this will be influenced not only by their past experiences but also by their cultural norms and an understanding and acceptance of the culture is essential.

g) In terms of management , support and treatment it really does not matter if we diagnose acute stress reaction, post traumatic stress or look at individual symptoms. In fact the diagnoses, being temporally defined, must to an extent be made in retrospect and with the knowledge of hindsight. It is important however to realise how long symptoms can last and that treatment for sufferers of post traumatic stress may in effect be lifelong.

Treatment Guidelines

The following guidelines are useful in planing treatment -

a) **Individual basis for intervention** - Treat the person and their own individual problems - not the ‘syndrome’ of PTSD.

There are various assessment methods that are used to gauge the position of the individual at the beginning of treatment and to plan the treatment programme and questionnaires can also be used to look at progress and outcome. Questionnaires tend to be used more routinely in North American treatment programmes than in European

settings where a psychodynamic approach and individual interview is a more common assessment method.

b) **Deal with crisis first** - Therapy cannot be effectively engaged in when the individaul is still experiencing trauma or crisis. These immediate problems need to be dealt with first.

Deal with the life threatening situations, crisis intervention, extremes of feeling and response before engaging in the therapy programme aimed at healing long term problems. The crisis situation may include panic, extreme fear or anger; it may include reactions to on-going situations such as continuing abuse or domestic violence or being actually threatened. In other cases the patient may have taken drugs or alcohol and their effects need to be considered. Other severe symptoms may need medication such as perhaps severe depression or psychotic reactions and there may be physical illness which requires treatment before the psychological and emotional treatment programme can be considered.

c) **Work together with the patient** - A traumatised individual who has survived disaster or personal tragedy or abuse needs to trust those working with them. The work of therapy thus must be a cooperative experience - a shared programme plan in which the patient and therapist can openly discuss and share problems and treatment aims.

The patient who has experienced the shock of unexpected assault, loss or disaster does not want further shocks, surprises or unexpected aspects of therapy, he or she must gently be led through relating and recalling the experiences and memories of trauma in a way which allows him or her to feel safe in the hands of the therapist. He needs to know he will not be overwhelmed by his recall and reliving of painful memories. He needs to feel

protected. The individual needs to feel he is in control of his life and his therapy and that when he is ready to let go some of that control to advance further - he will be able to let go into the hands of a trusted therapeutic ‘companion’.

Trauma focus

Management of treatment will of necessity involve individual issues associated with that particular person’s past, their emotional psychological makeup etc it will then also involve issues directly connected to the disaster or specific trauma. This aspect is often referred to as ‘trauma focussed’ work.

Trauma focussed work may be short term and may involve a simple ‘debriefing’ session conducted with moderately traumatised individuals who have few or mild symptoms. In this context it is good to remember that although practically all subjects experiencing a disaster or trauma will be ‘stressed’ - not all will be pathologically stressed and not all will require or desire treatment. In developed countries there has been a tendency for ‘trauma therapy’ be in vogue resulting in an often unseemly scramble for various therapeutic resources to squabble over trauma victims like vultures battling for parts of the carcass. A typical example of the needs of the individual being subjugated to the wishes of the ‘knowledgeable professional’ .

The ultimate aim of a ‘trauma focused’ approach is to help deal with unpleasant feelings and the memory of bad or frightening experiences and to impart in the individual the knowledge and confidence that they are capable of dealing with these feelings and memories. Thus their self worth is enhanced and their coping skills improved.

The memories will fade but some degree of memory will always remain - it is not a state of amnesia we are reaching for - it is the ability to cope with the memory. This will involve a degree of debriefing[5], learning and understanding the events and their significance for the individual, reframing[6] and perhaps attaching new meaning to the experiences, considering varying outcomes.

Sub-groups - Presentations

The following represent different situations where trauma related intervention could be appropriate -

a) **'Normal' stress reaction -**

A stress response can be a 'normal' stress reaction to a traumatic event which can produce some of the symptoms of traumatic stress such as unpleasant memories, emotional numbing, feelings of unreality etc. but is short lived and those involved get over their problems within a week or two.

