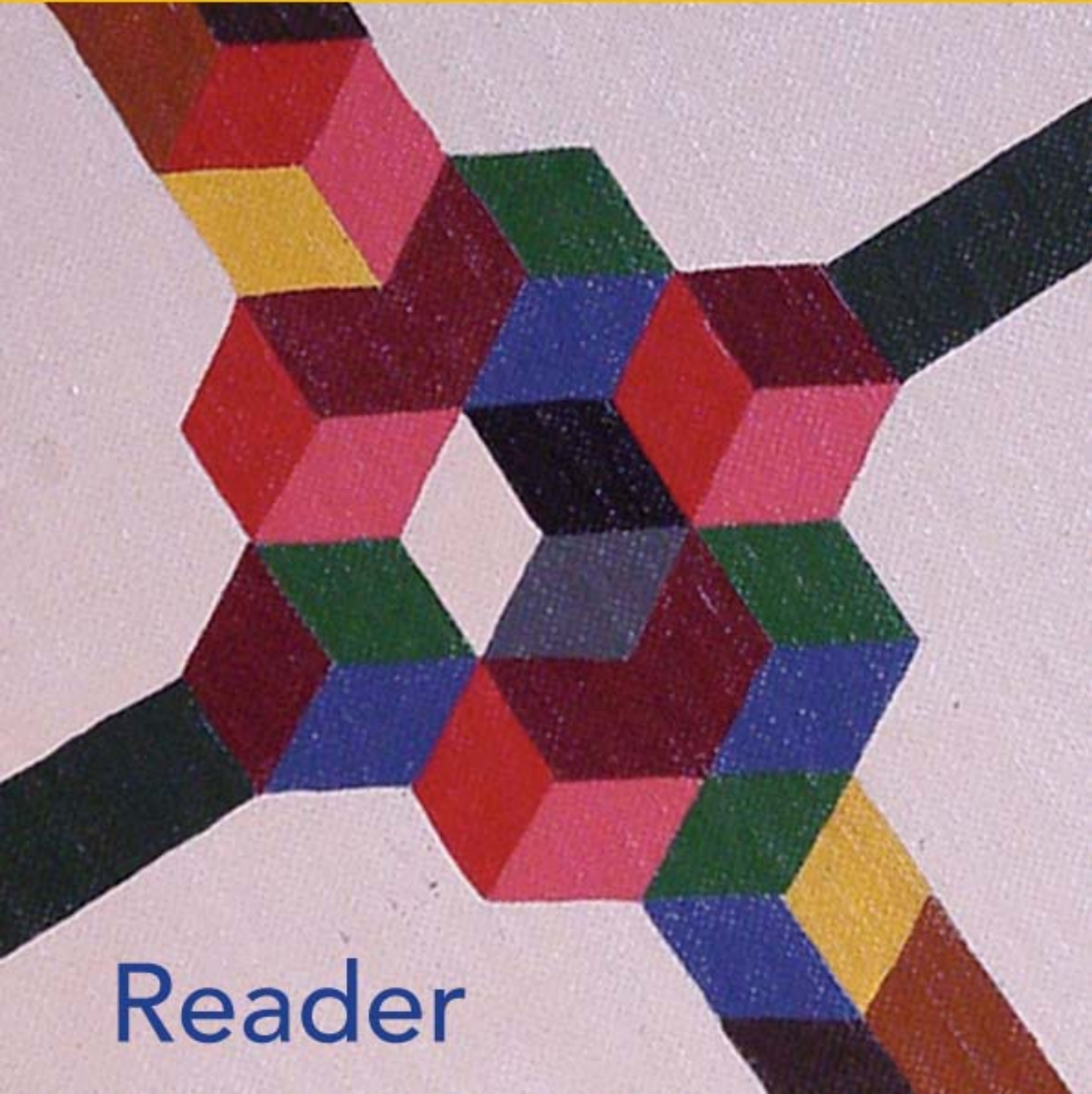
Martine F. Delfos

Rivers Arnhem
On inclusion

The Challenge of a new perspective

25-9-2025



Reader

Hardly any literature exists about having conversations with children.
Talking to children is a daily activity for almost everyone. For professionals who work with children it is even an essential activity. Nevertheless we learn little about it in college. Besides the attention given to open *question-and-answer sessions*, communication with children in general is described. It deals with therapeutic assistance for children and conversations in school in particular.

In *Are you listening to me?* Martine F. Delfos describes how to conduct conversations with children between four and twelve. How can we make them talk about what is on their mind? Should you talk and play at the same time? Which questioning techniques are fit for which age? How can you estimate the mental age of the child? How to enable the child to be a good witness?

Are you listening to me? is a book on communicating with children between four and twelve. The most recent research has been translated in a model of communicating with children adjusted to their age. It is fit as a textbook for those who work with children of primary school age. From teacher or police agent to therapist.

Dr. Martine F. Delfos, Utrecht, The Netherlands, is a psychologist and psychotherapist and is specialised in working with children and adults with multiple traumatic experiences. She works in the field of child welfare and teaches psychologists, doctors, social workers and group leaders in children's homes.

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Are you listening to me?
Communicating with children from four to twelve years old
Martine F. Delfos
SWP

Are you listening to me?

Communicating with children from four to twelve years old

Martine F. Delfos

In *Unravelling Autism* Martine Delfos presents a brief introduction to autism. Some of the confusion with respect to autism comes from the lack of distinction between what *autism* is and the circumstances that can foster *autistic behaviour*, such as neglect, severe trauma or a medical condition. Delfos introduces the theory of the Sociosceme and the *MAS1P* (Mental Age Spectrum within 1 Person). The clear description and the use of many examples makes this book readable without sacrificing scientific and solid ground.

Dr. Martine Delfos is a bio-psychologist. She is a researcher, a therapist and a teacher. One of her fields is autism, with special attention to differentiating trauma within autistic behaviour from autism spectrum disorders. With respect to autism she helps to develop autism care in several countries.
Information on her work can be found on: www.mdelfos.nl

In his foreword to Delfos' first and still basic textbook on autism (latest edition), *Wondering about the world. About Autism Spectrum Conditions*, Tony Attwood wrote: *She reviews each of the theoretical fields of study and then describes our current landscape of knowledge as though from an observation balloon to provide a single explanatory model for autism. The project has been remarkably ambitious but the author has an encyclopaedic knowledge of the academic literature and the various theoretical models, and extensive personal experience as a clinician. The author also has notable respect for those who have autism and Asperger's Syndrome and she is able to challenge and change attitudes as well as increase understanding.*

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PICOWO SERIES PART 12

Martine F. Delfos Unravelling Autism

PICOWO SERIES PART 12

Martine F. Delfos

Unravelling Autism

Introduction to Autism with the Sociosceme

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In *Developmental Perspective on Trauma* Martine Delfos presents a new model on trauma. The effect of traumatic events depends on many factors, biological as well as psychological factors. Until now research has mainly focused on the age-related symptoms in psychological well-being in reaction to trauma, a developmental perspective on effect instead of formation. The factor that has not been taken into account yet is the impact of the child developmental stage itself on the perception of traumatic events. This concerns the way trauma influences the performance of the developmental tasks, a formative developmental perspective. A frame of reference that has developed in adults is often still lacking in children. Children will not always be traumatised by the same events as adults, and children can be deeply traumatised by events that adults will not consider traumatising because of their knowledge of the world leading to a more mature perspective. In the model presented, the characteristics of the development with its developmental tasks, the development of the brain with its growing connectivity are applied to traumatic experiences to account for developmental differences in reaction to trauma. The model is applied to different traumatic experiences like sexual abuse and war trauma. A better understanding of the effect of traumatic experiences on children and adolescents is to be expected when the true developmental perspective is taken into account.

