Assessing childhood trauma: a holistic perspective

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Child abuse is but one cause of trauma on the child. The effects of childhood trauma are not only situated within the child, but also influence those around him/her. This necessitates an assessment that goes beyond the individual in order to ensure meaningful intervention. The aim of this article is to explore, by means of a literature review, the assessment of childhood trauma from a holistic framework in an attempt to move away from focusing only on the individual and also to explore the wider influence of other systems on the individual and vice versa.

INTRODUCTION

Over the past decades, the South African society has been affected by traumatic events that have influenced many, including children. Political riots, accidents and child abuse are but a few examples by which South African children are traumatised. According to Gibson, Swartz and Sandenbergh (2002:65), "trauma is an increasingly obvious part of our [South African] society".

Trauma affects both individuals and the communities in which they live (Van der Kolk 2005:401-408). Research suggests a correlation between childhood trauma and adult psychiatric comorbidity such as anxiety disorders (Lochner, Du Toit, Zungu-Dirwayi, Marais, Van Kradenburg, Seedat, Niehaus & Stein 2002:66-68) as well as physical conditions (e.g. heart diseases, cancer, skeletal fractures and liver diseases) (Van der Kolk 2005:401-408), which emphasises the pervasive influence it has on individuals and those around them. Sharon Lewis (1999:1) comments in this regard: "Many South African children are affected by trauma because of the high levels of violence, both within the home and the wider community". Gibson et al. (2002) further note in this regard that, "one of the key issues we need to think about in helping people cope with trauma and its effects is the social context within which the person is living." These comments reflect the wider impact that trauma has on the individual, but also the impact that the traumatised child has on the wider social context and a need to view and address it in this light.

In assisting traumatised children, a more holistic and wider assessment is necessary that takes all systems into account as well as the reciprocal effect that these systems have on each other and does not view it from a reductionist, prescriptive framework only. According to Visser (2007:12), "the realisation that mental health is not situated within the individual, but that interaction between people over time and that the social and physical environment plays an important role contributed to the acceptance of an ecological perspective", recognising a synchronous interdependence of individuals, the community and society showing inter- and intra-dependence of systems.

The aim of this article is, to explore, by means of a literature review, assessment of childhood trauma holistically in order to move past fixation on the individual, and to investigate the wider reciprocal influence of other systems on the individual as well. As the author is an Educational Psychologist, it will be through these lenses that the article will primarily be structured, yet it is not exclusionary to other disciplines and professions.

THEORETICAL FOUNDATIONS

A first step in assessing childhood trauma is to understand what each concept is.

Holistic perspective

The Concise Oxford Dictionary (Sykes sv. "holism") defines *holism* as "the tendency in nature to form wholes that are more than the sum of the parts by ordered groupings". The term "holism" was first introduced by the South African statesman, Jan Smuts, in his 1926 book, *Holism and Evolution*. Although viewed opposite to reductionism, it is a complementary aspect (Freeman 2005:154-155). Holism will be used as a working hypothesis in viewing the child as a whole living being who cannot be understood by an analysis of the constituent

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parts only. The child is also part of various interacting systems. The bio-ecological systems theory of Urie Bronfenbrenner will be used to illustrate this point of view. Although this idea of holism has been advocated by several theorists (Myers, Sweeney & Witmer 2000:252), Bronfenbrenner's theory will be used as hypothetical point of departure, especially due to the model's application to child development. As a thorough exposition of this theory is not possible within this article, its salient aspects will be highlighted to illustrate the interconnectedness of children with several systems.

Bronfenbrenner (1995) recognised the many interacting social contexts that affect human development. This perspective gives acknowledgment to the role that the human individual plays in the developmental process, but also acknowledges the social contexts in which they develop as they are in continuous interaction with and subsequently influence one another (Woolfolk 2007:72-73). Said differently, this theory views human develop-ment in terms of reciprocal influences within and between the individual and the multiple levels of the surrounding environment. To McWhirter, McWhirter, McWhirter and McWhirter (2007:17), "human development occurs within multiple embedded ecological systems".

Bronfenbrenner viewed human development as the interaction of process, person, context and time factors (Bronfenbrenner 1995:621). Therefore, interactions that occur in face-to-face, long-term relationships are paramount in forming lasting aspects of development. These interactions are termed proximal relations and are influenced by person factors as well as the social contexts in which they come about. Person, process and context factors alter over time due to children maturing and to varying social contexts (Donald, Lazarus & Lolwana, 2006:41).

