SUPPORTING THE STUDENT WHO HAS EXPERIENCED TRAUMA:

THE ROLE OF THE GUIDANCE COUNSELLOR

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INTRODUCTION

Some children and young people attending secondary schools in Ireland have experienced trauma, either a once off traumatic event, or trauma over an extended period. Some will be dealing with ongoing trauma during their years in secondary school. What does the guidance counsellor need to be aware of in relation to this, and how can s/he best support a young person who has experienced or is experiencing trauma?

The guidance counsellor is in a key role to support the young person. She or he is known and available, a potential resource to support the young person in being in and staying in school. The impact of trauma can make it difficult for a person to cope in their normal environment: impacts such as fear, hyper-vigilance, poor concentration and memory and dissociation[1] will have obvious impacts on the child's school life.

The guidance counsellor can provide a supportive, safe connection, a person who knows and understands what the young person has been through, someone to check in with, someone to help with symptom management and reduction, and a witness to the young person's experience, in so far as it is safe or good to tell the story. The guidance counsellor can also create a focus on maintaining the school as a safe environment for students who have experienced or continue to experience trauma.

While the guidance counsellor is in a key position to offer extremely valuable support to the young person, this support will also be limited by the time available and by the level of training and knowledge of the individual guidance counsellor. There will be circumstances where, while the guidance counsellor may continue to play an important supportive role, referral to external sources of counselling and support is most appropriate.

[1] By dissociation in this context we mean a separation from connection with the person's own experience. This can take the form of not being able to feel one's body, of numbing, of a sensation of floating above, being somewhere else, of watching what is happening from the outside with little or no emotional connection to the experience. This is an automatic, unconscious response.

1. TRAUMA

There are many different types of trauma, and the impact will vary greatly depending on the level of the trauma, whether the trauma is experienced in a significant relationship, where it is a single event, or over what period of time the child has to cope with ongoing trauma. It is difficult therefore to generalise about trauma: there is obviously a great difference between a child of fourteen, who is well supported in his or her life, having a once off experience of trauma, such as a car accident, and a child who from the age of six to fourteen has experienced ongoing sexual abuse by an older sibling living in the family home.

The incidence of trauma in the lives of children living in Ireland

The SAVI Report[2], an extensive research study carried out by the RCSI for Dublin Rape Crisis Centre found that of 3120 adults interviewed, 20.4% of women and 16.2% of men reported contact sexual abuse in childhood, that is before the age of 17. From this we can deduce, although perhaps struggle to believe, that in a mixed school of 600 students, it is probable that over 100 of the students have experienced contact sexual abuse by the time they leave school. These figures, particularly for boys, are significantly higher than in other Western countries from which we have reliable data. We do not have research on the incidence of other types of abuse or trauma which children may also have experienced. It is fair to conclude that an understanding of the impact of trauma, and a consideration of the fact that many students may be living with this impact, will be very useful to all school staff in school planning and in their interaction with students.

What do we mean by trauma?

By trauma we mean an event or situation that was experienced by the person as a threat to their survival. Events which are not objectively a threat to our survival – for example life saving surgery or the sudden death of a friend – can still have a traumatic effect as, in the surgery, our body experiences the knife as a threat to life, and the death of our friend threatens our assumption of our own safety and survival. A child who early in life was hospitalised for a series of life saving surgeries, may exhibit symptoms of trauma.

Automatic responses to threat and danger: Fight, Flight and Freeze

The possibility of a threat immediately stimulates an orienting response: we orient to the possible threat, identify and evaluate it, and where it is found to be a real threat we fly, or fight, or freeze. I may hear a step behind me as I walk home at night and am immediately alerted to danger.

[2] 'Sexual Abuse and Violence in Ireland Report (SAVI): A national study of Irish experiences, beliefs and attitudes concerning sexual violence', Hannah McGee et al, Royal College of Surgeons in association with the Dublin Rape Crisis Centre, Liffey Press, 2002

I orient to this: either physically turning to it, or turning all my heightened attention to it. I evaluate it: perhaps the steps begin to head in a different direction, in which case I evaluate them as not being dangerous and relax, or perhaps they are getting closer and faster, in which case I evaluate them as a danger. When I feel a hand on my shoulder I may respond by attempting to run – the flight response; attempting to confront the person – the fight response; or I may freeze.

We have all seen the scene in some film where the monster appears and one character stands frozen, while the other character pulls at him or her and shouts 'run, run!', or grabs the nearest object to ward off the monster. This is quite an accurate depiction of how two people may respond very differently to the same danger.

When a person is faced with a situation that is a threat to survival, that person responds automatically. The person may fight to escape – this response can range from using social skills to talk their way out of the situation, to using physical force. The person may flee – physically escape. Where fight or flight is successful, when the threat has passed, we shake or tremble, and return to equilibrium. We see this happen on wildlife programmes: the antelope perceive the lion, they flee, one is caught and the others, when they get to a safe distance, tremble and then relax. The antelope that is caught does not fight, but becomes floppy and seems to numb to what is happening

The freeze response

The person who stands frozen has not chosen to do this; it is an automatic unconscious response.

'In the animal kingdom, active defensive responses turn to passive freezing when active responses are likely to threaten survival. For humans as well, when active defences are impossible or ill-advised, they may be replaced by passive defences such as submission, automatic obedience and freezing.'[3]

Freeze may be at one or other end of the spectrum: at the end of what is sometimes termed hyper arousal, freeze will involve a highly activated state, with constriction, rapid or shallow breathing and dissociation. At the other end of the spectrum, what is termed hypo arousal, it will involve collapse, numbness and dissociation. This freeze and dissociation response allows survival. A survivor of torture or a life threatening attack will often describe how, while the attack was going on, s/he was not really present, felt at a remove, watching what was happening from above, as though it was being done to someone else.

For the person who froze, there can be considerable self blame after the event, and a fear that they will not be believed because of how they reacted. The person they tell about the event may ask or wonder 'why didn't you scream, there were people just in the next room?' The likely answer is that the victim simply froze, and lost their capacity to scream or to take any other action.

[3] Nijenhuis and Van der Hart 1999 Somatoform Dissociation: Phenomena, Measurement and Theoretical Issues

It is where the person freezes or is unable to escape, that traumatisation is most likely to occur. The orienting, fight or flight responses have been activated, but are truncated, and the individual is left with an unfinished response that can impact in many different ways.