A good example of this was in a group of young people who were intensely upset by the death of a companion who was performing a daredevil act on a railway line and was killed by a train. The sudden shock and the nature of the death left the friends traumatised. Much of the problem involved attempts at trying to visualise what had happened, how dreadful the circumstances were. The group were blocked in their mourning by the shock and this was not helped by the reaction of others and the media who created an environment of traumatisation - they expected the friends to be traumatised and requiring therapy, hence the young people in turn 'expected' do be traumatised and need help. A group debriefing experience helped them to describe and imagine what had happened, to share how they felt and to realise that they did have the coping

[5] Retelling and going over the story
[6] looking at events from a new perspective

skills to handle the situation. They were able to enter a group mourning process and ended the session by being able to say goodbye to their dead companion. Further work was not necessary.

The pattern of approach in this case is -

- Describe events - what happened
- Explore feelings - how did it feel?
- What symptoms have been caused - what did it do to me?
- Why do I feel this way? - learning about their responses.
- How can I cope - how am I coping? What skills do I have to deal with this?

b) **Acute stress disorder.**

As we have seen acute stress disorder is characterized by the sort of symptoms seen in full blown PTSD but is of shorter duration and has less effect on the social condition of the patient. We see panic reactions, mental confusion, dissociation, sleep disorder, poor self care, ad interference with work, and relationships. This reaction is seen when the trauma is a more long lasting phenomenon threatening death, destruction, loss of home and community. As stated above the first step is to remove them to safety and provide support. It maybe necessary to use medication for immediate relief of severe symptoms and then to initiate a programme of brief supportive psychotherapy as an aspect of crisis intervention.

c) **PTSD - Post Traumatic Stress Disorder.**

The symptoms of PTSD have been discussed. A number of treatment approaches may be used including group and individual work; psychodynamic psychotherapy, cognitive-behavioral therapy or drug regimes. Often a combined approach may be needed to deal with varying aspects of the disorder.

The general aim of therapy is to allow memories to be explored and to be able gradually to go over the history of the traumatic events. Telling the personal story relating to trauma is parallel to the 'life story' work which is of importance in relation to say drug abuse work or in Alcoholics anonymous - acheiving a level of trust to be able to state the 'story', acknowledge the facts and then move on. This movement from a painful past to a positive future is the hallmark of therapeutic change in that the patient is willing to move on from the victim position and ceases to be trapped in a position where at best he may 'feel sorry for himself' or at worst be lost in an ever deepening despair in which hopelessness drives his depression.

The principles of **group therapy** include shared experiences and empathy between group members - a group can provide an ideal setting for trauma or abuse victims to share since they are immediately able to empathise with each others experiences and can develop a degree of trust with peers. This has been the prime approach used by military treatment centres for helping war veterans.

Self help type support groups have a useful place here in that victims can accept that a fellow victim knows what they are talking about and can be trusted to understand adverse feelings and reactions without judging or blaming.

It is important however to include professional input and allow the group to be 'therapist led' rather than entirely self help

particularly when dealing with severe reactions and pathology otherwise there is a risk of developing a ‘victim elite’ which believes that professionals are unable to help them. The aim is to allow the patient to develop trust in the peer group and progress to trusting the professional so that a deeper level of work can be engaged in.

Brief psychodynamic psychotherapy allows the patient to develop trust in the therapist and to retell the story of the trauma under the auspices of a therapeutic alliance which is built between therapist and client. Gradually coping skills and self worth are enhanced.

Cognitive - Behavioural therapy involves various techniques including allowing patients to experience stressful symptoms and teaching them skills to cope with them. Exposure, flooding and desensitisation are some of the techniques used in allowing patients to confront their worst fears and learn to cope with them. These methods need to be carried out very carefully to avoid further traumatising the patient. The cognitive side looks at learning skills for coping for example with anxiety managing anger and negative emotions, relaxation techniques etc.