Bronfenbrenner (1977; 2005:1) noted child development as occurring within several nested systems. In the first instance, *Microsystems* are the immediate social settings in which the individual is involved and include family, friends, teachers, school activities, etc. These Microsystems interact within a *Mesosystem* – a set of Microsystems that continually interact with one another, directly or indirectly. *Exosystems* are settings in which an individual does not have an active role, but nonetheless influence the individual such as the health service, education system, media and public policies, while *Macrosystems* are broad ideologies of society, cultural values, laws and customs of individuals (Donald et al. 2006:41-43; Woolfolk 2007:72-73; Visser 2007:12, 25) on which individuals and families structure their lives. The *Chronosystem* refers to changes in individuals or environments over time (Donald et al. 2006:41-43), which have an influence on the individual and the environment.

Donald et al. (2006:44) note the importance in understanding ecosystemic interactions within the process of education:

> It is only through appreciating the continuous, dynamic interaction between these multiple contextual influences that we can understand why things are as they are at any stage of development. This is true of individual children and of other levels of the system. The ecosystemic view also helps us see how things might *change*, *develop*, and, if necessary be *healed*…. To achieve this understanding, we may need to concentrate on some levels of system more than others in addressing any one challenge.

These observations are indeed valid in this investigation and serve to guide the process of assessing childhood trauma as it lends a more holistic dimension to the process. They do not only view trauma as situated within the individual, but also its influences, and that it is influenced by several systems.

Childhood

When assessing childhood trauma it is imperative that the holistic development of the child, i.e. the interaction of process, person, context and time factors is understood, and the possible implications that this will have on a child who has experienced trauma. Nader (2004:519) avers this and noting the possible negative outcome of trauma states: "In assessing [trauma] symptoms endorsed by children, it is important to be cognizant of developmental issues. Some behaviors are common at specific phases of development, but signal disturbances at other age levels".

Although several definitions of the term "child" exist, it is generally referred to as the phase between infancy and puberty (Reber 1985, sv "child"). This phase is considered very broad as it encompasses several other sub-phases (i.e. the infant, toddler, pre-school child, and the middle years of childhood as well as pre-adolescence) (Stone & Church 1973). Middle-childhood (M-C) will be used in this

instance as example.

A first task would be to understand how children in their M-C develop. According to Prinsloo, Vorster and Sibaya (1996:32):

> [Children's] experience and behaviour are always dependent upon a specific level of physical, emotional, cognitive, normative and social development. At different age levels, children also differ in their involvement and giving meaning to relationships, in their learning and their becoming.

Therefore, it is firstly necessary to highlight these developmental characteristics (i.e. the physical, emotional, cognitive, conative, normative and social characteristics). Spiritual characteristics are also important and will be viewed as encapsulating all of the above. These categories will ensure that the child in this phase is understood holistically - not neglecting the interaction of process, person, context and time factors - and are illustrated in Figure 1:

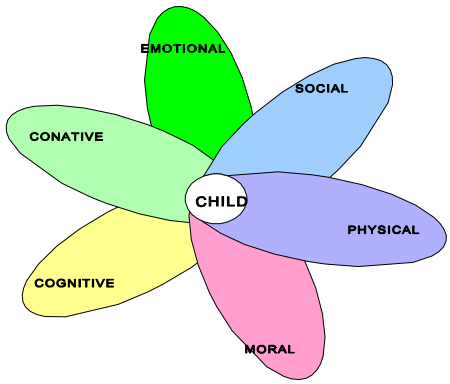

Figure 1: The holistic child

Physical development

M-C is generally referred to as the primary school phase (Prinsloo et al. 1996; Du Toit & Kruger 1991) and usually commences with the child entering formal schooling. Physical development, influenced by heredity, nutrition, health care and exercise, to name but a few, maintains a slow, steady pattern throughout these years. This growth rate is, however, at a slower rate than earlier and later stages – a concept referred to in the literature as "growth latency" (Stone & Church 1979:397).

Children in this phase are usually adventurous and lack experience and judgement, which can lead to accidents (Van den Aardweg & Van den Aardweg 1988 Sv "Physical development") and even trauma.

Cognitive development

Cognitive development in this context refers to the development of a child's mental capacity to engage in thinking, conceptualisation, reasoning, interpretation, understanding and insight, knowledge acquisition, remembering, organising information, problem-solving and analysis (Mwamwenda 1995:89).

To Piaget, children in their M-C are in the concrete-operational stage of cognitive development. This implies applying logical operations to concrete problems as opposed to symbolic and abstract concepts, which are formed later during adolescence and adulthood (i.e. formal operations stage). Vorster (1996:46) maintains that the earlier part of M-C is characterised by great advances in thought development with the latter part of this phase characterised by more flexibility and adaptability.