Traumatic shock

Sometimes a traumatic event does not require any action on our part, where there is no threat to life or limb – for example where we witness an accident or receive very bad news. Where we have an opportunity to feel, experience and process the shock at the time, we are likely to experience much less in the way of trauma symptoms than where the response to the shock has to be truncated e.g. where we have to take control to manage a crisis situation, or where our personality or the situation we find ourselves in leads to us disguising and cutting off the impact.

This is very relevant to situations such as where young people are subjected to the shock of the death of a peer. Some will register and process the shock. This may include physical processing which might be visible as shaking; emotional processing which might include tears and other expressions of grief and anger; cognitive processing where they struggle with the impact of this event on their beliefs; and spiritual processing, where they somehow find a way to place what has happened into their meaningful world view. Others may not register or process the impact, may dissociate or move into caring for others, and may as a result be left with the impact of the trauma longer term.

These experiences may be quite common in our lives: parents may have multiple experiences of witnessing their child have an accident or near miss, and moving straight away into managing the situation without having an opportunity to register and process the shock. Over time, and particularly where the events were relatively serious, we can accumulate quite a degree of traumatic shock in our bodies. We may find ourselves replaying particular moments from years ago, and still feeling the shock of the moment, perhaps still carrying self blame and considerable fear. Or we may experience sudden seemingly inexplicable moments of panic, or very strong reactions to perceived threat, or a continuing very heightened sense of danger.

The impact of truncated orienting, fight or flight

Where a situation is one where there is a perceived threat requiring action, truncation may occur during orientation: the person who is suddenly attacked without prior warning will not complete the orienting process, and may be left prone to disorientation, easy startling, hyper vigilance and physical symptoms in neck and shoulders. This could be a passenger in a car, who did not see any danger coming prior to impact. Where fight or flight responses were initiated but overwhelmed, or were never initiated due to an automatic freeze response, the truncated fight or flight response may lead to symptoms such as panic attacks, overwhelming impulses to 'get out of here' which may manifest in a myriad of ways, immobilisation in the face of threat. Paralysing levels of anxiety felt as physical sensation in the solar plexus, chest or stomach and named by the individual as fear, may in fact be a truncated fight or flight response.

How will a person appear immediately after a traumatic event?
There are many different ways in which an individual may respond to shock and trauma.

- ➢ Some people after a severe trauma will be dazed and quite numb and collapsed, or frozen and constricted
- ➢ Others may be confused or hysterical, crying and very panicked
- ➢ A person may be very angry
- ➢ Some people in the aftermath of trauma become extremely rational and capable and disconnected from emotion
- ➢ A person may move through a number of these different responses
- ➢ Where a person who has experienced a traumatic event has also experienced trauma in childhood
    - they can be in an even more severely traumatised state after the recent incident, and may be very dissociated and 'out of it'
    - may relate to the new event as though it happened to someone else
    - may have laughed while the event was happening, and minimise and joke about it afterwards
    - may be triggered into delayed Post Traumatic Stress related to the earlier childhood trauma

Post-traumatic stress disorder
The degree of fear and powerlessness, and the extent to which the person's defences were disabled or overwhelmed, will influence how likely the person is to suffer PTSD and how severe it may be. Where a person experiences repeated trauma, the impact is reinforced and added to. Children who suffer repeated abuse or witness ongoing family violence are therefore very vulnerable.

Symptoms of PTSD can include some or even all of the following:

- ➢ Disturbed sleep and nightmares
- ➢ Isolation
- ➢ Recurrent flashbacks
- ➢ Great fear, which is sometimes paralysing
- ➢ Panic attacks
- ➢ Suicidal thoughts and attempts
- ➢ A spiritual impact
- ➢ Great difficulty coping with normal routines and daily tasks
- ➢ Impaired concentration and memory
- ➢ Inability to continue in work or study
- ➢ Self blame and guilt
- ➢ Hypervigilance and startling easily
- ➢ Difficulties around eating: not eating at all, or compulsive over eating
- ➢ Using alcohol or other substances to 'numb out'
- ➢ Washing obsessively, particularly after a sexual attack
- ➢ Mood swings, outbursts of anger
- ➢ Impulsiveness
- ➢ Anxiety
- ➢ Depression
- ➢ Re-enactment of the event, unconscious and disguised

- Chronic physical symptoms
- Avoidance of people, places, activities associated with the trauma
- Developmental regression

The impact of the trauma may continue over a very long time and the person may become more and more debilitated.

The impact of trauma that occurs in relationship

Where trauma is visited on the individual by another person or persons, as opposed to by some natural disaster or accident, all or many relationships may be fundamentally affected. This may:

- Include close personal relationships
- Involve a fearfulness of and inability to trust others
- Be gender specific eg a rape victim being afraid among men
- Where the trauma involved a person whom the victim thought was safe, s/he may lose trust in his/her own capacity to judge people
- Involve feelings of intense shame and self-blame and fear of judgement and rejection from others
- Include social settings – eg fear in crowds, or in settings where the person feels unable to get away easily

Delayed Post-traumatic stress

In some incidents of trauma, the event is so overwhelming or potentially annihilating that the person enters a period of denial in relation to what has happened. It is as if to fully experience the event at that time would involve serious risk to psychological or physical integrity, and instead the event is 'suspended' in an unassimilated form.

This may include:

- Repression of some or all memories associated with the trauma. This may involve blocking recall of the actual details of what happened and also emotions which are connected to the trauma.
- For a period of time (which may persist for years) the person may show no symptoms of PTSD beyond a pattern of avoiding behaviour (in an attempt to avoid situations reminiscent of the event that may provoke a traumatised reaction of being overwhelmed with fear or panic) and depressive symptoms associated with a lack of spontaneity or engagement in life.
- The symptoms of PTSD may then be activated by some other event in the person's life. This may be another similar trauma, but the trigger may be almost anything: a TV programme, a conversation, being mugged etc.

Repeated trauma

Where trauma is prolonged and repeated (domestic violence, child abuse) the psychological symptoms of PTSD are amplified and generalised. The somatic impact emerges in insomnia, startle reactions, agitation, headaches, gastrointestinal problems, back and pelvic pain, tremors, choking sensations, nausea. There may be protracted depression.