When **medication** is used in treatment of PTSD it is on a smptomatic basis - eg for the depressive symptoms , for the insomnia etc.

d) **Complicated PTSD**

PTSD may be combined with other psychiatric disorders. In fact tis is a common situation. It is hard to say which comes first or in some cases to distinguish at what point the depressive symptoms of PTSD constitute a separate defined depressive disorder and the same argument may be made in the case of anxiety disorder. Substance abuse may coexist with PTSD. In all cases the principle is to treat both problems at the same time and thus the tautology of diagnostic label is merely theoretical.

e) **Severe or Complex PTSD**

This has been described by some sources and has also been termed 'Disorder of Extreme Stress'. whether it constitutes a true subgroup is questionable but it has been linked to *'individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, such as childhood sexual abuse'*. These are patients who may show signs of personality disorder and the extreme forms such as borderline personality disorder or dissociative disorders and it is likely that early trauma produced these personality problems which are often regarded as untreatable. Symptoms include behavioral difficulties impulsivity, aggression, sexual acting out, eating disorders, alcohol/drug abuse, and self-harming, extreme intense emotional reactions. There may be also thought disorder. Although treatment is considered hopeless b many - specialised long term treatment programmes can make a great deal of difference and render the patient's difficulties 'containable' rather than 'curable'.

The Problems faced by Disaster Rescue and Aid Workers

Those among us who spend time effort and often place themselves at risk to help others in extreme circumstances deserve our thanks of course and we number them among the heroes of our society.

We must also remember though that they are human beings just like the rest of us - in reality there are no ‘supermen’ or ‘wonder women’ protected and aided by magic powers! Our rescue workers are flesh and blood emotional people who can be harmed physically and mentally traumatised by their experiences.

They are exposed to the dangers of those they are helping as well as witnessing horrors while maybe far from home and while obliged to act ‘tough’ and emotionally strong.

The reasons for their taking up such occupations also need to be considered - some may be playing out re-enactments of their own earlier experiences and otehrs may be escaping from personal difficulties by concentrating on those of others.

Whatever the antecedents, factors and circumstances, the welfare and avoidance of burnout in workers needs to be taken seriously by other professionals and by the rescue workers themselves in taking care of their personal wellbeing.

US rescue service oranisations have estimated that as many as a third of rescue workers experience significant stress symptoms, which may lead to lasting post-traumatic stress disorder (PTSD), anxiety disorders, or depression.

The symptoms and signs of PTSD in rescue workers are the same as those in their subjects whom they may have rescued (see PTSD) eg dissociation; re-experiencing; emotional numbing; hyperarousal; anxiety; depression.

Rescue workers are also at risk in similar circumstances to those in which their subjects find themselves - eg those who directly experience or witness life threatening danger or physical harm (especially to children); gruesome death, bodily injury, or bodies; extreme environmental or human violence or destruction; loss of home, valued possessions, neighborhood, or community.They may also be affected by loss of communication with friends and relatives and may be fairly cut off from their home environments and from the support of friends and family.

During their duties they are experience intense emotional demands made of them by others themselves in despair, searching for lost family members and survivors who may be in extremis. They will need to deal with loss and bereavement all around them. All this time they may suffer exhaustion, lack of food, lack of adequate shelter, cold and extremes of weather, lack of sleep or somewhere safe to sleep, plus danger from spread of disease, infected water supply and toxins.

In addition, just like their rescued subjects they may have pre-existing factors which predispose them to develop traumatic stress symptoms or which may be recalled during their rescue activities. These may include - exposure to other traumas and being in unsafe conditions such as in warfare or being involved previously in severe accidents, abuse, assault. Chronic medical illness or psychological disorders; poverty, homelessness, unemployment and major life stressors or emotional strain.

Tips for workers

The following tips have been put forward by one of the major US support organisations for rescue workers as ways to manage stress -

During a disaster operation:

- Develop a "buddy[7]" system with a co-worker
- Encourage and support your co-workers
- Take care of yourself physically, with regular exercise and eating frequently in small quantities
- Take a break when you feel your stamina, coordination, or tolerance for irritation diminishing
- Stay in touch with family and friends
- Defuse briefly whenever you experience troubling incidents, and after each work shift

After the disaster:

- Attend a debriefing if one is offered, or try to get one organized, 2 to 5 days after leaving the scene
- Talk about feelings as they arise, and be a good listener to your co-workers
- Don't take anger too personally -- it's often an expression of frustration, guilt, or worry
- Give your co-workers recognition and appreciation for a job well done
- Eat well and try to get adequate sleep in the days following the event
- Maintain as normal a routine as possible, but take several days to "decompress" gradually

After returning home:

- Catch up on your rest (this may take several days)

[7] Buddy system – mutual looking out for each other

- Slow down - get back to a normal pace in your daily life
- It's perfectly normal to want to talk about the disaster, and equally normal *not* to want to talk about it; remember that those who haven't been through it might not be interested in hearing all about it - they might find it frightening, or simply be satisfied you're back safely
- Expect disappointment, frustration, and conflict - sometimes coming home doesn't live up to what you imagined it would be -- but keep recalling what's really important in your life and relationships so that small stressors don't lead to major conflicts
- Don't be surprised if you experience mood swings; they will diminish with time
- Don't overwhelm children with your experiences; be sure to talk about what happened in their lives while you were gone

A comment made in our panel discussion by Sig Spinachi – from the Fire Rescue Service.

Apart from the quake in Fabriano, I have lived through that of Valvano in the province of Potenza and that of Gemona and these two earthquakes, more than ours, hit us in a major manner. There were moments of real terror – pulling people out of a church where they had been severely injured, and in Gemona buried under various types of dwellings. This truly leaves wounds which do not heal easily. But the spirit of those who go to help in such circumstances is strengthened and they become tenacious in their efforts to bring aid to those in difficulty.

A problem of the quake which is very important for youth is that it has left scars, some scars are self evident. I saw our youth, our young soldiers and workers who had been struck whilst in some building – and when they came back to barracks and had to sleep in bunk beds, when the person above them turned over in their sleep, they would be startled and scream out! This happened in the days after the quake. Then later bit by bit, we began to get used to it – however these are things that

you don’t forget easily and in general the young people were affected more severely by this type of fright and fear. I hope that this has not happened to you. However this has been an effect even in our earthquake which by other standards was not so severe. Because as I said I have felt worse in other zones where I saw buildings crumbling even after the first shock, and this was really frightening.

It is important at times to leave your fear aside. In these circumstances you need a lot of courage and I would say you have to force yourself to have courage and to give courage to others who are near you. That fear at a certain point must be held inside and must not be dissipated to those around or to those close to you. This is especially important for a teacher, it should not be as we were saying yesterday that a teacher leaves first, a teacher should always be the last to leave. It stands to reason that in the face of danger, even from our own point of view, we cannot just run out and save ourselves No! We must help those people who are in difficulty and the children and pupils must be helped at that moment – to be brought out to safety and freedom. The most essential thing is to behave as a responsible adult”

The Last Word

The conference ‘Gioventu` Duemila’ was a great opportunity to unfold a dialogue with youth of the province of Ancona. We thank all who helped us in this initiative. The young people threw themselves enthusiastically into the workshops – that dealt with PTSD, Violence, The family, Drugs, and bullying. And we were moved by their role plays that were based on semi invented stories of the following characters inspired by boxes of props – broken toys, pieces of clothing ...

Elian Gonzalez - Elian is six years old. His mother was on a boat heading for Florida where she would have been an illegal immigrant when the boat capsized and she was drowned. Elian was found drifting at sea. He was taken to his relatives in Miami and there then followed a battle for custody. He was eventually returned to his Cuban father after an armed raid on his family’s home by FBI.

Kiko Yamashita - The Kobe earth quake struck without warning and Kiko’s house was destroyed. She (aged 7) was found under the rubble but her family - father, mother, little brother were killed.

Ivan Marcovitch - Ivan is twelve he lives in Kosovo with his family. He has not been to school for a year because of the war. One day he goes to look for bread and on his return sees smoke rising from his family home. He goes in and finds his family gone. The house is wrecked and strafed with bullets. Andrea , A rescue worker from Rome finds him crying.

Jan Heineken - Jan is a Dutch construction worker who has taken time to work for charity. For two weeks he has been driving a lorry full of bricks to help build a new hospital in Turkey after the quake. He is tired after a long day at work. He Stops to have a couple of drinks. On his way home the lorry he is driving goes out of control and kills a small child .

Mi Lee - Mi Lee lives in Cambodia. Her family was involved in the wrong side of an argument with terrorist troops. One night they came to her village and threw petrol on the houses and burned them down. Her father was a village elder and he was tied up while she watched. The raiders put petrol on him and lit a cigarette smoked it slowly and threw it at him. Mi lee was hiding in a tree. She was the only one left alive in the village. Should she have helped her father?