Traumatic event appraisal therefore becomes more abstract as the child gets older (Van der Merwe 1999:111), but is initially still largely concrete.

Emotional development

According to Prinsloo et al. (1996:113), emotional development entails the child's increasing understanding and control of his or her emotions. Children in the M-C years reflect a greater sense of emotional maturity and development with a noticeable change from helplessness to independence and self-reliance. They also show greater emotional differentiation and flexibility. Children in the early part of M-C are still fairly egocentric and emotionally inflexible, yet with a better intellectual control of their own emotions and better comprehension of the emotions of others (Vorster 1996:46). This rigidity will later change due to an increased rationality and ever-widening frame of reference due to learning experiences. The latter part of M-C is also generally characterised by a more balanced emotional life and a better intellectual control of emotions. However, this refers to favourable conditions; several factors can cause possible emotional distress, e.g. the influence of traumatic events such as crime and violence (Prinsloo et al 1996:113-114).

Emotional expressions manifest in several ways in children during the M-C phase. Emotions reflect a more internal locus than an external one reflected in the previous phase (Du Toit & Kruger 1991:117). These expressions include fear, anger and aggression:

- As children now start school, previous fears relating mainly to physical safety diminishes and fears take on a new dimension, such as fear of school. Fears are now also linked to social issues such as crime. Suppressed fear may manifest itself in psychosomatic and defiant behaviour (Du Toit & Kruger 1991:118; Unisa 1996:84-85).
- Although children in this phase gradually learn skills to cope with frustrating situations, anger can manifest itself in the child who is moody, negative and quarrelsome, and in some instances where authority is lacking, force may even be used to solve problems or relieve frustration (Du Toit & Kruger 1991:118; Unisa 1996: 84-85).

Among others, emotional disturbances due to certain stressors during this phase can lead to: depression, withdrawal, disobedience, avoidance, aggressive and uncontrolled behaviour, inability to adjust to change and deterioration in school work (Van den Aardweg & Van den Aardweg 1988, Sv "Affective development") and may even effect a child's self-concept as they may feel helpless after a traumatic event (Van der Merwe 1999:109).

Moral development

Moral development refers to a child's cognitive ability to distinguish between correct and incorrect, just or unjust, and permissible and inadmissible behaviours within a specific society in which the child lives (Van den Aardweg & Van den Aardweg 1988, Sv "Moral development").

Several theories explaining moral development have been proposed. The most prominent are those of Piaget and Kohlberg. In essence, both agree more or less that during the earlier part of the M-C, children are more egocentric in their judgement and they find it difficult to generalise values. They also have limited development of conscience. During the latter part of this phase, they are still egocentric, but to a lesser extent. They are more able to generalise their values and to move towards a state of understanding that all rules are not hard and fast, but are, at times, flexible. According to Piaget, M-C children gradually move from heteronomous morality (ages 5-10, where rules are inflexible) to autonomous morality (10 onwards, where rules are arbitrary). Kohlberg theorises the move from pre-conventional morality (± 4-10 years; egocentric, obedience based on fear) to conventional morality (± 10-13 years, characterised by increased acceptance and internalisation of societal norms as well as the development of a strong concern about law and order) (Van den Aardweg & Van den Aardweg 1988 Sv "moral development").

Although moral development is culturally determined, there are universal values that various cultures strive for. These include honesty and friendliness (Unisa 1996:87-88) as opposed to violence. Moral confusion may also arise if children experience trauma in the wake of authority being misused and abused.

Social development

According to Van den Aardweg and Van den Aardweg (1988 Sv "Social development"), "social development is the development of relationships and associations with others." These relationships and associations occur largely within the self, family, school and peer-group. The child's relationship with him or herself largely determines the relationship he or she will have with others and contributes towards the formation of a healthy self-concept. This relationship contributes to the child's realisation that the relationships that he or she has can meet his or her own expectations, those of the peer group and significant others (Du Toit & Kruger 1991:124).

According to Prinsloo et al. (1996:120), the family remains the child's main support system and is the most important influence on the M-C's socialisation process, satisfying both physical (e.g. sustenance and clothing) and psychological needs (e.g. emotion, protection and affection) (Mwamwenda 1995:56). The family forms a system of interacting elements that are influenced both on micro-, meso- and macro-levels and contribute towards the child's proximal relationships.