Traumatic bonding may occur between the captive child or adult and the captor (a child or adult in an ongoing abuse situation can be considered as a captive). As the abuse continues, the captive no longer thinks of escaping, but of how to stay alive and survive. S/he may become completely identified with and dependent on the captor. The range of initiative becomes very narrow and habitual, and will have to be unlearned after release.

A person who is a captive prisoner cannot express anger as to do so increases the danger. Controlling the anger will exacerbate paralysis and withdrawal. Internalised, it can lead to self hatred and suicidality. Externalised, it will damage relationships and have social consequences, or may lead to self-harm.

The child who lives in a situation of ongoing trauma

Where a person is living with ongoing trauma, s/he has to find a way to survive and to live a more or less meaningful daily life. The capacity of the human being to do this is sometimes quite extraordinary, for example people living in times of war and severe disruption. A child living with ongoing trauma also has to find ways to continue his or her core task - to develop in every aspect of him or herself. Where the trauma involves core relationships – which it almost inevitably does as the caregivers are experienced by the child either as traumatising or as failing to provide and protect – the child's fundamental need to protect his or her relationship with the primary caregiver(s) will affect the mechanisms which emerge to allow survival.

A child who is living/has lived with ongoing trauma within a relationship

How does a child learn to survive and develop in a context of ongoing trauma within relationship? This category includes a child who experiences emotional, physical or sexual abuse, or who is living in a situation of domestic violence. It also applies to the child who experiences neglect or absence or removal of primary caregiving, perhaps due to parental illness or the illness of a sibling, not necessarily through anybody's fault. The relationship with the adult caretaker is essential to the survival of the child, and the absence or removal of such a relationship is perceived at the deepest level by the child as being life threatening.

Keeping the secret

Many of these situations will be surrounded by secrecy and shame and self blame. The child may have been pressurised or threatened to keep what is happening secret. The child not only will have to find a way of coping with the trauma, surviving it and achieving as much development as possible, but will also have to show no observable signs of this to the outside world, will have to appear 'normal'. The extraordinary thing is that so many children do this so effectively, although often at very great cost to themselves. The degree of resilience, courage and creativity that children draw on to survive in these situations is truly remarkable.

A child who is experiencing sexual abuse may take on the necessity of protecting his or her parent/s from the knowledge of this. It is imperative for the child that their family and their relationship with the primary caregiver/s, survive.

Without these a young child can feel in great danger, even where these are a grave danger in themselves, so any threat to these can feel like a threat to the child's very survival. So he or she may have the experience of being raped by a sibling in the evening while their parents are out, and may get up and have breakfast the following morning with that sibling without the parents suspecting that there is anything wrong.

How do children do this? In this situation of trauma which threatens the survival of the child, s/he is forced to develop extraordinary survival capacities. An understanding of what these might be and how they might operate is very helpful as we attempt to support this child. They will be individual to each child, a unique attempt to cope with a unique set of experiences in a unique environment, and will be related to the age and stage of development of the child.

How the child reacts and copes

The work of Judith Herman[4] is very useful when attempting to broadly understand how the child copes. Herman writes of how the child's adaptations will necessarily be primarily focussed on preserving the child's primary attachment to the parents. Deprivation of this attachment is felt by the child as life threatening.

> *'The child is forced to develop extraordinary capacities and abnormal states of consciousness in which the ordinary relations of mind and body, reality and imagination, knowledge and memory, no longer hold'.*

The protective mechanisms which are adopted at an unconscious survival level may include psychological defences such as avoidance, dissociation, internalisation of responsibility and a deep sense of badness, the development of a false self, taking responsibility for others, idealisation of the parents, inner fragmentation. The child may act out emotionally, or withdraw; may remain hypervigilant; repress all or some memories. S/he may regulate his or her emotional state through self destructive behaviour. S/he may experience anxieties and phobias, or be physically ill. The view of the world and relationships and the self image will be made up of extremes, and harsh self criticism may be the default position in the relationship with the self.

Impact on the child's development

The child's development in relationship with himself and with others will be immensely impacted by these protective mechanisms. He may be very wary and find it difficult to trust, may have a constant sense of unsafety and danger, of the world as being unpredictable and a place where it is necessary to be defensive. And he may not be aware that he perceives, feels or experiences in these ways, leading to extreme confusion. A sophisticated defence system may allow the child to disguise what is going on at the deeper level from all around, including him or herself. For example, the child may unconsciously know that others must be kept at a distance, that relationships are dangerous and painful, and in order to keep others at bay may develop a very charming, funny, chatty apparently open personality, such that

[4] Trauma and Recovery: The aftermath of violence Herman; Judith Lewis Basic Books 1997

others believe they know him very well, while the child's own experience is of isolation and of not really relating to anyone. Alternatively the child may reinforce his or her defensive boundary with aggression, or with socially unacceptable habits such as lack of hygiene.

As a child moves through adolescence, the longer term effects may include

- Little sense of self and low or negative self-esteem. This will affect every aspect of the person's life
- Deep emotional pain. Some individuals will resort to substance abuse to numb the pain. Others may self mutilate
- A fundamental view of the world as a place which victimises and harms them. This will have profound effects on the individual's relationships and life choices. This may result in their feeling and being powerless, or at the other extreme having a very strong need to be in control or to be dominant
- Difficulty with intimacy and with forming deep relationships
- Issues around sexuality
- Difficulties with maintaining and managing boundaries and control
- Difficulties separating from and developing independence of the family
- Depression and suicidality
- Development of a 'false' sense of self, where the young person's identity, for example as a high achiever, becomes almost a matter of life or death. Parallel with this the young person may feel worthless, and fearful of being 'found out'

2. WORKING SAFELY AND PREVENTING RE-TRAUMATISATION: THE WINDOW OF TOLERANCE[5].

No matter what the circumstances of the trauma, one issue is always relevant: ensuring that in the work we do to support the child or young person we do not create a situation of retraumatisation.

So what do we mean by re traumatisation? Quite simply we mean where a situation arises that for the traumatised individual replicates the original experience and the original response. This can occur in the individual's daily life, and it can occur in the counselling room. Where this happens, the original impact of the trauma is reinforced. Our aim in counselling is to provide an opportunity for the client to have a different experience and a different response to that which they had in the original traumatising situation.