Dr. Martine Delfos is a bio-psychologist. She is a researcher, a therapist and a teacher. One of her fields is autism, with special attention to differentiating trauma within autistic behavior from autism spectrum disorders.
With respect to autism she helps developing autism care in several countries and is visiting professor at the Universidad Central del Ecuador in Quito-Ecuador and also at the International University of Sarajevo in Bosnia-Herzegovina.
Information on her work is to be found on: www.mdelfos.nl

From the foreword of Prof. Dr. Rolf Kleber:
In her book Martine Delfos presents an outstanding model of such a developmental perspective. She outlines a comprehensive and innovative approach based on in-depth scientific knowledge and extensive clinical expertise. She broadens the regular approach and goes beyond thinking in terms of pathology. She does that in her own way: original, profound and inspiring. Thus she builds a bridge over the gap between science and the concrete suffering of the affected individual, between the expertise of scientists and professionals and the thoughts and feelings of victims and survivors. Her book shows how each child builds its own framework and seeks to control the pain, how his or her life will be changed and how we can help and support them.

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Developmental Perspective on Trauma

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PICOWO-SERIES PART 5

Martine F. Delfos

Developmental Perspective on Trauma

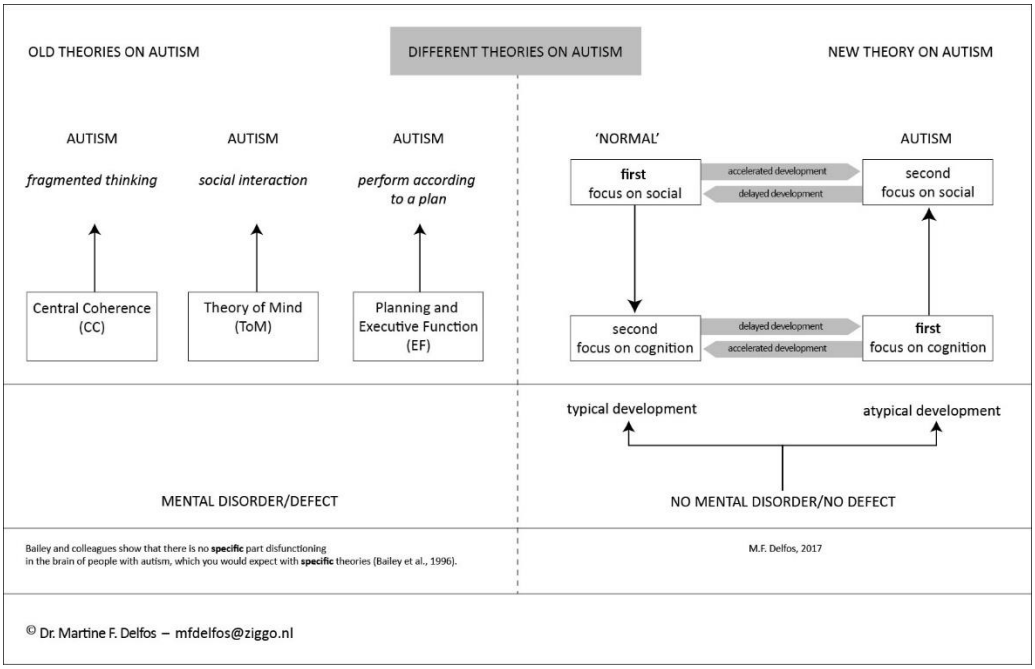
PICOWO SERIES PART 15

Martine F. Delfos

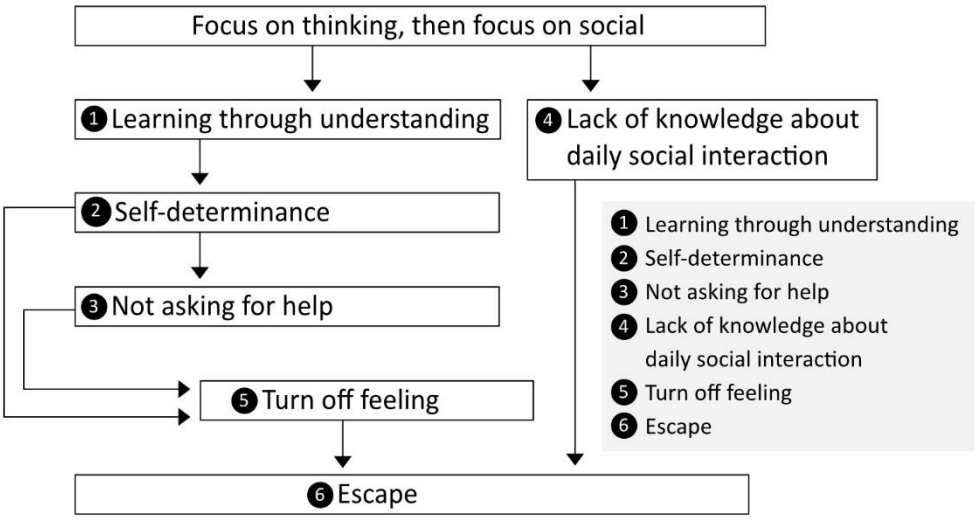
I am attached to them!

