SESSION

1

INTRODUCING THE POST-TRAUMATIC SYMPTOMS INTERVENTION TO CHILDREN AND PARENTS

SESSION TOOLS

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A National Center for PTSD Fact Sheet

Fact Sheet 1: PTSD in Children and Adolescents

By Jessica Hamblen, Ph.D.

The diagnosis of Posttraumatic Stress Disorder (PTSD) was formally recognized as a psychiatric diagnosis in 1980. At that time, little was known about what PTSD looked like in children and adolescents. Today, we know children and adolescents are susceptible to developing PTSD, and we know that PTSD has different age-specific features. In addition, we are beginning to develop child-focused interventions. This fact sheet provides information regarding what events cause PTSD in children, how many children develop PTSD, risk factors associated with PTSD, what PTSD looks like in children, other effects of trauma on children, treatment for PTSD, and what you can do for your child.

WHAT EVENTS CAUSE PTSD IN CHILDREN?

A diagnosis of PTSD means that an individual experienced an event that involved a threat to one's own or another's life or physical integrity and that this person responded with intense fear, helplessness, or horror. There are a number of traumatic events that have been shown to cause PTSD in children and adolescents. Children and adolescents may be diagnosed with PTSD if they have survived natural and man made disasters such as floods; violent crimes such as kidnapping, rape or murder of a parent, sniper fire, and school shootings; motor vehicle accidents such as automobile and plane crashes; severe burns; exposure to community violence; war; peer suicide; and sexual and physical abuse.

HOW MANY CHILDREN DEVELOP PTSD?

A few studies of the general population have been conducted that examine rates of exposure and PTSD in children and adolescents. Results from these studies indicate that 15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime. Of those children and adolescents who have experienced a trauma, 3 to 15% of girls and 1 to 6% of boys could be diagnosed with PTSD.

Rates of PTSD are much higher in children and adolescents recruited from at-risk samples. The rates of PTSD in these at-risk children and adolescents vary from 3 to 100%. For example, studies have shown that as many as 100% of children who witness a parental homicide or sexual assault develop PTSD. Similarly, 90% of sexually abused children, 77% of children exposed to a school shooting, and 35% of urban youth exposed to community violence develop PTSD.

WHAT ARE THE RISK FACTORS FOR PTSD?

There are three factors that have been shown to increase the likelihood that children will develop PTSD. These factors include the severity of the traumatic event, the parental reaction to the traumatic event, and the physical proximity to the traumatic event. In general, most studies find that children and adolescents who report experiencing the most severe traumas also report the highest levels of PTSD symptoms. Family support and parental coping have also been shown to affect PTSD symptoms in children. Studies show that children and adolescents with greater family support and less parental distress have lower levels of PTSD symptoms. Finally, children and adolescents who are farther away from the traumatic event report less distress.

There are several other factors that affect the occurrence and severity of PTSD. Research suggests that interpersonal traumas such as rape and assault are more likely to result in PTSD than other types of traumas. Additionally, if an individual has experienced a number of traumatic events in the past, those experiences increase the risk of developing PTSD. In terms of gender, several studies suggest that girls are more likely than boys to develop PTSD. A few studies have examined the connection between ethnicity and PTSD. While some studies find that minorities report higher levels of PTSD symptoms, researchers have shown that this is due to other factors such as differences in levels of exposure. It is not clear how a child's age at the time of exposure to a traumatic event impacts the occurrence or severity of PTSD. While some studies find a relationship, others do not. Differences that do occur may be due to differences in the way PTSD is expressed in children and adolescents of different ages or developmental levels (see next section).

WHAT DOES PTSD LOOK LIKE IN CHILDREN?

Researchers and clinicians are beginning to recognize that PTSD may not present itself in children the same way it does in adults (see What is PTSD? below). Criteria for PTSD now include age-specific features for some symptoms.