The Window of Tolerance

A model I find it very useful to offer to clients who have experienced trauma and to have in mind myself as I work with them is the template of the Window of Tolerance. This is a useful model for explaining the impact of trauma, and also has applicability to stress and vicarious traumatisation.

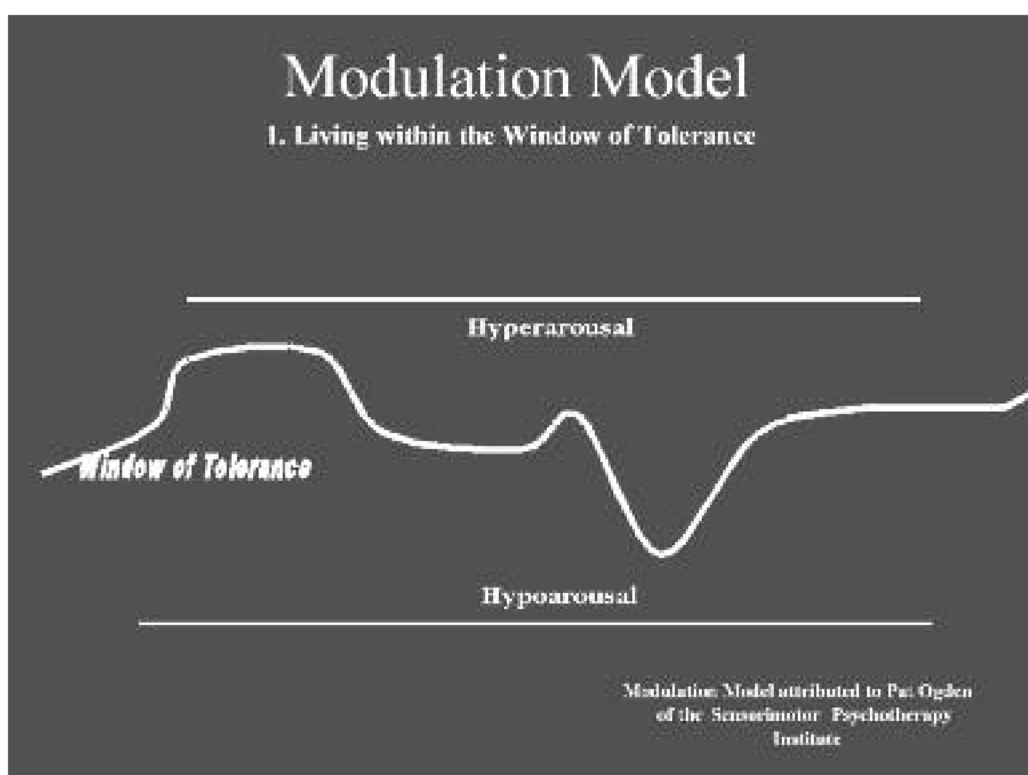
This model suggests that each of us has a range of daily experiences that we find it possible to tolerate or manage. We can find ourselves feeling stressed, frightened, uncertain, sad – but these experiences at emotional, psychological and physical levels remain within what is tolerable and manageable for us and we do not become overwhelmed.

An example might be a student approaching exams. While he may feel quite anxious or stressed about the exams and the workload, he has his notes and books reasonably well organised, has worked consistently all along and knows this. He uses a variety of resources to support himself – chat and fun with peers, calming internal self-talk, study notes, sport, parents, extra classes, TV, help from older brother maths genius – and so maintains his equilibrium. He may when he realises there are only three weeks left and he has not yet covered certain topics feel panic and overwhelm and become very upset 'I can't do it, I just can't, I'm going to do really badly, I might as well give up'. The usual resources are not enough, but he reaches out to a supportive teacher or parent, or a level headed friend, who acts as an additional resource and supports him until he returns to his Window of Tolerance – 'I'll be okay'.

A different student, maybe coping with additional sources of stress or with less resources available, or who has experienced trauma in the past, may not be able to remain within or return to his Window of Tolerance, may stop sleeping, feel nauseous and not eat, find concentration impossible, experience panic attacks or depression … and move further and further outside of his capacity to cope.

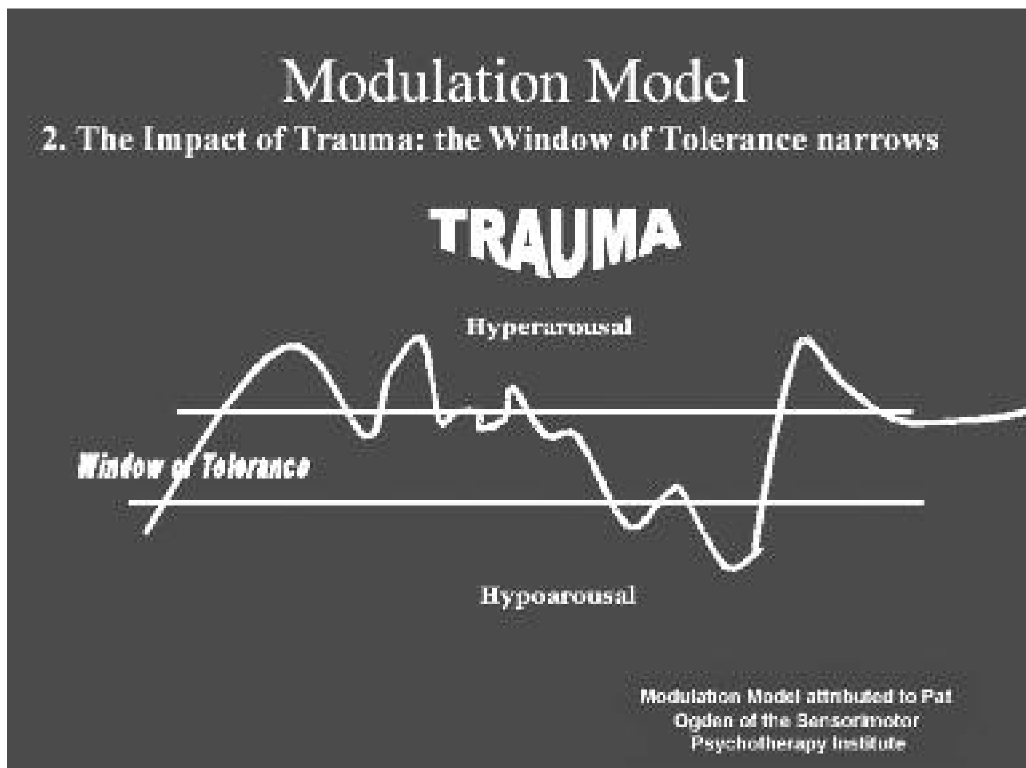
[5] Trauma and the Body: A Sensorimotor Approach to Psychotherapy. Pat Ogden, Kikune Minton, Clare Pain WW Norton 2006