However, the family is not the only influence on the child in the M-C phase due to the emancipatory nature of the child involved in this phase, such as the commencement of formal education. The school also exercises a profound influence upon the M-C's socialisation practice. The school introduces the M-C child to a new set of norms and values relating to authority figures, learning material, as well as different friends and cultures (Prinsloo et al. 1996:120).

Peers also have a profound influence on the socialisation process of the M-C. Children in the late M-C phase also interact easier on a

social level (Vorster 1996:47). Play acts as an important function of the socialisation process of the child in the M-C phase and, although it becomes more individualised, its influence is profound on aspects such as self-exploration and peer-group acceptance (Du Toit & Kruger 1991:125; Unisa 1996:85). Going back to school after a traumatic experience, for example, may be stressful as children may be concerned about the reactions of others (Van der Merwe 1999:1-9).

Conative development

Conative development pertains to the central driving forces which give rise to the child's behaviour and includes his or her needs, tendencies, impulses, aspirations, motives, aims, wishes and will to succeed (Van den Aardweg & Van den Aardweg 1988, Sv "Conative development").

In the M-C years the focus of conative development is on the satisfaction of social and personal needs and aspirations, with a yearning for success becoming quite evident (e.g. recognition, approval, autonomy, group acceptance, love, safety, aesthetic and ethical aspirations, challenges and adventure). This interplay of aspirations results in the child being confronted by a number of choices which can at times lead to conflict situations and even stress (Du Toit & Kruger 1991:130) and trauma. This conative situation leads to the child's realisation that choices have certain responsibilities and results that are either positive or negative (e.g. trauma).

Given these developmental characteristics, the environment in which children develop invariably has an influence on them (Van der Merwe 1999:111) and may contribute towards the way they process traumatic events.

Trauma: A conceptual analysis

T*he Concise Oxford Dictionary of Current English* sees the word "trauma" as being derived from the Greek word *trauma-matos* which literally means a "wound" produced by a (physical) wound, external violence or emotional shock (Sykes, 1976, Sv "trauma"). Definitions and explanations of the concept "trauma" vary and tend to focus on specific aspects of emphasis. According to Wilson (2004:8), "traumatic events are defined by the existence of stressors that have differential effects [biological and psychological] on organismic functioning", while to Lewis (1999:6), a traumatised person believes that he or she and those around him or her will be gravely hurt or killed.

Lewis (1999:5-6) distinguishes between stress, crises and trauma, and although they are inextricably linked, they do differ conceptually. Stress is a feeling of pressure experienced during a challenging time. A crisis is a reaction felt during a difficult time, which may lead to feelings of confusion and an inability to cope, yet can possibly have a positive outcome. Both stress and crises can have positive outcomes and do not necessarily lead to trauma. Trauma on the other hand is negative in nature. There are several kinds of trauma that occur at individual, familial, community and societal level as well as singularly and cumulatively. They are: human-caused disasters (e.g. terrorism); natural disasters (e.g. floods), and unintended or intended violence (e.g. a car accident and child abuse). Indirect trauma or secondary trauma is when someone has witnessed a traumatic event or has direct contact with the victim of a traumatic event.

The DSM-IV-TR identifies two disorders associated with trauma: *Acute Stress Disorder* (ASD) and *Posttraumatic Stress Disorder* (PTSD). Both require exposure to an extreme stressor (psychological or physical) and differ primarily regarding duration and ASD's emphasis on dissociative reactions to the trauma. Reactions include: emotional numbing, depersonalisation, dissociative amnesia, intrusive thoughts, avoidance behaviour, insomnia, concentration deficits, irritability and autonomic arousal (Bryant 2004:46). Bryant (2004:47) does note that the ASD diagnosis may in some ways be limiting as it focuses on PTSD-type symptoms and notes that some clinicians and researchers rather follow the definition of acute stress reactions as is reflected in the *International Classification of Diseases* (ICD-10; World Health Organization, 1992), which recognises generalised anxiety, withdrawal, attention narrowing, noticeable disorientation, anger or verbal aggression, hopelessness, over activity and extreme grief. Given this, Nader (2004:520) does note the ongoing debate surrounding the complex nature of the childhood traumatic reaction and its applicability to DSM-IV-TR criteria and further suggests the need to study the varying character of traumatic symptoms over time and the complexity of reactions to continuing and numerous traumas. To this call, Van der Kolk

(2005:401-408) notes a shortcoming of the PTSD diagnosis as being lacking in developmental understanding and that it does not adequately describe the effect of exposure to childhood trauma on the developing child and therefore expresses a need for a more precise diagnosis for children with complex histories of trauma. *Developmental Trauma Disorder* (DTD) is conceptualised provisionally and is based on the concept of multiple exposures to interpersonal trauma as having consistent and predictable consequences that affect many performance areas of the child.