About attachment as a buoy in distress

Old and new theory compared:

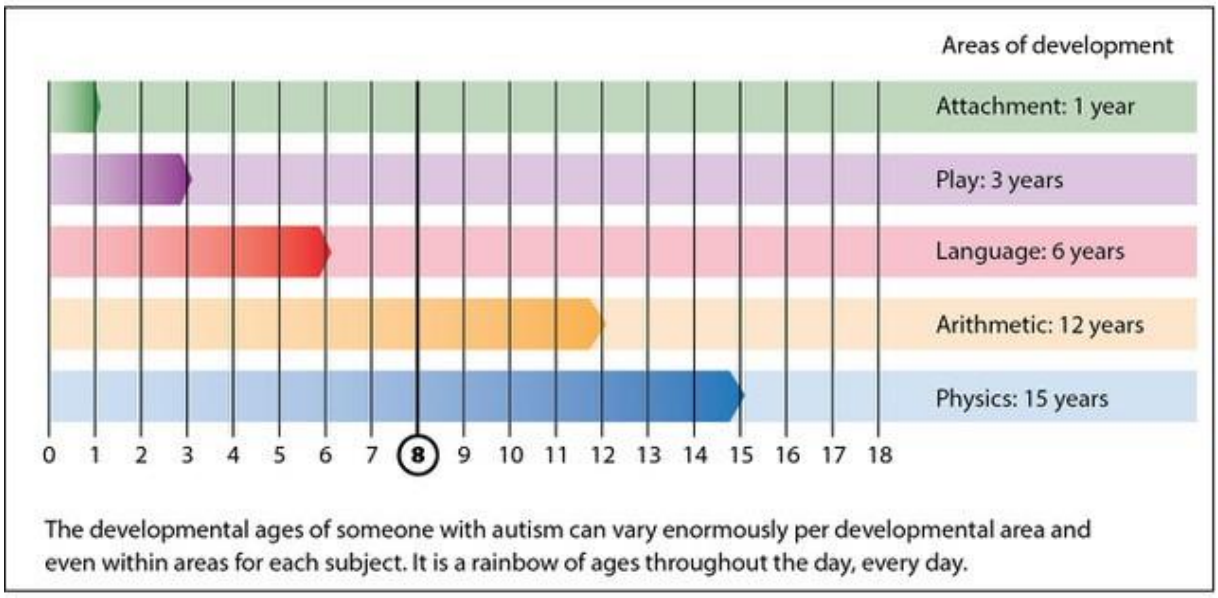


Characteristics of Autism / ASS/ ATD/ The Thinkers



Dr. M. F. Delfos

Some developmental ages for a girl with autism with a chronological age of 8 years



Dr. Martine F. Delfos, 2017

What do you think are the main challenges in the autism community right now?
There are too many to mention, so I'll just focus on one: the level of rancor and backstabbing in the entire autism community is emotionally devastating to everyone. It comes from all directions: from parents, from clinicians, and from people on the spectrum themselves. No one is spared. The toll this takes on the community as a whole is absolutely tragic. Many of the autistic bloggers who inspired me when I started writing *NeuroTribes* have "gone dark," silenced because they couldn't take the sheer level of personal attacks that were aimed at them daily.
Steve Silberman

What do you think are the main challenges in the autism community right now?
The most challenging for people with autism is the idea that people around them think they understand, which leads to a kind of 'taking over their life' and 'controlling' them. From family to professionals, being able to take one's life over leads to a feeling of superiority, which easily leads to discrimination and fighting for your own opinions against all odds. All this with the best of intentions, leaving the people with autism bewildered by a kind of feeling of inferiority, their self-esteem severely damaged. It causes their potential for growth to be seriously suppressed, a kind of psychological lynching. It is living in a psychological war-zone. An attitude of 'not-understanding' with modesty and respect would not only lead to asking the people with autism about their self-knowledge, which would be of decisive importance, but also simply respectful and civil.
Martine Delfos

Inclusive education: chances and challenges

In Ecuador the government agreed to develop inclusive education. An important decision supported by the inspiring former vice-president of Ecuador Lenin Moreno. It is an important decision because it aims at giving education to every child, and education empowers someone and makes it possible to take its own fate in its own hands. It is also the most powerful weapon against poverty.

The idea of inclusive education stems from the Salamanca agreements of 1994, where education for all was the focus. On the Unesco website you can read: *In June 1994 representatives of 92 governments and 25 international organizations formed the World Conference on Special Needs Education, held in Salamanca, Spain. They agreed a dynamic new Statement on the education of all disabled children, which called for inclusion to be the norm. In addition, the Conference adopted a new Framework for Action, the guiding principle of which is that ordinary schools should accommodate all children, regardless of their physical, intellectual, social, emotional, linguistic or other conditions. All educational policies, says the Framework, should stipulate that disabled children attend the neighborhood school 'that would be attended if the child did not have a disability.'*

Certainly the last sentence, *disabled children attend the neighborhood school 'that would be attended if the child did not have a disability',* is quite a challenge. If you live in a country without mountains and a good infrastructure it still remains a challenge, because if the school is not adapted to the specific disability of a child it will not be able to provide the necessary education. Sometimes disabilities do not create physical problems for a school. For instance diabetes as a disability is totally different from having to move around in a wheelchair.

With respect to inclusive education explicitly are mentioned: the Roma children, street children, child workers, children with disabilities, indigenous people and rural people. In Ecuador we have all these children, so we need a huge effort to make education for all possible. It will only be possible if the country as a whole becomes aware of the lack of education for many children and the need for education for all. If the focus is on empowering children, that is empowering our future, because children are the future.

The UNESCO Convention against Discrimination in Education (1960) and other international human rights treaties prohibit any exclusion from or limitation to educational opportunities on the bases of socially ascribed or perceived differences, such as sex, ethnic origin, language, religion, nationality, social origin, economic condition, ability, etc. Education is not simply about making schools available for those who are already able to access them. It is about being proactive in identifying the barriers and obstacles learners encounter in attempting to access opportunities for quality education, as well as in removing those barriers and obstacles that lead to exclusion.
Barriers can be congenital deafness and not able to hear the teacher and the pupils, but also psychological barriers like learning disorders. Obstacles that lead to exclusion can be physical: make the school accessible for blind children but also psychological, for instance discrimination or bullying by peers.

Parents want the best for their child, but it is not always easy to ensure education for their child. The most pregnant reasons are three: economic, geographic accessibility and disabilities of the child. Extra should be mentioned girls, because where education is difficult to access, parents choose their boys to have education and not their girls. This is proves to be a bad choice as to academic success. When girls get access to education, within a short while they do better than boys, women do better than men. This happens at every level of education all over the world. So, when aiming for academic success it would be more wise to send girls to school than boys.

From a philosophical/psychological perspective inclusion should not be so difficult. For at least 95% we all are the same. We all have a smile and at least one kidney. For 1 to 2% it is the difference caused by an affliction/disability, and for 3 to 4% it is the difficult behavior caused by the strange behavior towards children/people with an affliction/disability.
Still inclusion is difficult, all over the world. The most important reason is neither economic nor political but a psychological reason. We have the tendency to look at the difference, but we cannot attach to someone on the difference, we can only attach on what is the same between us and the other. Focusing on the difference will only make the connection *im*possible, and therefore will make ourself and the other insecure, not feeling safe. And that leads to strange and difficult behavior in people. In children it often will cause troublesome behavior, which will make it difficult to connect to each other.