It is the level to which we are resourced that decides the width of our Window of Tolerance at any time and the range of experiences that we can cope with. We all recognise that after a number of nights without sleep, what we can cope with is reduced, and a small event that we would normally manage with no trouble suddenly can seem overwhelming and we panic, over-react or become deflated and hopeless. One good night's sleep can restore our capacity to cope. Unfortunately, it is when we are under stress or feel we are barely coping that we tend to withdraw from our resources, the very things that help us to keep our equilibrium and to cope. 'I know a walk on the beach/a night out with my friend/taking a lunch break usually does me good, but I just don't have the energy or the time for it right now'.



Modulation Model 1: Living within the Window of Tolerance

A well resourced person will be able to deal with the ups and downs they encounter in their life, while remaining within their Window of Tolerance.



Modulation Model 2: The impact of trauma: the Window of Tolerance narrows

One of the impacts of trauma is that we are separated from our normal coping mechanisms. Our capacity to deal with the normal events of our lives is greatly impeded. We find ourselves being triggered outside our window very easily and suddenly: a noise, a smell, a thought, one extra task to do, and we are hyper or hypo aroused.

Where a person moves outside the window at the hyperarousal end, this may appear as panic attacks, breathing difficulty, blanking out, stiffening and constriction in the body, or as emotional overwhelm – eg crying/sobbing to a level where they don't know if they will ever be able to stop, outbursts of uncontrollable anger -, and lead to dissociation. Hypoarousal may appear as helplessness and hopelessness, collapse and numbing.

So we take evasive action and avoid the situations that may evoke these responses. 'The last time I went to the canteen it was so crowded and busy I had a panic attack, my chest got really tight, I couldn't breathe, I felt dizzy and I thought I would faint. So I will just stay in the classroom during lunch and hope no-one notices. But people come into the classroom and ask me what I am doing there and I just freeze and don't know what to say. I wish I could just not go to school at all, maybe I'll say I am sick tomorrow.'

In this way as the individual limits the exposure to situations that trigger hyper or hypo arousal, s/he also loses access to important resources: contact with friends, distraction, activity, fun, food, occupation, achievement, intellectual stimulation, hope. And the Window of Tolerance becomes narrower and narrower. Individuals may attempt to widen their capacity to cope by numbing out, or through using substances or medication.

Modulation Model 3: Reconnecting with and developing new resources widens the Window of Tolerance

In our work with individuals who have experienced trauma, we want to restore, strengthen and widen the Window of Tolerance. This is done through identifying, reconnecting with and developing the resources of the individual. This is very concrete and practical work: restoring basic resources such as the capacity to eat and sleep are fundamental. It will include developing ways of coping with symptoms such as panic attacks, intrusive images, nightmares, and supporting the client to identify, access and develop resources which ground, calm, energise them.

> *'Since it happened I haven't been going out with my friends. This means I am deprived of resources such as fun, contact, empathy, distraction, occupation, exercise, achievement, proportion, learning, new clothes, meeting new people.'*

A first step to restoring the whole range of these resources might involve identifying the one or two friends I feel most supported by and a place I could go with them that I would enjoy but that is not too challenging: the local shopping centre, on a Wednesday after lunch when it is not too busy, just for an hour or so. The counsellor may work with the client to develop or identify resources that will help: self talk; eating beforehand; breathing; positioning myself with a friend on either side; reminding myself my Mum will be at home when I get back; creating an image of her putting her arms around me; knowing I don't have to stay if I don't want to; wearing my favourite t shirt; having lucky Ted in my pocket; seeing this as an experiment, no matter how it goes I will gather useful information about myself that I can bring back and look at in counselling. With this information, client and counsellor can identify the resources that will allow the client to take the next small step.

Using the Window of Tolerance model in the work

The Window of Tolerance model is an extremely helpful template for the counsellor when attempting to work safely with a young person who has experienced trauma. Basically, we are working safely where the person is within their Window of Tolerance, and we are risking re-traumatisation as they move towards the limits of this window. Where they move outside what they can tolerate and resource, they will have the same reaction they had at the time of the trauma, that is they will be overwhelmed, will freeze and will dissociate. The impact of the original trauma will be reinforced, not diminished, by this.

What will indicate that the person is moving outside the Window of Tolerance?

Where a person is becoming hyper activated, we will see stiffening, rapid or held breathing, heightened or patchy colouring, agitated movement, and dissociation. Where a person is moving towards hypo arousal we will see blankness, a collapse, lack of muscle tone, numbness and dissociation. Where we see these indicators, we need to support the client in becoming resourced in the here and now: breathing, grounding, coming into the present. When working with a young person in the guidance counsellor's office, I believe it will be wise and appropriate to work very much within this Window of Tolerance, to avoid deepening into areas that trigger the young person into hyper or hypo arousal, while developing the young person's resources so as to widen the range of what they can tolerate, manage and enjoy in their daily life. I offer this model to many of my clients, who find it very useful in understanding themselves and their responses, and in managing these.

The Window of Tolerance as a useful map for everyday living

The Window of Tolerance model, while developed to describe the impact of trauma, also has applicability in relation to stress and vicarious traumatisation. The map of the Window of Tolerance is a very useful tool in understanding how we react as we do, and why it is that this can vary so much. It is a tool that could with value be passed on to all students. They might then see that when they suddenly flare up and shout at a parent, or spend an evening feeling numb and hopeless, it does not mean that they are a horrible person, or that they are a total loser – they are just outside their Window of Tolerance for now, and need to draw on resources that will allow them to cope and in time to return to equilibrium.