In telling and exploring these fictitious stories they were also able to express their own thoughts and feelings. Thus they had a safe, non threatening means of healing their emotional wounds.

Aldo Crialesi encouraged us and the idea of this conference was partly his. We will give him the last word -

“My words are of satisfaction for this lovely initiative which was taken by an organisation which is not local, they have come from London, A very important organisation – We in Fabriano had not thought of some of these things because we were thinking of material problems, houses destroyed and economical problems rather than these psychological problems infact these problems were outside of our sphere of thinking. However they are very important and therefore there is my recognition, and I expect that of many other people in Fabriano, a recognition of this suport that you have been abel to give the community of Fabriano. You come from far away but one must say that the Busini women are ‘Fabrianesi’ and I see that they have always maintained constant contact with the reality of their origins. So again our utmost thanks”.

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Available from the National Mental Health Association 1021

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Journal of Traumatic Stress, Plenum Press 2333 Spring Street New York, NY 10013

Clinical Quarterly, National Center for Post-Traumatic Stress Disorder; Education Division ; Veterans Palo Alto Health Care System; Mail Code 323-E112; 795 Willow Road Menlo Park, CA 94025

PTSD Research Quarterly, National Center for Post-Traumatic Stress Disorder VAM ROC 116D White River Junction, VT 05009

Combat Related Post-Traumatic Stress Disorder Association for Advancement of Behavior Therapy 305 Seventh Ave. New York, NY 10001 (212) 647-1890

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York, NY 10001 (212) 647-1890

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Post-Traumatic Stress Disorder Anxiety Disorders Association of America 1900 Parklawn Drive, Suite 100 Rockville, MD 20852-2624 (301) 231-9350

Post-Traumatic Stress Disorder Packet #OM-0026 National Institute of Mental Health Rm 7C-02, MSC 8030 5600 Fishers Lane Bethesda, MD 20892

Further Information about Post-Traumatic Stress Disorder

National Center for Post Traumatic Stress Disorder, Education Division Veterans Medical Center 795 Willow Road, Menlo Park, CA 94025 (415) 493-5000

National Center for Post Traumatic Stress Disorder maintains *PILOTS: PTSD Database* (**P**ublished **I**nternational **L**iterature **O**n **T**raumatic **S**tress), the largest bibliographic database on traumatic stress. This database may be accessed via computer modem by dialing (603) 643-66310 (Dartmouth College On-line System) and entering C LIB at the @ prompt or via the Internet by telnet to lib.dartmouth.edu. For information on PILOTS data system, contact National Center for PTSD at (802) 296-5132.

National Mental Health Association 1021 Prince Street Alexandria, VA 22314-2971 (800) 969-6642

National Mental Health Association has developed an automated fax-on-demand and voice-message-on-demand to provide information on mental health disorders and problems, including PTSD. This system can be accessed by calling 1-888-836-6070.

Fact Sheet Series on Anxiety Disorders (including Panic,

Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder; Phobias; and Generalized Anxiety disorder) National Mental Health Association. 1021 Prince St.
Alexandria, VA 22314-2971 1-800-969-NMHA

Let's Talk Facts About Mental Illness (series including Anxiety Disorders, Panic Disorder, Obsessive-Compulsive disorder, and Post-Traumatic Stress Disorder) American Psychiatric Association Division of Public Affairs-Code NIMH 1400 K St., NW Washington, DC 20005 (202) 682-6220

On Target, a quarterly newsletter. Freedom from Fear 308 Seaview Ave. Staten Island, NY 10305 (718) 351-1717 http://www.freedomfromfear.org

Videotapes

Adolescent Group Therapy: An Introduction for Parents Care Video Productions. Westlake, OH, 1989 (order 216-835-5872).

After the Tears: Teens Talk About Mental Illness in their Families United Mental Health, Inc. Pittsburgh, 1986 (order 412-391-3820).