In the Netherlands as in many countries, pedagogues try to find solution to improve school education. Inclusive education in fact was started in the Netherlands in 1991 with the nation-wide project named: Together To School Again (WSNS). It aimed at making it possible for children to attend regular school again, because the amount of children going to special school increased enormously in the years before 1991. In 1994 The Netherlands signed the Salamanca agreement and made a huge effort. They gave pupils with specific disabilities financial support on pupil level, so per child, the pupil-based funding, called a 'backpack'.
The terrible thing is that all these efforts only resulted in many more children in special schools than before. A lot of initiatives were developed and all kind of new perspectives on education arose, with the government supporting these in order to stop the explosion of children attending special schools. In the spirit of inclusive education the following visions on school education developed: cooperative learning; action-oriented learning; the new learning; natural learning; education based on development of children; result-oriented education; problem-based learning; adaptive education. The costs were enormous and the Dutch government decided a new vision on education that will be implemented from august 2013 on: the Appropriate Education. The pupil-based funding disappears from 1 August 2013. Instead, with the Appropriate Education, school boards are required from that date to offer as appropriate education as possible for each child who needs extra support.

The result of all previous endeavor with all the new pedagogical solutions is still that even more children attend special schools. Many countries developed in a similar way before and after the Salamanca agreement. Huge costs without more inclusion, indeed more exclusion. The most important factor of the increase is what happened with the psychological/psychiatric disabilities. To know whether a child has special needs we have to assess its problems. For physical disabilities the assessment of the disability is clear most of the time. For psychiatric/psychological problems the assessment is very different. The disability is assessed on the base of behavior. The standard manual on mental disorders (DSM-IV/ICD-10) formulates criteria that are based on behavior, not on physical or any concrete criterion. Because of all the misdiagnose going on in the world, the DSM-IV changing to the DSM-5 tried to take this into account. The DSM-5 is yet not implemented and will be published this year. So, the DSM-IV and ICD-10 are in fact no longer valid. All this means that people need a multidisciplinary team and people with a lot of experience with a specific disability to be able to distinguish between the disability, an educational problem, traumatic experiences or any other problem the child experiences while growing up. When we spoke about an increase of children attending special schools, it was mainly an increase in special needs of children with behavioral problems and psychiatric disorders. It is all about ADHD, ADD, Autism Spectrum Disorders, Conduct disorder, OCD and mistakes that are made in this field.

In Ecuador, the vice-presidency took upon itself to prepare books on the disability. It were nine books, ranging from blindness to psychiatric disorders. Of all the nine books, the most voluminous book is the one on psychiatric/psychological disorders. The books on disabilities like blindness are practical and to the fact, the book on psychiatric problems is filled with questionnaires. Those

‘instruments’ are only safe in the hands of people very experienced in the specific disorder and trained in academic tradition, to be able to distinguish between practice and science. We do not have enough trained academics yet. As a result many problems are still invisible. For instance, in Ecuador the first prevalence research on Autism Spectrum Disorders ASD has been performed by the PUCE university of Quito and the PICOWO (The Netherlands). If we take the supposed universal prevalence of 1% (1 in 100 people) of ASD in the country, we did not find the pupils with ASD in the schools, because we found only ??0,11% instead of the expected 1%. They are somewhere, but not in the regular schools. Most of them are not diagnosed as such, because the diagnose also has to develop yet.

The risk is that with questionnaires we will find an enormous quantity of children seemingly having a psychiatric/psychological affliction, where there is not a psychiatric problem. With using questionnaires a misdiagnose is a serious risk without the proper clinical experience. In many countries a tidal wave of psychiatric diagnoses was brought about by the DSM-IV/ICD10 and the questionnaires based upon them. Do not think this is without consequences, because being offered help for something you have not is not only not helping, but it can be seriously damaging. Certainly the self-esteem can be damaged, and the attachment to others who will approach the child on the basis of a diagnose it does not apply to the child.
What do people need while everyone is trying to develop a new perspective on help? Before we address the special needs that we are not even sure are assessed correctly, we need to address the basic needs that all children with and without special needs have. That is the non-specific factors. Every child needs the connection. If we look at the amount of problems as a result of not being able to connect with the child (3 to 4% of the difficulties), we already can solve a lot by the way we approach the child. When the case for special need is absolutely clear, then we can join the special needs to the non-specific factors.

Let us take autism as a metaphor for psychiatric disorders/psychological problems. Autism is the most difficult disorder to understand. The reason is because if we are really speaking about autism spectrum disorder based on the autism gene pattern, and not only autistic behavior, then that means that people with Autism spectrum disorder have an MAS1P, that is a Mental Age Spectrum within 1 Person. It is a rainbow of ages within one person, younger than its calendar age and older than its calendar age at the same time throughout the day. This makes it so difficult to understand and to raise children with ASD and educate them. The calendar age of 9 years old would enable the child to attend school, but the attachment age of 9 months will not, also the play age of three years old will not help him attaching to peers. Structure and pictograms, methods we use in the help of children with autism, will not be helpful enough, and teachers will be confronted with a broad variety of behavioral problems associated to younger social-emotional ages.

To conclude let us first empower children by making an attachment, making them feel secure, then try to understand what causes the child, with or without a supposed disability, not to attend school in the same way as children without disabilities. Discover the possibility of special needs by first communicating with the child and second with parents before we apply diagnoses and special needs to children who need something totally different. This is called action-oriented education, be active upon what the child shows, not become active only on the basis of a diagnose. Let’s try to prevent in Ecuador the tidal wave of diagnoses that happened in so many countries.

Felipe Perez, psychologist, Ecuador
Dr. Martine Delfos, psychologist PICOWO, The Netherlands

Trauma is not only about effect but about formation

Martine F. Delfos, PhD
Picowo, Psychological Institute for Consultation, Education and Research

Abstract
In psychiatry and psychology the interest on trauma evolved from thinking that trauma was directly connected to the event to realizing it has its impact long after the event. In the evolution of the concept of trauma it took till 1994 to acknowledge the fact that children have specific reactions to trauma and till 2013 to begin to mention that internet could have a traumatic influence. The theory on trauma was about the effect with anxiety as a primordial element. This resulted in a treatment concept as EMDR, which neglects the deeper layers of trauma. Because it was only discovered long after the birth of the concept that trauma also affects children, we did not really pay attention in research to the effect of trauma in the sense of formation. We need a new theory that encompasses effect and formation. Therefore we need a developmental perspective on trauma.
Keywords: trauma, brain networks, formation, treatment, sexual abuse, war

Introduction
Almost everyone has experienced a traumatic experience (TE) in one way or the other, an event causing a traumatic reaction (TR, trauma) during and after the event. Many people even experienced multiple TE's during their life. Whether something can be considered to be a TE is largely determined by the reaction of the person who is confronted with it, or as a reaction to people reacting to a TE. The TR reaction to a TE is a *direct* reaction, the TR in reaction to a person reacting to a TR is an *indirect* one. This can be witnessing someone undergoing a TE, or experiencing a TE in a virtual environment mediated by internet for instance in a game, or not knowing about a TE but experiencing the action of someone else as a frightening thing. In the following example you see such an *indirect* reaction that can have a lot of influence.

Peter, a young adult, remembers very clearly that his father and he were looking out of the window, listening to a sound outside. Suddenly his father drew him away from the window. Peter felt a strong anxiety, and only later he discovered that his father expected a bomb attack and wanted to protect him. Peter still is afraid to stay close to a window.