From the above it is evident that there are different types of trauma that need to be addressed in a specific way in order to ensure effective intervention. What is also evident is its non-static and complex nature. Even when noting its systemic and ecological influence, one has to agree with Jerusalem et al. (in Van der Merwe 1999:27) who note the multifaceted interlink between individual and community level trauma due to the complex and overlapping nature of stress phenomena. This necessitates a comprehensive and holistic assessment.

Trauma in children

All the above categories and manifestations of trauma manifest in children and this, together with their developmental levels is necessary in understanding and assessing childhood trauma. Acknowledging childhood experiences of trauma have not been readily acknowledged as it was only since 1987 that PTSD has been recognised as a possible childhood traumatic response in its inclusion in the DSM-III revised edition (Van der Merwe 1999:175-176) and includes the following reactions: reliving or re-experiencing the trauma, evasion of trauma-related stimuli or emotional restriction and numbing of general receptiveness and levels of increased arousal. Even given this, this diagnosis is not fully reflected in children's experiences of trauma and may differ with age and maturity (Perrin, Smith & Yule 2000:278). However, given these ongoing challenges pertaining to the understanding of the phenomenon, several outcomes of childhood trauma will be discussed.

Children's behavioural reactions to trauma and stress are typically complex. These responses to trauma include cognitive, behavioural, emotional, spiritual and physical responses (Perrin, Smith & Yule 2000:278-279). Cognitive responses include concentration lapses, while physical responses include tiredness and headaches. On an emotional level depression, denial, numbing, anger, aloneness, guilt, helplessness, grief, irritability, fear and anxiety may be prevalent while behaviourally, temper tantrums, destructiveness, anger outbursts and conflict may manifest.

Children who have experienced trauma may react on specific cognitive and behavioural levels, such as magical thinking (wishing someone close would die after conflict with that person and it does actually happen), devastated assumptions (everyday assumptions of themselves and their external world are broken), misperceptions, time alteration, omen formation and experiencing trauma as multiple traumatic episodes within a single event, confusion over good and bad, bargaining, symptom contagion, foreshortened future, re-enactment, school and performance problems, troubled sleep and nightmares, fears, separation anxiety, regression, personality changes and somatisation (Van der Merwe 1999:192-223; Perrin, Smith & Yule 2000:278-279) are but a few manifestations of children experiencing trauma.

ASSESSMENT OF CHILDHOOD TRAUMA

Sattler and Hoge (2006:61) note that "an effective assessment strategy requires that you develop a plan and choose tests and other assessment procedures to meet your goal". Depending on your profession and the concern with childhood trauma informs the assessment strategy and approach. Foxcroft and Roodt's (2005:3-4) view of psychological assessment is that it "provid[es] information to guide individuals, groups, and organizations to guide and make appropriate decisions", in this instance individuals, groups and organizations from the area of psychology. The functions and dimensions of assessment informing this article will be from the context of educational psychology, as this is the researcher's frame of reference.

Mash and Wolfe (2005:79) do note the following general assessment procedures: interviews, observations, questionnaires and tests. In assessing, several assessment tools as well as other pieces of information, such as school performance, life history, and family background are taken into account in order to get a developmentally contextual picture.

Assessment does have several functions. They are: identifying strengths and weaknesses, mapping development or progress, assisting in making a diagnosis, intervention and therapy needs; gathering data for research needs or to inform policy making. Sources of information are also multidimensional originating from multiple measures, domains, sources, settings and occasions (Foxcroft & Roodt, 2005:3, 6; Mash & Wolfe, 2005:79). These assessment methods should furthermore have high reliability, validity, cost effectiveness and value for treatment. This provides the investigator the opportunity to conduct a comprehensive and holistic assessment and furnishes an all-inclusive picture of human (*read* child) performance (Elkonin, Foxcroft, Roodt & Astbury 2005:206-207).

As a trauma diagnosis is a rather complex process and there is no one single test or process to identify it, several data sources are to be considered and in multiple contexts. Nader (2004:513) notes that, "it has become clear that multiple methods, measures, and sources of information are important in accurately assessing children [with trauma]" over time. As children respond and behave in diverse contexts, different observers may perceive and infer behaviours in different ways. Invariably multiple methods enhance trustworthiness and are therefore preferred.