For ourselves too it can be useful to view how we and others are through this template. If a usually supportive and respectful colleague suddenly snaps rudely at me, I can certainly object, but might also consider that this is not usual and may be a signal that my colleague is experiencing stress that is pushing him outside his Window of Tolerance. He may need not just a reminder that this behaviour is not okay, but also some extra support and resourcing.

Viewing my own responses through this template, I can see a small eruption in anger or sinking in despondency as a signal that I am at the edge of what I can manage. I can at that point take action to reduce pressure and stress and/or to increase my resources. This map encourages a very practical and much more understanding and less judgemental attitude in our relationships both with ourselves and with others.

3. THE GUIDANCE COUNSELLOR AS A SUPPORT TO THE YOUNG PERSON IN THE AFTERMATH OF TRAUMA

School staff will not necessarily know which children are experiencing ongoing trauma. Some trauma will be known about; others will be very effectively hidden.

How the guidance counsellor can support the child

This will depend on how the trauma manifests itself. The young person may exhibit obvious symptoms of post traumatic stress – such as panic attacks, flashbacks, nightmares, suicidal thinking – and where the trauma is known about and does not involve too deep a level of shame, may be able to let others know that they are experiencing these symptoms. However much childhood trauma is not known about by others, and may involve secrecy, shame and self blame, and the child may attempt to disguise the trauma symptoms from others. Or they may not make any connection between their experiences and the symptoms – often we don't- and may be terrified, feel they are 'losing it' or going mad. Where the trauma is ongoing in the life of the child s/he will have to adapt in order to survive, and the adaptive protective mechanisms such as dissociation will become part of how the child lives in the world, part of their sense of themselves, and may effectively disguise the impact of the trauma from others and indeed from themselves.

So how might trauma show up?

- In what the child believes about himself and the world
- In how the child relates to others
- In symptoms of high activation – panic attacks, flashbacks, nightmares – and overwhelm – freezing, emotional flooding, numbing and dissociation.
- In the child's behaviour both towards themselves and others: withdrawal, aggression, over responsibility, over compliance, over focus on study, risk taking behaviours, self harm etc.

Child development

It will be very useful to keep in mind what you know about child development. What cognitive resources were available at the age at which this child first experienced trauma? What stage were they at in moral development, is there evidence of very black and white thinking, and very direct cause and effect, wrong and right?

For a teenager who first experienced trauma at the age of six, his understanding of that experience, of himself and the world will essentially remain the understanding reached by that six year old. It may be overlain with the more sophisticated rationalisations and logic of a 15 year old, but at the base the six year old will be the one who made the map of how things are in the world.

That internal six year old will keep guard over that map because he has worked out how to survive in that world, and any suggestion that the map is not accurate, and that his survival strategies are not needed or are invalid, will throw the child into extreme panic and confusion. So taking note of the stage and level of development - cognitive, emotional, moral - that the core belief maker was at when creating the beliefs and understanding around the trauma, will help a great deal in supporting the older child.

An example

If the child experienced a serious trauma at age nine when they took a short cut home down a lane they had been warned not to walk down, the child will internalise the responsibility for what happened, using egocentric, concrete, cause and effect, black and white thinking. 'I didn't do what I was told and this happened. So it is my fault. If I wasn't bad it wouldn't have happened. Look at the trouble I caused for everyone'. The 15 year old may word this differently, but careful listening by the counsellor - to the language used and the tone and mannerisms - will reveal the age and stage at which the belief was formed. All of this can be explained to the 15 year old, it is useful information, and s/he can become an ally in working with the internalised nine year old, gently explaining the true situation – 'you should have been able to take a shortcut and still be safe – it was not your fault' in a way that will allow the strong core belief – 'I was bad, I caused it so I deserved it' to soften and change, and the nine year old to see the situation as s/he could not see it at the time. 'I was only nine, I just didn't want to be late home, I was trying to be good, I didn't deserve it, I should have been safe, it was not my fault'.

The counselling process: disclosure, stabilisation and symptom reduction

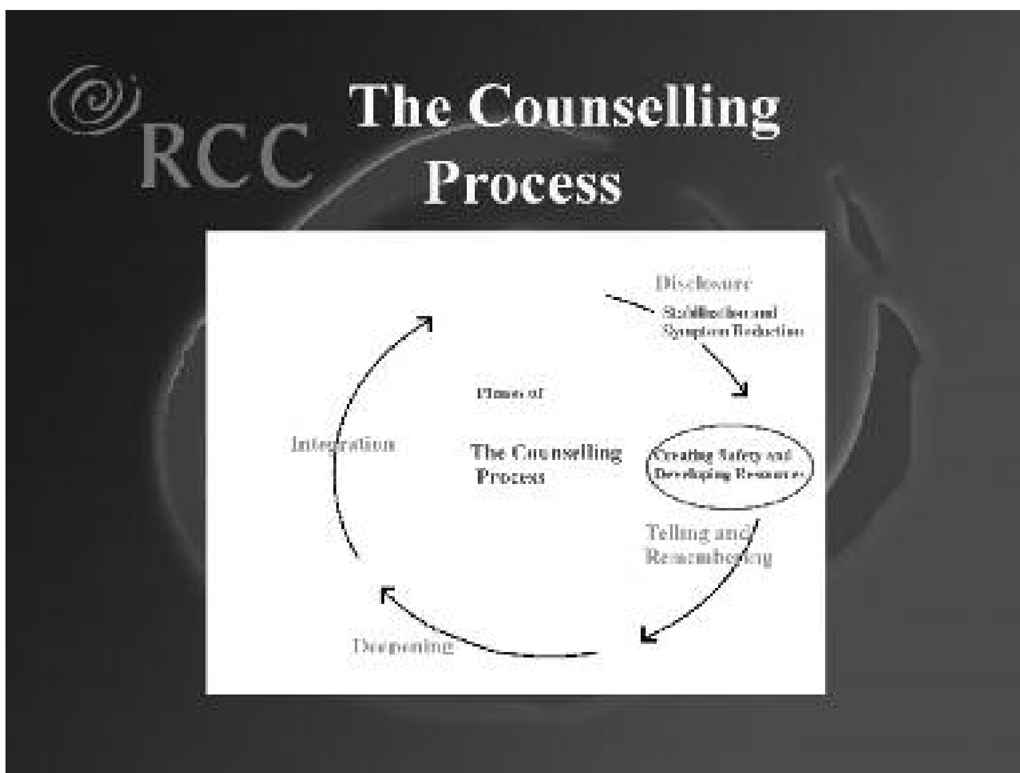
Our work with a survivor of trauma involves supporting them to become resourced enough to be able to live a full life without continually re-experiencing the trauma or being focussed on avoiding it, and without being controlled or impeded by it.