Many factors play a role whether a TR to an event will occur in someone, one of them is age. Children can experience trauma during and after a TE where adults do not, and adults can experience trauma where children do not. A second factor that influences whether an experience leads to a traumatic reaction is life-experience. Of course life-experience correlates to an important extent to age, but also to the social environment, historical situation and culture.

The consequences of a TE can be huge. We always talk about the fear and anxiety caused by a TE, such as the nightmares and re-experiencing the TE afterwards with flashbacks. This, however, is only part of the possible consequences of a TE. It is the tip of the iceberg, especially when it comes to *childhood trauma*. The anxieties only express two

important elements of a TR: the urge to understand what has happened and the fear of recurrence.

A new theory has been developed about trauma viewing it from the a *developmental perspective* (Delfos, 2014). This new theory on trauma goes one step beyond what was hitherto the only focus on trauma. From the developmental perspective trauma has not only an *effect* in the sense of feelings and cognitions resulting possibly in disturbing daily life and sleep, but a TE has also a consequence in the sense of *formation* that deeply influences the perspective on the world and the self-esteem, certainly when it concerns trauma occurring during childhood and youth.

Trauma in the diagnostic handbooks

The TE someone experienced belongs to the past, not to the present. In fact, we no longer think it is the TE itself which is the problem, that was what we thought in the beginning of the concept of trauma, with the DSM in its first version in 1952, DSM-I (Diagnostic Statistical Manual of Mental Disorders) (APA, American Psychiatric Association, 1952). The trauma, then classified as *gross stress reaction*, was considered to take place at the moment the TE occurred, for instance at the precise moment at war when the bomb exploded. The problem of the TE was the exact reaction (physical and psychological) at that moment. That is why it was situated in war (*combat*) and *civilian catastrophes* in the first DSM. The somewhat strange consequence of this perspective on trauma is that the concept disappeared the second version, DSM-II (APA, 1968), because the DSM originating from the American background and no war or catastrophes happening in America for some time after the two World Wars, the *gross stress reaction* disappeared from this handbook. It was in 1980 that the concept of trauma appeared again, in the DSM-III (APA, 1980), when America got involved in March 1965 in the ongoing Vietnam war, which took place from 1-11-1955 to 30-4-1975. The Vietnam Veterans showed serious problem behaviour after the war, even long after their participation in the war. In the end more Vietnam Veterans died from suicide after the war than were killed during the war (Pompili et al., 2013). Researchers discovered that there was an important difference between the American soldiers after the World Wars and the Vietnam soldiers. The American soldiers from the World Wars went home together on boats that took several weeks from the country at war to the home land. The soldiers were together with their companions for quite some time, and not yet in the 'normal' world that awaited them at home. The Vietnam soldiers, however, took the plane and within a short while they were home, expected to pick-up normal life. This insight in trauma led to the idea of putting soldiers in quarantine between the country at war and their home land, three weeks in Greece for instance. We discovered that trauma developed after the TE and as a result this was called PTSD, *Post Traumatic Stress Disorder*, classified under *Anxiety Disorders* in the DSM, also in the ICD (International Statistical Classification of Diseases and Related Health Problems, WHO, first in 1948, the 10th in 1990, and 11th due in 2018). The general idea was that feelings were affected through stress, which could – severely – influence daily functioning and sleep. This *effect* of trauma after the TE can be recognized in feelings, memories, and disruption of daily life. This perspective on trauma went on in the fourth and fifth DSM (DSM-IV, APA-1994 and DSM-5, APA-2013), and more or less the same idea holds for the second handbook, the ICD (WHO, 1948-2018). This view on trauma is about the *effect*, we could say *affect* because the ground feelings of the person shift to anxiety and fear. Refinements in the DSM after the discovery of PTSD are mainly about the

fact the children can also experience trauma with different symptoms and that not only *real life* but also the *virtual environment* (Delfos, 2013) via internet can engender PTSD (APA, 2013). Astonishing is that with regard to the last element – internet – it is explicitly mentioned that trauma due to internet experiences can only happen in the context of work, as if one could not be traumatized by internet when not working or as a child.

On effect, 1: The first layers of traumatic reaction

The impact of trauma can be categorised in different layers (Delfos, 2014). The first three layers are about the *effect* of a TE.

A. The first layer of trauma is about the daily effects in terms of memories and visual recall such as flashbacks, re-experiences, alertness (*arousal*) and anxiety. These elements can interfere with and restrain normal functioning.
B. The second layer of trauma is the fear of recurrence and feelings of guilt that disturb functioning in certain areas, associated to the TE.
C. The third layer of the trauma is about the development of cognitive and emotional detrimental patterns, detrimental for normal functioning. It is the area of serious anxieties forming phobias and compulsive thoughts and behaviour.

These three layers all have to do with anxieties. This is why in the DSM and ICD trauma is classified under Anxiety Disorder. The evident anxiety is a signal for the idea that trauma could be the source.

On effect, 2: the fear of recurrence

The problem of the reaction to a TE is not so much the moment itself, but more important is, what remains after the TE. One of the important things that lingers behind is the fear of recurrence. The TE is terrible to experience, and therefore it creates the fear that it will happen again, the *fear of recurrence* of the TE, even if is improbable or impossible in reality.

If the TE has occurred under exceptional circumstances, for example on holiday, it has a different effect on the fear of recurrence than when it occurred in daily life, at home or at school. In the case of a TE during a holiday seems relatively easy to cope with the fear of recurrence by changing the holiday destination. If it occurred in a regular daily atmosphere than daily life is more easily affected. We see that for example in the trauma arising from the fireworks disaster in Enschede, a city in the Netherlands, where an explosion of a firworks factory exploded in the middle of an ordinary day. This catastrophe penetrated the ordinary lives of people deeper than if it had occurred at midnight with the transition from the Old year to the New Year, when fireworks are expected. This TE had a long-lasting and broad effect on the people of the city.

The usual way people try to cope with the fear of recurrence is by developing feelings of responsibility and guilt. It is as if thinking that the TE occurred through their own fault makes it possible that changing their behavior will prevent the TE to occur again. We see people say things such as: '*I should have taken another train'* or '*If I would have said goodbye when I left home it would not have happened.*' This guilt gives hope that in one in one way or the other, one has control over events. In fact, this is a kind of the magical thinking of young children. It is as if the anxiety causes a cognitive regression to an earlier period when a less refined thinking was operational.

Because a TE basically occurs unexpectedly and unintentionally, the reason is often difficult to grasp and reasoning become limited and the feelings of guilt are often farfetched. Therapists often feel they must help people shake off their feelings of guilt by saying that it is

not their fault and that is happened by accident. Instead of diminishing the anxiety they increase the anxiety by trying to make people understand they have no control over the TE. In that case, these feelings of guilt prove to be quite persistent, even when the TE cannot be repeated. This conjuring magical feelings come across people, defying reality. The fear of recurrence is often an important element of the burden trauma represents.