Child and parent interview

The clinical interview continues to be the most frequently used assessment method with parents and children (Mash & Wolfe, 2005:80). Interviews are an initial step in the assessment process (Elkonin et al. 2005:205) and besides contributing to establishing rapport; it provides an opportunity for the child to talk about the traumatic event and parents to provide information on the child's condition. In the opinion of the researcher, the assessment starts with the initial contact between the health professional and the traumatised child and/or the guardian, and invariably leads to an appraisal of several systems. Interviews also give the therapist an initial assessment to see if there are any visible signs of trauma which necessitate reporting.

Although there are several approaches to assessment, Van der Merwe (1999:439) suggests that it should start off with interaction with the parents, teachers and caregivers where several pieces of pertinent information are given (e.g. a child's developmental and family history). This information may be in addition to the information obtained from other sources and may include getting information on the context of the traumatic event and resources within the various systems (micro-, meso- and macrosystems) and may take the form of an interview or questionnaire (Mash & Wolfe 2005:80). Nader (2004:520) suggests that children's physical and safety needs are firstly met and restored. It also is an opportunity to take down a thorough history of both the family and the child and an opportunity of ruling out or exploring possible abuse. This information provides an assessment of the child from the family's perspective and also provides contextual information pertaining to the child and family's experience of the trauma.

An interview with the child contributes towards an understanding of the nature of the traumatic response where trauma symptoms (Perrin, Smith & Yule 2000:280) as well as the actual event itself are explored. Depending on the nature of the contact, the interview may be in the form of play therapy, projective techniques or a non-threatening interview, genograms, three wishes and sandplay (Van der Merwe 1999:439; Carey, 1999:78). To Dodds (1987:33), "the play interview is simply a way to obtain a sample of the child's behavior". However, taken further within a trauma context, this interview contributes towards an assessment of the child's experience thereof. Information from several sources contributes towards a more holistic and systemic understanding of the trauma. Various contributory sources contribute towards a richer understanding of childhood trauma and a more balanced assessment. A mental status examination may also form part of the initial interview where several areas of functioning are assessed, such as behaviour and appearance, thought processes, mood and affect, intellectual functioning and the child's sensory awareness of his/her environment (Mash & Wolfe 2005:81), and areas of the child possibly affected by trauma. However, Sattler and Hoge (2006:155) remind us to "interpret all areas in the mental status examination within a developmental framework, using age-appropriate norms or age-appropriate expectations".

This process of interviewing provides the following information on several personal variables applicable to trauma: the child's

unique characteristics (age at trauma onset, personality, character, attachment style, coping skills, pre-morbid functioning, gender, support systems and cognition); family history and status (early and subsequent history, culture and socio-economic status); the nature of the traumatic event and current phase (if ongoing trauma); the way in which trauma unfolds; duration and phase of trauma; extent of threat; individual meaning ascribed to the event; the way it ties in with other issues in the child's life; response to treatment and support; and possible impact that it may have on recovery (Van der Merwe 1999:88; Nader 2004).

Numbing, avoidance and re-experiencing are some symptoms that may be present between ongoing and intermittent childhood trauma and in this regard Nader (2004:515-521) emphasises the need to get information prior to, during and after the traumatic event/s. Children may also not present with all PTSD symptoms initially, as they might believe that, when others do not present with traumatic symptoms, theirs are not present and important, thereby minimising their symptoms.

Time and context also play a role in trauma and the experiencing thereof. Children under the age of eight, for example, have difficulty with the concept of time and this may influence their interpretation of trauma. Nader (2004:516) notes: "In addition to the need to examine trauma in relationship to pre-existing child attributes, experiences, and circumstances, is the need to understand that, especially for children, some characteristics [of trauma] are in an ongoing state of change". Children differ with regard to the amount of change that they display and also the degree of the traumatic exposure. This change is influenced by several factors, such as environmental, biosocial, hereditary, historical and experiential factors. Dissociation, for example, has been found to be linked to age, gender, and the duration and severity of sexual abuse. According to Nader (2004:519), "to clearly establish the course and nature of childhood traumatic response, it may be necessary to assess changes in symptoms and development of behavioural patterns over time as well as onset, duration, frequency, and intensity of symptoms".

Culture, ethnic and religious backgrounds also play a role in how children experience trauma and react to treatment (Nader 2004:521-522). As culture shapes meaning attribution (Lewis 2001:272-288) the acknowledgement or silence of traumatic events as well as the assistance or non-assistance varies from one culture to the next. Social variables, which include family and situational variables, may contribute towards the protection of or further vulnerability of a child's pre- and post-experience of traumatic events and therefore need to be taken into consideration when assessing a child affected by trauma. Aspects such as family support structures, proximity to traumatic location, and social support are but a few such factors that need to be considered. This casts a light on the different systems that may contribute towards the experiencing of and reaction to traumatic events. Assessing population density, a community's educational ability to react to trauma, the identification of specific vulnerable groupings within a community, and government response (Van der Merwe 1999:122,143) are but a few aspects that need to be taken into consideration during the assessment process.