Very young children may present with few PTSD symptoms. This may be because eight of the PTSD symptoms require a verbal description of one's feelings and experiences. Instead, young children may report more generalized fears such as stranger or separation anxiety, avoidance of situations that may or may not be related to the trauma, sleep disturbances, and a preoccupation with words or symbols that may or may not be related to the trauma. These children may also display posttraumatic play in which they repeat themes of the trauma. In addition, children may lose an acquired developmental skill (such as toilet training) as a result of experiencing a traumatic event.

Clinical reports suggest that **elementary school-aged children** may not experience visual flashbacks or amnesia for aspects of the trauma. However, they

do experience "time skew" and "omen formation," which are not typically seen in adults. Time skew refers to a child mis-sequencing trauma related events when recalling the memory. Omen formation is a belief that there were warning signs that predicted the trauma. As a result, children often believe that if they are alert enough, they will recognize warning signs and avoid future traumas. School-aged children also reportedly exhibit posttraumatic play or reenactment of the trauma in play, drawings, or verbalizations. Posttraumatic play is different from reenactment in that posttraumatic play is a literal representation of the trauma, involves compulsively repeating some aspect of the trauma, and does not tend to relieve anxiety. An example of posttraumatic play is an increase in shooting games after exposure to a school shooting. Posttraumatic reenactment, on the other hand, is more flexible and involves behaviorally recreating aspects of the trauma (e.g., carrying a weapon after exposure to violence).

PTSD in **adolescents** may begin to more closely resemble PTSD in adults. However, there are a few features that have been shown to differ. As discussed above, children may engage in traumatic play following a trauma. Adolescents are more likely to engage in traumatic reenactment, in which they incorporate aspects of the trauma into their daily lives. In addition, adolescents are more likely than younger children or adults to exhibit impulsive and aggressive behaviors.

BESIDES PTSD, WHAT ARE THE OTHER EFFECTS OF TRAUMA ON CHILDREN?

Besides PTSD, children and adolescents who have experienced traumatic events often exhibit other types of problems. Perhaps the best information available on the effects of traumas on children comes from a review of the literature on the effects of child sexual abuse. In this review, it was shown that sexually abused children often have problems with fear, anxiety, depression, anger and hostility, aggression, sexually inappropriate behavior, self-destructive behavior, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, and substance abuse. These problems are often seen in children and adolescents who have experienced other types of traumas as well. Children who have experienced traumas also often have relationship problems with peers and family members, problems with acting out, and problems with school performance.

Along with associated symptoms, there are a number of psychiatric disorders that are commonly found in children and adolescents who have been traumatized. One commonly co-occurring disorder is major depression. Other disorders include substance abuse; other anxiety disorders such as separation anxiety, panic disorder, and generalized anxiety disorder; and externalizing disorders such as attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder.

HOW IS PTSD TREATED IN CHILDREN AND ADOLESCENTS?

Although some children show a natural remission in PTSD symptoms over a period of a few months, a significant number of children continue to exhibit symptoms for years if untreated. Few treatment studies have examined which treatments are most effective for children and adolescents. A review of the adult treatment studies of PTSD shows that **Cognitive-Behavioral Therapy (CBT)** is the most effective approach. CBT for children generally includes the child directly discussing the traumatic event (exposure), anxiety management techniques such as relaxation and assertiveness training, and correction of inaccurate or distorted trauma related thoughts. Although there is some controversy regarding exposing children to the events that scare them, exposure-based treatments seem to be most relevant when memories or reminders of the trauma distress the child. Children can be exposed gradually and taught relaxation so that they can learn to relax while recalling their experiences. Through this procedure, they learn that they do not have to be afraid of their memories. CBT also involves challenging children's false beliefs such as, "the world is totally unsafe." The majority of studies have found that it is safe and effective to use CBT for children with PTSD.