Trauma treatment therefore, begins with the treatment of the fear of recurrence. And this starts with treating the feelings guilt. If these feelings of guilt lie at the surface, and people are aware of it, the treatment of these feelings is most effective in overcoming trauma.

She was nineteen when she came to me for treatment. It was one of my first patients in a long line of people suffering from trauma. She said that she had sex with her father since she was three years old and that it was still going on. But it's her own fault she adds defiantly. I am surprised. "But it's not your fault if your father had sex with you when you were three years old, is it?" "Yes," she answers, sounding sure of her case. I try to discover what it means what she says and asks her if she knows a girl of three years, she does, and whether she could visualize her in her mind. "Can that girl want to have sex with her father," I ask her. "No," she said, "but I did." Her reaction made it clear to me that she could comprehend cognitively what she was talking about, but that she felt it did not apply to her. I let go of trying to convince her that it was not her fault, and started a joint investigation of her guilt. "Why is it your fault," I asked her kindly." "I had a very nice dress with polka dots and I looked very pretty in it, and I knew that," she answered without any hesitation. "Did he always have sex when you had that dress on," I asked her. "No," she replied with some surprise in her voice. "When then," I asked. "When he's drunk," she replied, using the present tense. "Then you know when it's dangerous," I continued. At that moment started my experience in dealing with feelings of guilt by trauma as the most effective way to treat the fear of recurrence. I discovered that speaking about the feelings of guilt most of the time made it possible to discover ways to protect oneself.

The young girl was no longer abused by her father after this conversation. This probably has to do with her voicing her problem in therapy, with the conversation itself, and with the fact that guilt was examined and by that investigation she discovered the way to protect herself, that is stay away from him when he was drunk.

In the upper layer of trauma the effect of anxiety, nightmares and flashbacks restrict normal function. Still deeper lies the fear of recurrence, feelings of guilt and malfunctioning in some areas associated to the TE. Again a layer deeper there is the possibility that the trauma is embedded in cognitive and emotional harmful patterns that could lead to phobic behavior and compulsive thoughts and behavior. Still below these layers are the extensive problems caused by the *formation* trauma causes.

On formation, 1: The placement of traumatic experiences in brain networks

People try to understand a traumatic experience. One of the first questions that arise is: *Why did this happen to me?* or *Why me?* Brains do something with the trauma, including storing in into memory. In the brains there is the white and grey matter. The grey matter are the brain cells and the white matter is the substance that makes the connections between brain cells. In the organization of the brain there is a basic network that is still active in resting state. This is called the *Default Mode Network* (DMN) (Greicius et al.,2003). In young children the DMN is limited and connectivity grows with maturation(Daniels et al., 2011). A

traumatic experience can be stored in the networks of the brain organization, named *Conceptual Brain Networks*, CBN's by me; networks which are formed in the brains, around concepts and to connect interrelated concepts. In young brains, these conceptual networks, which have a concept or concepts related subject, are still quite rudimentary, simple. Also, there are not many of such strong and comprehensive networks formed in the very young child. With growing maturation and growing life experience the networks get developed, refined and strengthened. In Figure 1, an example of a young CBN, where the network 'mummy and daddy' is already well developed, but 'school' not. The fireworks catastrophe (TE-F) mentioned before will have a totally different memory-storing effect in a four year old than in a thirty year old.

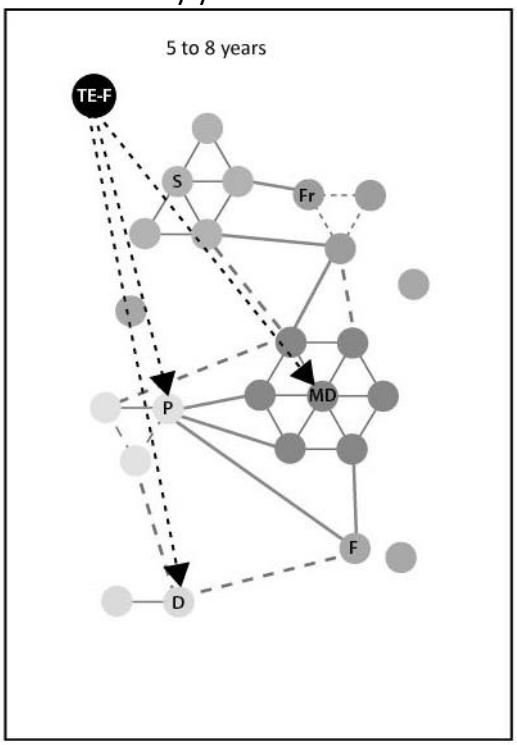


Figure 1: *CBN's in a child between 3 and 8 years old* (Delfos, 2014)

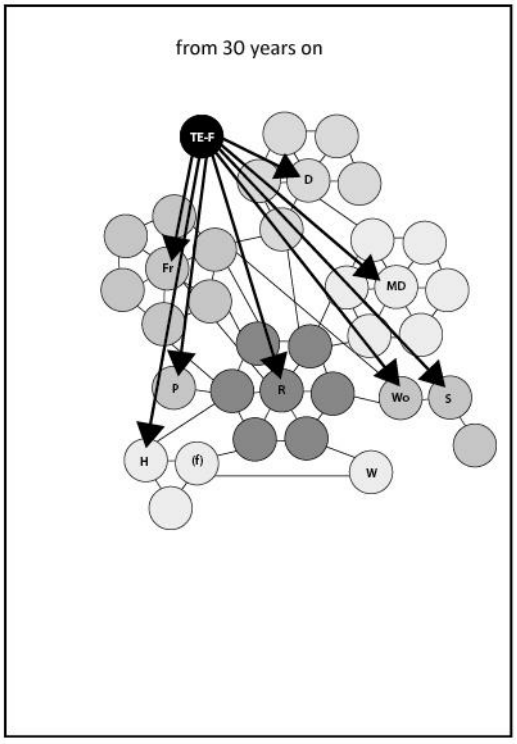


Figure 2: *CBN's of an adult from 30 years old* (Delfos, 2014)

In Figure 1 we see an already well-developed mummy-and-daddy network (MD), only minimal CBN Friends (F), school (S), pets (P) and diseases (D). The TE-F will be placed temporarily (dotted lines) in the CBN's M (because this is the most important network), in D (because of the association between ill-fever-hot-fire) and P (because the pet died after being ill).

In Figure 2 we see a well-developed systems of conceptual brain networks with the CBN MD less central, R (relation/partner) in the middle, F well developed, et cetera. The TE-F is placed in a definite way, because of the already developed CBN's through maturation and life-experience (straight lines). Of course this is only a part of the CBN organization in the brain, just to illustrate.