Childhood trauma questionnaires and checklists

There are several specific questionnaires and checklists for children in their M-C who have experienced trauma that may aid the clinician in gaining a more comprehensive and quantifiable assessment of the traumatic experience. Both McNally (1996:147-161), Perrin, Smith & Yule (2000:278-279) and Nader (2004:522-528) refer to several generic child psychopathology and trauma-specific questionnaires and checklists. A need to be flexible and sensitive to the impact that trauma has on children by selecting and adapting questionnaires ad checklists appropriately, is propagated. One example of a measure given by Nader (2004:525-526) is the Angie/Andy Cartoon Trauma Scales that is a semi-structured child interview for children between the ages of 6 and 11. This instrument was generated from research on child abuse, community violence and complicated trauma, thereby acknowledging the systemic influence of trauma on the child. No mention is made to its reliability and validity to South African conditions and therefore it needs to be standardised for this specific context.

Parents also complete a therapist's questionnaire on the child's holistic development to date (medical and developmental history; family medical and social history and school history) as a means of augmenting the interview process in assessing childhood trauma. Sattler and Hoge (2006) provide several interview questions to

address certain types of trauma and the possible influence of trauma on the child. This questionnaire may be further augmented with the Strengths and Difficulties Questionnaire (SDQ) as a means of identifying certain aspects of the child's functioning that may have changed over time as well as within certain contexts. This brief checklist (25 items) is a useful instrument in the initial phase of assessment to be used by clinicians, researchers and educationalists and includes items based on the following scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour (Goodman 1997:581-586). Hill and Hughes (2007:383) do offer a word of caution when using the SDQ. "These [brief screening] measures are intended to be used to screen children for more comprehensive assessment and are not intended for diagnostic use. Therefore, the SDQ's sensitivity to detect specific disorders may be poor". Yet, Mellor (2004:396) does note the use thereof transcending the individual: "it thus assesses pro-social behavior, subjective distress, and impairment in home, school, and peer relationships in leisure activities". The SDQ has been translated into more than 60 languages (Vostanis 2006:367), yet so far, no reference is made to it being standardised for South African conditions, but it is available in Afrikaans (SDQ-Afr).

The child and parent interview as well as questionnaire revealed the importance of understanding a child's micro- and meso-systems and the dynamics within such systems. Specialised training and sensitivity are essential in understanding worsened symptoms and pathology (Nader 2004:516).

Scholastic information

A report from the teacher (and other appropriate school personnel) who knows the child well is requested and contributes further to an understanding of the child from a varied context (i.e. the school) (Sattler and Hoge 2006:60) and may assist in understanding the impact of trauma on the child. Permission to gather this information is acquired from the client and parents or guardians. This scholastic information gives the Educational Psychologist an opportunity in understanding the client's micro- as well as meso- and exosystemic relationships.

Psycho-educational assessment

Forming hypotheses based on the information from the initial interview and other additional information assists in understanding the client's experiences of the nature and origin of the trauma. This will in turn lead to the further investigation of the hypotheses by means of an assessment battery of all areas of performance (Elkonin et al. 2005:206-207). A comprehensive psycho-educational assessment from an Educational Psychologist provides intellectual, emotional and scholastic data that contributes towards an understanding of childhood trauma from another context and further contributes towards diagnosing and understanding the child's psycho-educational reality largely from a quantitative and qualitative perspective. According to Lewis (1999:186), "in [childhood] trauma cases, the testing is helpful in establishing whether the child's difficulties stem only from the trauma or whether the child is also having learning difficulties or is affected by other family problems". Several psycho-educational assessment tools can be used in this regard and include an evaluation of cognitive functioning by means of, for example, the Senior South African Individual Scale – Revised (SSAIS-R) (Van Eeden & De Beer 2005:127), scholastic functioning tests, and projection media (Draw-A-Person, Kinetic-Family-Drawing). Studies (Sturner & Rothbaum 1980) of the use of projective drawing techniques in childhood trauma support their use, in conjunction with other media, in assessing childhood trauma while Naudé, Du Preez and Pretorius (2003:10) indicate the use of the SSAIS-R in highlighting the impact of child abuse as traumatic environmental stressor on the plasticity of intelligence – brain functions are restructured by stress and certain memory functions are selectively either depressed or activated.