How to find help

Pamphlets, Brochures and Other Publications

A Consumer's Guide to Mental Health Services National Institute of Mental Health Rm 7C-02, MSC 8030 5600 Fishers Lane Bethesda, MD 20892

Guidelines for Choosing a Behavior Therapist Association for Advancement of Behavior Therapy 305 Seventh Ave. New York, NY 10001 (212) 647-1890

How to Choose a Psychotherapist American Psychological Association 750 First St., NE Washington, DC 20002
(202) 336-5500

Seeking Help for Life's Challenges: What is Counseling? American Counseling Association 5999 Stevenson Ave. Alexandria, VA 22304 (703) 823-9800

Internet

Child Rights Information Network(CRIN):
http://www.crin.org
Coordinator c/o Save the Children 17 Grove Lane London SE5 8RD UK
An excellent source of information on the Convention and Committee on the Rights of the Child and on child rights issues such as children in armed conflict and displacement, child labour and initiatives against the sexual exploitation of children. Also very useful for links to other organisations working on children's rights.

Coalition to Stop the Use of Child Soldiers
http://www.child-soldiers.org
Coordinator 11-13, chemin des Aménones 1219 Châtelaine (GE) Switzerland

UNICEF (United Nations Children's Fund)
http://www.unicef.org
All relevant information about the activities of UNICEF can be found from this site.

UNICEF: International Child Development Centre
http://www.unicef-icdc.org
Piazza SS. Annunziata, 12 50122 Florence Italy
An excellent information source on subjects including juvenile justice

The Girl-Child, Platform for Action, Fourth World conference on Women, Beijing 1995
http://www.un.org/womenwatch/daw/beijing/platform/girl.htm

Working Group on Girls http://www.girlsrights.org

University of Minnesota Human Rights Library: http://www1.umn.edu/humanrts/instree/ainstls1.htm

general information and information about ratification of different human rights instruments

Swedish Save the Children http://www.rb.se
Children at War project

Human Rights Watch - Children's Rights Division
http://www.hrw.org/about/projects/children.html

Defence for Children International (DCI)
http://193.135.156.14/webpub/dcihome

World Organisation Against Torture - Organisation Mondiale Contre la Torture - Organization Mundial contra la Tortura (OMCT) http://www.omct.org/children.html

Earthquake Questionnaire (translation of Questions asked)

Date School Class
Name Date of Birth
Address Age

How were you affected by the earthquakes?

Injured
Family member injured
Friend injured

House damaged
House destroyed or uninhabitable
Loss of property How else?

How did this affect you personally?
Did you have any difficulty with the following –

Sleeping
Bad dreams
Appetite
Weight loss
Stomach upset
Vomiting or nausea
Tiredness
Weakness or fatigue
Problems concentrating
Headaches
Feeling anxious
Feeling afraid
Palpitations
Breathlessness

Afraid to be at home alone
Afraid of the dark
Afraid to go out alone
Eyesight
Stomach pain
Indigestion
Crying
Feeling faint
Schoolwork suffers
Dizzyness
Feeling depressed
Feeling sad
Don’t enjoy life
Feeling guilty

Anything else?

Were you worried about yourself?
Were you worried about your family?
Were you worried about your friends?

What were you most afraid of?
What were you most worried about?

How has this affected you personally, since the earthquakes?

Have you had any of these problems – for how long? Do you still have any difficulty with the following?

Sleeping
Bad dreams
Appetite
Weight loss
Stomach upset
Vomiting or nausea
Tiredness
Weakness or fatigue
Problems concentrating
Headaches
Feeling anxious
Feeling afraid
Palpitations
Breathlessness

Afraid to be at home alone
Afraid of the dark
Afraid to go out alone
Eyesight
Stomach pain
Indigestion
Crying
Feeling faint
Schoolwork suffers
Dizzyness
Feeling depressed
Feeling sad
Don't enjoy life
Feeling guilty

Anything else?

Do you worry about yourself?
Do you worry about your family?
Do you worry about your friends?

What are you most afraid of?
What are you most worried about?

Please write any other comments you wish to make about the earthquakes and how they have affected you or your community.