A TE can be placed in an inadequate CBN or not being placed in certain CBN's that would be relevant. In the course of life the CBN's are becoming more extensive. By faulty connections the child's makes because of lack of knowledge and life experience TE's are placed incorrectly, that is why in young children they are placed 'temporarily'. In addition, the memory and storing in the memory is strongly influenced by the presence or

absence of verbal abilities. Around seven years, what I call the *hinge age* (Delfos, 2015), there is a great activity in the expression of genes (Fulker et al., 1993). At this time experiences are mainly placed under sensory elements in the memory: smell, color, taste, sound and touch. After seven years of reorganization takes place where experiences are stored around verbal concepts. This is one of the reasons causing the adults often cannot easily reach the early childhood memories. Looking for words, the adult only find sensory experiences.

In addition, a decrease in white matter production will take place in the brains in the advent of trauma; certainly in the case of childhood trauma the white matter decreases (Daniels et al. 2013). The ability to connect brain cells and CBN's as a result decreases. Possibly this has to do with the negative associations surrounding the trauma through which the brains protect people against getting overwhelmed by trauma by making it less approachable.

On formation 2: Formation through trauma

The fear that accompanies trauma is often where attention is focused on. Treatments follow this main focus. Yet this is not the main problem that trauma causes. The most profound consequences of trauma is not the *effect*, but the *formation*. Especially in childhood trauma you see this, because children are still is full process of formation. Children and adolescents are still developing and their brains are still maturing. That means that trauma can profoundly form a child and may affect the development tasks. This applies especially to the idea that a child has on certain issues and the idea of himself and his perspective on the world. This perspective is often not realistic from an adult's point of view, and not based on life experience. Because the child that still cannot express himself in words or when he is ashamed and afraid to express himself to others or because his still high egocentricity does not make him aware that he should share with others, there will be no verification and no reality testing. This way childhood trauma can find a place in the brains of adults and without the adult being aware of it, the trauma affects thoughts, feelings and behavior in the adult. The forming can be described according to the different ages and the associated development stages. This is called the *Developmental Perspective on Trauma*, DPT, which encompasses five developmental phases, and can be applied to different subjects as war (*Developmental Perspective on War Trauma*, DPWT, in five developmental phases) and sexual abuse (*Developmental Perspective on Sexual abuse Trauma*, DPST in ten developmental phases).

The following is an example of the consequences in *formation* of a TE about the death of a father of a boy of four years old, and the influence on his self-image as a young adult.

A young man of 18 years comes to therapy. He is friendly, shy and does not use many words. After some time it becomes clear what image he has of himself. He says that he is a monster, that is literally the word he uses to describe his personality. A strong statement, which he voices in a serious tone and without any doubt. Completely inconsistent with the gentleness he expresses in his behavior. At one point he says to the therapist: "You are afraid of me." The therapist answers truthfully and kindly, "No." "That is not correct", he quietly replies; his certainty about him being a monster high. A while later, attention is paid to the experience from his early childhood, the death of his father, which could be a child-trauma. He was four

years when his father died. The therapist asks, "Do you remember something about that?" The young man makes a screwing movement with his hand and after a little moment it was as if he 'throws' the word 'screw' by voicing it. Because the non-verbal gesture followed by only one word, it becomes clear that he never spoke about the death of his father, he is at loss for words and te gesture was first, in line with the strongly preverbal period the TE happened. In fact he said later that he never spoke about it before. He tells that he had to screw tight one of the screws of the coffin where he dead father was lying in.

When we place ourselves in the boy's shoes when he was four years old, it becomes clear that awareness of the irreversibility of death is not yet developed, not formed yet. He is not yet in the developmental phase from five to eight years. At that age, dead is 'being away' or 'being asleep'. Children from five years can look at an adult and say with a big smile: *You will die*! Proud that they are they understand that everyone dies. Young children do not have the sense of the irreversibility of death yet; that realization is slowly formed in the following years. During the developmental phase between five and eight years children try to grasp the great concepts of life, such as mother, father, school, animals, young, school, teacher, death and so many. And this developmental ages forms the basis of their perspective on the world.

In the boy from the example above, the awareness of the irreversibility of the death was not yet developed. That means that his feels has screwed close the coffin where his 'living' father was lying in. Not surprisingly, he feels bad about himself, a feeling that in due course developed in the perspective of himself as a monster. The feeling is not associated only to the death of his father, he is truly impregnated with this, because it has become his perspective on himself, all this without the reason being clear to him and without he spoke about it with others. His self-image was therefore not tested against reality. Now he spoke about it in therapy, he realized that his feeling and his self-image were developed without him being aware of the true cause and when he became aware his self-image was thoroughly reconsidered. The idea of monster disappeared.

For quite some time already his development had stagnated, eventually he stopped going to school, and was at home lying in his bed for a very long time before he entered therapy. His short admittance to a psychiatric child hospital failed, because it was mainly based on medication.

In the therapy his philosophical inclination was discovered. He began to delve into philosophy and discovered Nietzsche. Full of enthusiasm he talked about Nietzsche and he said he felt as if he was the reincarnation of Nietzsche. After some time talking about the philosophy of Nietzsche, the therapist said. "I think that Nietzsche lost his father when he was young". The next session the young man is says full enthusiasm: "Nietzsche was the same age as I was when he lost his father!" That was why he could so intensely adopt the philosophy of Nietzsche, and that philosophy itself was suddenly put in the context of the loss of a father at age four. Of course there are other factors, including the sharp intelligence of this young man and that of Nietzsche, but in the trauma and the two life join each other by their life experience.

The Trauma Impact Model, TIM

In the treatment of trauma there should be paid attention to:
1: What is the trauma.

2: What are the circumstances of the trauma.
3: What is the resilience of the person who experiences trauma.
4: How is the socio-emotional network around the person.
5: What is the person's age.
6: What is the possible development task where the child or young person is performing at that moment of the TE.

The answer to these questions can help us to see how necessary treatment of the traumatic experience is.

Assessing the circumstances and characteristics of the person who experiences a TE results in discerning three groups of *impact* of a traumatic experience.

The first group consists of those traumatic experiences that have an impact, but where the conditions are favorable. The latter is mainly about the socioemotional network around the person and in the case of children, these are basically the parents. In this group, the person can process the TE in principle by itself. People, including children, under these conditions do not require professional treatment, but support and help. On the contrary. Professional treatment would teach the person that he or she cannot overcome the trauma by his own and is dependent on others to overcome things. Overcoming trauma with the help or support from people around you, makes someone psychologically stronger and increases the resilience of children. One learns new coping mechanisms, self-confidence grows and life insight increases.

The second group consists of people for whom the TE has serious consequences and infringes upon everyday life, while the conditions are less favorable. Help is needed and maybe professional treatment may be needed.

The third group involves TE's that have severe, profound and formative impact under adverse conditions. Professional treatment is necessary in all probability to prevent long-term damage and to promote ongoing development.

Conclusion

This article is not the result of an experimental research project, but an encompassing new theory on trauma. This theory on trauma and its following models, can shed a new light on and offer a deeper insight in trauma and its consequences throughout life. The most important and most devastating traumas are the childhood trauma, they resonate throughout life. This theory offers a framework to discover the workings of trauma in the person as a whole, and not only in the way he or she handles fear and anxiety. It makes clear how the trauma feeds itself from developmental tasks and leave the adult sometimes at loss for adult behavior.