Aspects that should be considered when assessing are again, multiple assessment media and taking the child's holistic context into consideration (Hagood 1992), which includes time and space.

Physical and neurological examination

A physical and/or neurological examination forms part of the educational psychologist's assessment of the nature and extent of the trauma and suggesting appropriate treatment. Grieve (in Foxcroft 2005:228) notes for example that South Africa has one of the

highest risks of traumatic brain injury in the world. Children fall into this grouping as they are also victims of accidents and related trauma. Several types of injury exist and vary according to several factors such as individual physiological differences, temperament and ability differences; and social factors. The outcome of the trauma may cause cognitive, emotional and behavioural impairment. An intelligence measure is not sufficient to make a brain impairment diagnosis and necessitates a neurological examination as well by trained professionals, being neuro-psychologists and/or neurologists.

Further special investigations

Neurodevelopmental delays caused by trauma can further be assessed by an occupational therapist (OT). OTs "use scientifically chosen, meaningful activities to assist diverse clients with a range of problems to maximize their functioning" (POTS 2007:3) and this follows that after a traumatic event, a person's occupation (any activity a person performs on a daily basis) may be hampered. Assessing the previous roles and routines of a person affected by trauma with the eventual goal of returning to these activities (POTS 2007:144,148) is an integral part of OT practice, children as well. To Alers (2008), "occupational therapists have a vital role in their intervention to recognize the challenges that trauma adds not only impairment, but also disablement to the communities as a whole".

Social context

Within mesosystems it is necessary to assess whether there is a supportive or unsupportive environment within which the child is functioning. Gibson et al. (2002:66) note that, "one of the key issues we need to think about in helping people cope with trauma and its effects is the social context within which a person is living. Is there a supportive or unsupportive environment?" Traumatic practices that are widespread within certain communities may possibly result in justifications for the maintaining thereof and create challenges for individuals and organisations assisting traumatised children.

Wider policy safeguarding children

As part of assessment, it is imperative to take aspects of the wider exosystem and macrosystem into account. Several government policies based on democratic values have recently been implemented to ensure the safeguarding of children within micro- and mesosystems and a few of these national initiatives will be discussed saliently.

Chapter 2 of the Constitution of South Africa (108 of 1996) places a legal obligation on teachers, principals, school authorities and parents to ensure the safety of children at home and at school. These principles are encapsulated in the South African Schools Act (84 of 1996) and its amended insertion in the Education Laws Amendment Act (31 of 2007), which allows for the searching of weapons and drugs (Jamieson, Proudlock & Waterhouse 2008:13). This latter insertion came about in an attempt to safeguard learners from possible trauma within the school context. A new Children's Act (38 of 2005) was gazetted on 19 June 2006 and the Children's Amendment Act on 18 March 2008 amended aspects of this Act. This Act protects and promotes the rights of children and recognises the role of the community and society in protecting them (RSA 2006; RSA 2008). Furthermore, another piece of legislation, the Domestic Violence Act (116 of 1998) places a legal responsibility on educators to report any type of maltreatment, neglect, abuse or degradation of children to social welfare or the child protection unit of the South African Police Service (SAPS) (Prinsloo 2005:1-10). Additionally, in an attempt to prevent children who commit serious crimes from being further traumatised in jail, the Child Justice Act was passed in May 2009 (RSA 2009). Statistics of the Department of Correctional Services show that there were nearly 2000 children in detention as of the end of March 2008 (*Sunday Times* 2008:6), which has rather led to an approach of restorative as opposed to punitive justice towards children.

These government policies contribute towards the combating of childhood trauma within society and need to form part of the assessment protocol and bigger understanding of the position that dealing with trauma is reflected in wider South African society.

IN CONCLUSION

Foxcroft and Roodt (2005:247) observe the traditional approach to psychological assessment as being largely limited to the individual. This does not imply a discarding of such an approach, but rather acknowledging the individual and his/her influencing systems, or "systemic wholeness" as Lewis and Newmark

(2006:24) refer to. Therefore, there is a need to look at childhood trauma from a holistic perspective. This not only highlights the necessity to assess, diagnose and intervene in childhood trauma from an holistic perspective, but that parents, teachers, medical specialists and communities are harnessed and trained to also assess and approach challenges from such a perspective. Understanding childhood trauma and addressing it do not always reflect a neat and simple picture. Assessing, diagnosing and intervening can take place at certain levels and may only encompass other levels once certain levels are addressed.

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