In the Dublin Rape Crisis Centre (DRCC) when working with a person who has recently experienced sexual violence, our first concern is to re-establish the person's resources, and to stabilise their daily living. In the aftermath of trauma, people will respond in many different ways. Our first response is to hear what their experience is: how this person is affected. Are they sleeping? How is their eating and their digestion? How has their daily routine been affected? Are they able to continue going to work, college, the shops? Are they hyper alert? Are they experiencing symptoms such as panic attacks, flashbacks, nightmares? Does anyone know about what they have been through, and who is willing to support them? Do these supporters need information or support themselves?

We work with the person towards stabilisation and reducing symptoms. This is the first phase of therapy with any trauma survivor, whether the trauma was a once off event or repeated over a long time. This phase can be quite prolonged. With some very vulnerable and unresourced clients, the work may never move past this stage.

Only when the individual is well resourced and stable and has developed certain capacities that can be accessed in the therapy – capacities for mindfulness, staying present, dual awareness, modulating arousal - will the therapy move on to deal at a deeper level with the traumatic events. And where the individuals' life circumstances change – eg where a person becomes pregnant, is facing exams, is bereaved – the therapy may revert to resourcing and stabilisation again.

The guidance counsellor, working within the school setting, with a young person, is likely to find their focus throughout remains on stabilisation, symptom reduction, the creating of safety and development of resources, and the integration of these. Because of a range of factors including the age and stage in life of the young person, their outside circumstances, the limits of time, the limits of the guidance counsellor's training, deepening into the distress and trauma may never be appropriate.



Offering support to a young person in the immediate aftermath of a trauma

The work of the early days and weeks is about helping the young person to reconnect with his or her strengths and to use them to help maintain safety in a world that s/he knows now, at a very deep level, to be more dangerous and harmful than s/he felt or believed it to be before the trauma.

Assessment of the impact

The first session/s will involve an assessment of the immediate impact, and addressing very practical issues. In the aftermath of a trauma, a gentle authoritative directiveness on the part of the guidance counsellor about self care and support will allow the young person to feel held.

Early sessions will focus on

- Sleeping
- Eating
- Fear, hyper vigilance
- Connection - isolation
- Whether the person is talking about what happened, or not
- Impact on relationships
- Panic attacks
- Nightmares
- Physical symptoms: diarrhoea, constipation, headaches
- Self blame
- Drinking, substance misuse to numb out
- Suicidal thinking or actions
- Flashbacks
- Capacity for concentration
- Daily routine: socialising, study, friendships, job
- Boundaries: have they become rigid, or over permeable
- Access to and use of resources and supports, both internal and external
- Self harm, self punishment
- Exercise routine
- Motivation
- Impact on sexuality or sexual life

Identifying resources available

The guidance counsellor has an important role in identifying with the young person their supports and resources, both internal and external, which they can draw upon in the days and weeks ahead.

Telling about the trauma

The guidance counsellor can offer an opportunity to tell the story if this is needed, but with no pressure. There is a risk of re traumatisation where the person connects at a feeling level with the experience while still very vulnerable and unresourced.

Normalising

A crucial role for the guidance counsellor is that of normalising the impact. Often a person feels s/he is going mad, feels out of control.

- It is normal to have great difficulty sleeping, or to wake in terror. It is also normal to sleep all the time, and to be unable to stay awake.

- It is normal for the body to respond to trauma with diarrhoea. It is also normal to respond with constipation.

- Panic attacks, bewilderment and confusion, great difficulty with concentration, errors are all normal in the aftermath of a trauma.

It is also crucial that the guidance counsellor conveys the message that while people react like this to trauma, they also recover their coping strategies, and that there are ways of coping with these symptoms. The guidance counsellor can explain that s/he will work with the young person to explore strategies which might work for him or her.

Focus on the here and now

Focus on the here and now: is the young person able to eat? To sleep? Support him or her in developing strategies to deal with difficulties arising eg panic attacks, intrusive thoughts, inability to concentrate. All of these symptoms add to the client's fear, bewilderment and feelings of loss of control. Conversely, being able to address them practically and concretely and find ways to help themselves will begin to restore feelings of safety and control.

Eating

In the aftermath of some traumas, for example sexual trauma, eating may be affected. Work if necessary in detailed and focused ways on reinstating eating if the person is finding it difficult, so that the eating problems do not have a chance to become habituated. What happens in her body when she tries to eat that makes it difficult? What might be easiest to eat or drink to begin with? Using relaxation before, during and after eating.

Flashbacks

We sometimes think of memory as being almost like watching a film on a screen. Flashbacks to trauma are not 'viewed' memories, they are felt memories both emotionally and physically. Thus for example the fear and terror which arise during flashbacks are equivalent to the fear felt during the rape or the stabbing, and may be felt as physical paralysis or gut wrenching terror.

Encouraging a movement away from dependence

During a crisis the young person may need to be dependent for a short while, believing that he/she cannot help him or herself. Where this continues for too long it increases the client's sense of powerlessness and helplessness. Look for small ways in which the client can begin to feel able and to take back power again.

Highlighting the positive

The guidance counsellor needs to be mindful of being as interested in the positive aspects of the young person's day to day life as in the difficulties s/he is experiencing, of celebrating small achievements and returns to self and normality, of identifying and highlighting for the person where this is happening.

Generalising the experience

> *'I went to the shop today, I was shaky but I did it.'*

The guidance counsellor's role is to celebrate this achievement and identify what resources and strategies were used by the client. What were the resources you drew on? How did you do it? You can use those resources, plus the additional resource of knowing you did it, in other situations also.