References

APA, American Psychiatric Association. (1952). *Diagnostic and Statistical Manual of Mental Disorders*. (DSM-I, 1st ed.). Washington, DC: American Psychiatric Association.

APA, American Psychiatric Association. (1968). *Diagnostic and Statistical Manual of Mental Disorders.* (DSM-II, 2nd ed.). Washington, DC: American Psychiatric Association.

APA, American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders.* (DSM-III, 3rd ed.). Washington, DC: American Psychiatric Association.

APA, American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders.* (DSM-IV, 4th ed.). Washington, DC: American Psychiatric Association.

APA, American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders.* (DSM-5, 5th ed.). Washington, DC: American Psychiatric Association.

Daniels, J.K., Frewen, P., McKinnon, M.C., & Lanius, R.A. (2011). Default Mode alterations in posttraumatic stress disorder related to early-life trauma: a developmental perspective. *Journal of Psychiatry and Neuroscience, 36* (1), 56-9.

Daniels, J.K., Lamke, J-P., Gaebler, M., Walter, H., & Scheel, M. (2013). White matter integrity and its relationship to ptsd and childhood trauma-A systematic review and meta-analysis. *Depression and anxiety, 30*, 207-216.

Delfos, M.F. (2013). The virtual environment from a development perspective. In B. Heys, M. Matthes, & P. Sullivan (Eds.). *Improving the Quality of Childhood in Europe 2013. Volume 4,* 102-157. East Sussex/United Kingdom: ECSWE-European Council for Steiner Waldorf Education.

Delfos, M.F. (2014). *Trauma from a development perspective*. Amsterdam: SWP Publisher, Amsterdam.

Delfos, M.F. (2015, 7th edition). *Ontwikkeling in vogelvlucht. Ontwikkeling van kinderen en adolescenten*. Amsterdam: Pearson. [Development from a bird's eye. Development of children and adolescents.]

Fulker, W., Cherry, S.S. & Cardon, L.R. (1993). Continuity and Change in Cognitive Development. In R. Plomin & G.E. McClearn (Eds.). *Nature, Nurture and Psychology*, 77-95. Washington DC: American Psychological Association.

Greicius, D.Krasnov, B., Reiss, A.L. & Menon, V. (2003). Functional connectivity in the resting brain: A network analysis of the default mode hypothesis. *PNAS*, vol.100, 253-258; doi 10.1073/pnas.0135058100.

Pompili M., Sher, L., Serafini, G, Forte, A., Innamorati, M., Dominici, G., Lester, D., Amore, M., & Girardi P. (2013). Posttraumatic stress disorder and suicide risk among veterans- a literature review. *Journal of Nervous and Mental Disease, 201*(9), 802-12.

WHO, World Health Organization (1948-2018). *International Statistical Classification of Diseases and Related Health Problems*. First edition in 1948, the 10th in 1990, and the 11th due in 2018. Geneva: WHO.

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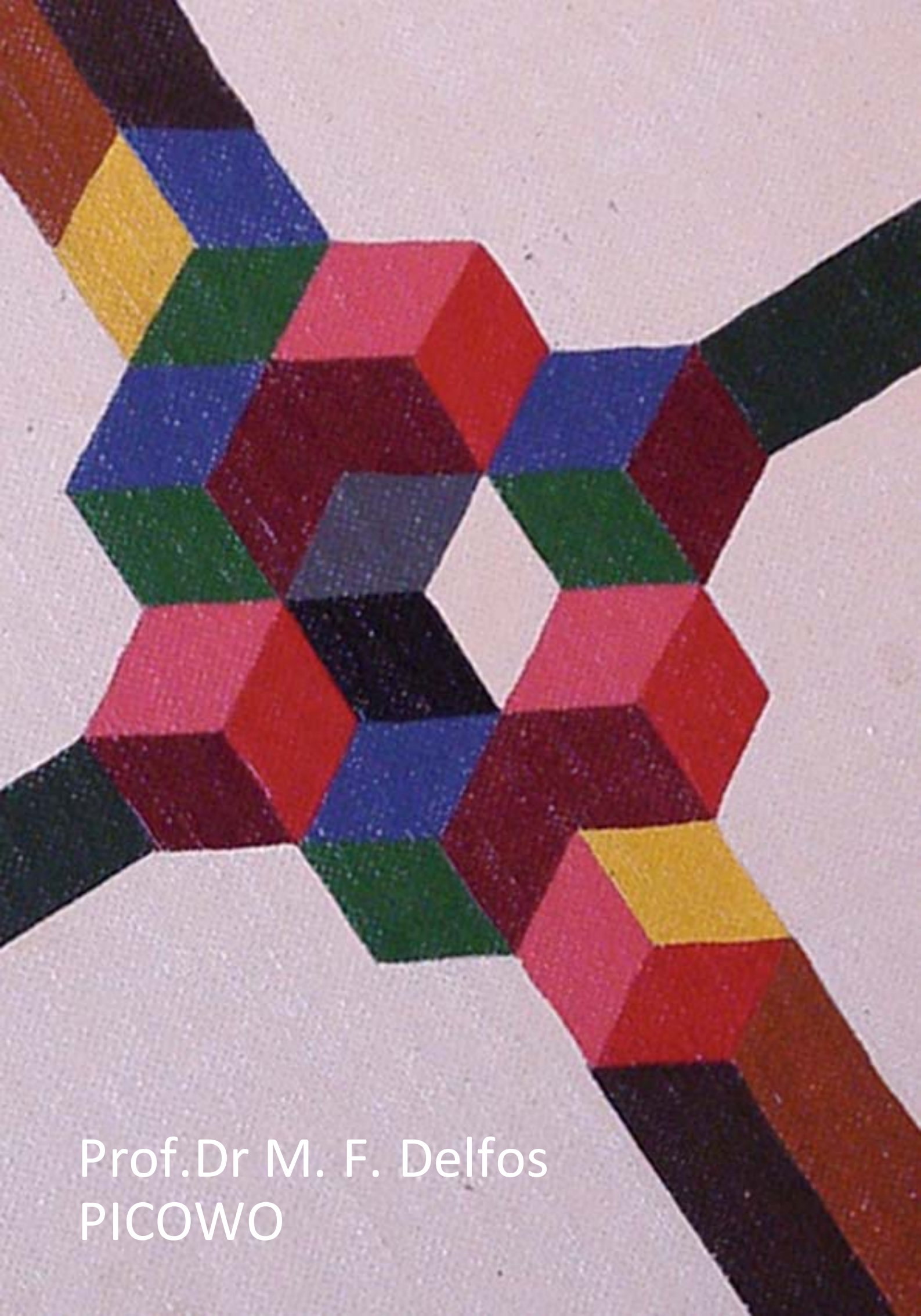

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