Self Esteem Questionnaire

		Yes	**No**
1	I wish I was younger		
2	People like to be with me		
3	I usually give up if a job is too hard		
4	My family never gets angry with me		
5	I only have a few friends		
6	I have lots of fun with my parents		
7	I like being a girl / boy		
8	I am a failure at school		
9	Myparents usually make me feel that I am not good enough		
10	I usually fail when I try to do important things		
11	I am happy most of the time		
12	I have never taken anything that did not belong to me		
13	I often feel ashamed of myself		
14	Most people do things better than I do		
15	I often feel I am no good at all		
16	Most people are cleverer than I am		
17	My parents don't like me because I am not good enough		
18	I like everyone I know		
19	I am as happy as most people		
20	Most people are better than I am		
21	I like to be with people younger than me		
22	I often feel like giving up		
23	I can do things as well as other people		
24	I would change many things about myself if I could		
25	There are many times when I would like to just run away		
26	I never worry about anything		
27	I always tell the truth		
28	At school my teachers think I am a failure		
29	My parents think I am a failure		
30	I worry a lot		
Totals	G S A P L Total		
	General Social Academic Parents Lie		

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Professional

Are you My Sister, Mummy? – ISBN 1 870717 02 3
Dr Diana M L Birch Retail Price - £7.99
A longitudinal study of 200 school age mums (2nd edition, first published 1987) the first comprehensive description of the subject in Britain. 262 pages containing statistics, case studies, questions and answers.

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Dr Diana M L Birch Retail Price - £9.99
Proceeding of the Second Youth Support International Conference on Adolescent Health and Welfare in London 1998. Containing 70 transcripts of lectures and workshops from many leading International Experts working with young people around the world. Topics include Adolescent Sexuality, Health and Physical Challenge, Teenage Pregnancy, Disability, Education and Employment, Youth in a Multicultural Society, Mental Health, Social and Behavioural Issues, Youth and the Family, Abuse and Self Harm, Runaway and Homeless Youth.

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Laura Busini-Birch Retail Price - £4.99
First published 1985 by Fontana Paperbacks, 2nd edition 1996 by Diamond Books. 281 pages. If you are one of those fastidious persons whose culinary taste does not venture outside the twelve-mile limit around the British Isles, and shudder at the thought of not only eating, but cooking Italian food, do not read on; this book is not for you. It is meant for people who already know what Italian food is about, appreciate it, and are prepared to try more unusual dishes, especially the traditional ones that Italians like to eat at special times of the year, at festivals and family celebrations. You need to be a very lucky tourist and be in the right place at the right time in Italy to succeed in trying them all.

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About the Author

Diana Birch- born in London -her Italian mother was 'liberated' in world war II by her English father. Bilingual roots have ensured an international flavour to her work with periods in Italy, Russia, Jamaica, USA and other states. Trained at the Royal Free & St George's, interest in youth arose on starting advice clinics for schools.Absence of training in UK in Adolescent health motivated a 'personal' programme progressing via paediatrics to sexuality, psychotherapy. Dissatisfied with statutory services she founded Youth Support and works solely for the charity. Aspects are court work child protection, family assessment. Wide experience of family disorder alcohol substance abuse and research in teen pregnancy for which she was awarded Doctorate at London University, holds Fellowships of the Royal College of Physicians, the Royal College of Paediatrics and Child Health and the Society for Adolescent Medicine (USA). Author of several books "Are you my sister, Mummy?"school age pregnancy; "The child that rocks the cradle" long term results; "Bonds and boundaries"- child protection in the family; "Inner Worlds" on emotional issues. Interests include drama and animal therapies. Youth Support has branched into a mini farm, pet shop and Cyber-cafe. Animals play a major part in her life she is never without a Great Dane having bred dogs for many years, also plays at music and Judo. She has an actress daughter and a musician son.

Traumatic Stress
Gioventu` Duemila – Youth 2000

It was the 15th anniversary of Chernobyl and 25 years since the Vietnam war ended. In Miami a bereaved five year old boy hit the headlines as he became a pawn in an international battle he could not comprehend. And in Fabriano, almost two years after the '97 earthquake, students and professionals met to discuss, role play and tell stories of these and other sources of traumatic stress.

Although this book was inspired by research conducted on school children after the Italian earthquake and includes presentations from our Italian conference, it's scope is wide. Chapters cover traumatic stress as induced by disasters such as earthquakes, floods and fire and the more personal disasters of abuse, violence and bereavement.

We look at coping strategies and the pathological reactions of acute stress and post traumatic stress focussing on the effects on families and the young.

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