Prolonged shock and denial

Be aware that the young person may continue in shock and denial for an extended time: it could be six months or more after the event before the full impact of what has happened registers. By then the people around them may be suggesting that it is time to 'get over it' and move on, and the client may feel the same, and be impatient and blaming of him or herself.

Past trauma

A current crisis nearly always evokes any previous unresolved trauma. Until the person is resourced and sturdy in the world again, earlier experiences need to be named and told about, but then contained and held.

4. IS TELLING THE STORY OF THE TRAUMA HELPFUL OR NECESSARY?

Over the weeks and months following a traumatic experience, the client may or may not wish to talk about it. This should be left to the client: the guidance counsellor can be open to hearing, but without pressure.

The young person may need to tell and to try to make sense of what happened; to find a way of living with it not making sense; to re examine what happened. The guidance counsellor can listen, help to contain, reassure, and gently but firmly open up and challenge distorted beliefs eg self blame.

Is telling the story helpful? When is facilitating this telling contraindicated?
It can be extremely helpful to us to tell another person about a difficult experience we have had, and to feel supported by that person. Telling helps us realise that this thing really did happen; it helps us to understand what happened better; it helps us fit a powerful event into our life story so that it becomes part of rather than all of the story. The other person's response of empathy, support and non-judgement can allow us to respond to ourselves in those ways too. The witnessing of the client's experience and story is a very important role of the counsellor. While witnessing we can assist the client in re examining limiting beliefs they hold about their experience.

And we do tell about traumatic experiences - being attacked in the street, or about finding our kitchen on fire, or a sudden phone call that told us a loved one had been injured. Other traumatic events we do not speak about, through fear, shame, self blame, or expectation of being judged. We may not be able to tell about a humiliating experience of being bullied. We can find it hard to tell about eruptions of family conflict. And we find it especially difficult to tell about domestic violence, addiction related events and sexual trauma.

Is telling necessary for recovery?
Where telling can happen safely and without re traumatisation and where it is met with a helpful response, it can aid recovery. However telling the story is not a necessary part of recovery. Encouraging a person to tell their story when it leads them back into the trauma is merely reinforcing the traumatisation of the person.

When we are working with clients who have experienced severe trauma such as sexual violence, we are working with people who have known extremes of danger, terror, and pain. We must work always respectfully, in gentleness, safety and non-violence.

We should maintain a consciousness of this person's experience of trauma which informs our work. It is our role to notice when the client describes experiences of successfully defending, setting boundaries, escaping, surviving, being joyful - in their current or earlier life - and to know the value of deepening into these experiences when working with a person who has experienced trauma.

It is our role also to create new opportunities for these experiences in the counselling, and to deepen into these. And always to work only within our own capacity, our own training, skills and experience.

Some clients will wish and need to tell about traumatic experiences, to have their experience witnessed. Some clients, when sufficiently resourced and in the appropriate therapy setting, will be able to approach past experiences in order to process the trauma. Parts of the story will assist in connecting with the hurt child, and in accessing and working with limiting and distorted beliefs. Through contacting fragments of the story and working with these, learning to modulate the arousal that accompanies them, gradually the client becomes able to experience his or her history as a narrative that makes sense, with decreasing capacity to trigger him or her into trauma or emotional overwhelm.

But we do not pursue the trauma or its story, we do not force the client to retell, re enact, re experience. We never revisit past traumatic experiences just for their own sake. To do so, especially with a client who is insufficiently resourced, can be extremely damaging. Some clients may never tell the story of past trauma, or may not reveal its specific nature. Some may not know the full story of their trauma themselves. However, the impact will be visible to the attuned eye, and we can work with what is brought to us: as the young person describes his or her response to being shouted at in class, or to being the one who ended up without a partner for a project, or what it is like to come and talk to us today.

Everything we need to work with past trauma is here in the room with us; right here right now. It is here in how it is for the client to come in and be in our presence. It is here in what our clients bring in out of their current life and how they are affected, how they have reacted. It is part of our role to bear in mind the past history of the client, so that we can work with them in the present, with what they bring to us in the present, in ways that will help to heal and process the trauma that happened in the past.

'When I sit in front of you,
Do not look only for my wound,
Do not scratch around
Creating new rawness.
Notice rather how I avert my eyes,
When it is that I tighten,
When I shift in my chair;
Notice how I open and expand
When laughter bubbles.
Work with that
And you touch my wounded-ness
But gently.'

AK and LOD

APPENDIX

RESOURCES

What do we mean by resources?

- By resources we mean all those capacities, qualities, skills etc that we possess within us, and all those supports which are external to us which allow us to manage our daily lives in ways which are healthy and balanced.

- There are many different types of resources which we draw on in our daily lives, -innate qualities, skills, abilities, relationships, and services that support us and help us maintain our sense of self and ability to self-regulate, regardless of what is going on in our lives.

- The quality of a person's life is directly related to the resources they have available to them, whether internal or external, survival resources or creative resources.

A well-resourced person can adjust and respond in a balanced and creative way to a wide variety of events and interactions. He or she can sustain autonomy and individuation in the face of stressful relational experiences. Such a person is described as healthy and adaptive.

Developmental resources

As we pass through different developmental stages, we develop skills and capacities that become resources in negotiating our way on the world: this could include the ability to ask for support, set boundaries, express our feelings, avail of relationships to help us cope.

Trauma and resources

When people experience trauma, they employ survival resources. Survival resources help us survive and cope. They may be passive responses such as freezing and dissociating or active resources such as running, fighting, and hyper-vigilance. These responses allow survival, but they can become habitual and rigid. The person may have little choice as to how they respond to future situations: they may always respond in this habituated way. Survival resources can therefore prevent the development of creative responses.

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National guidelines on child protection, which includes clear and comprehensive explanations of different categories of child abuse and neglect.

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Leonie O'Dowd is Head of Education and Training with Dublin Rape Crisis Centre, and in that role develops and provides training workshops for professionals who in whatever capacity work with people who have experienced child abuse, sexual violence and other trauma. Her interest is in developing the capacity of staff to provide services in ways which are accessible to and supportive of the very significant number of people in Ireland who have had these experiences. Leonie trained as a guidance counsellor many years ago, and considers the role of the guidance counsellor to be a very important resource for the child or young person. Leonie is also a psychotherapist in private practice.