CBT is often accompanied by **psycho-education** and **parental involvement**. Psycho-education is education about PTSD symptoms and their effects. It is as important for parents and caregivers to understand the effects of PTSD as it is for children. Research shows that the better parents cope with the trauma, and the more they support their children, the better their children will function. Therefore, it is important for parents to seek treatment for themselves in order to develop the necessary coping skills that will help their children.

Several other types of therapy have been suggested for PTSD in children and adolescents. **Play therapy** can be used to treat young children with PTSD who are not able to deal with the trauma more directly. The therapist uses games, drawings, and other techniques to help the children process their traumatic memories. **Psychological first aid** has been prescribed for children exposed to community violence and can be used in schools and traditional settings. Psychological first aid involves clarifying trauma-related

facts, normalizing the children's PTSD reactions, encouraging the expression of feelings, teaching problem solving skills, and referring the most symptomatic children for additional treatment. **Twelve Step** approaches have been prescribed for adolescents with substance abuse problems and PTSD. Another therapy, **Eye Movement Desensitization and Reprocessing (EMDR)**, combines cognitive therapy with directed eye movements. While EMDR has been shown to be effective in treating both children and adults with PTSD, studies indicate that it is the cognitive intervention rather than the eye movements that accounts for the change. **Medications** have also been prescribed for some children with PTSD. However, due to the lack of research in this area, it is too early to evaluate the effectiveness of medication therapy. Finally, **specialized interventions** may be necessary for children exhibiting particularly problematic behaviors or PTSD symptoms. For example, a specialized intervention might be required for inappropriate sexual behavior or extreme behavioral problems.

WHAT CAN I DO TO HELP MY CHILD?

Reading this fact sheet is a first step toward helping your child. Gather information on PTSD and pay attention to how your child is functioning. Watch for warning signs such as sleep problems, irritability, avoidance, changes in school performance, and problems with peers. It may be necessary to seek help for your child. Consider having your child evaluated by a mental-health professional who has experience treating PTSD in children and adolescents. Many therapists with this experience are members of the International Society for Traumatic Stress Studies, which has a membership directory containing a geographical listing of therapists who treat children and adolescents. Ask how the therapist typically treats PTSD, and choose a practitioner with whom you and your child feel comfortable. Consider whether you might also benefit from talking to someone individually. The most important thing you can do now is to support your child.

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Fact Sheet 2: Terrorist Attacks and Children

By Jessica Hamblen, Ph.D.

When terrorist attacks occur, our children may witness or learn about these events by watching TV, talking with people at school, or over hearing adults discussing the events. For instance, the September 11th, 2001 attacks and the Oklahoma City bombing received widespread attention and media coverage and many children were exposed. But how should we speak to our children about these events when they occur? Should we shield them from such horrors or talk openly about them? How can we help children make sense of a tragedy that we ourselves cannot understand? How will children react? How can we help our children recover? Fortunately, there have been relatively few terrorist attacks. One consequence of this is that there is little empirical research to help us answer the above questions. Information from related events can be used to provide answers.

HOW DO CHILDREN RESPOND TO TERRORISM?

There is a wide range of emotional, behavioral, and physiological reactions that children may display following a terrorist attack. From previous research, we know that more severe reactions are associated with a higher degree of exposure (i.e., life threat, physical injury, witnessing death or injury, hearing screams, etc.), closer proximity to the disaster, a history of prior traumas, being female, poor parental response, and parental mental health problems.

There is some research on children from the September 11th, 2001 attacks and the Oklahoma City Bombing. In a national sample of adults surveyed 3-5 days after the September 11th attacks, 35% of parents reported that their children had at least one stress symptom and almost half reported that their children were worried about their own safety or the safety of a loved one. Two factors related to increased stress symptoms were 1) amount of television coverage viewed by the child, and 2) parental distress. Children who watched the most coverage were reported to have more stress symptoms than those who watched less coverage. Similarly, parents who endorsed more stress symptoms were also more likely to report that their children were upset, indicating a relationship between parental and child distress.[1]
Findings from a study following the Oklahoma City bombing indicate that more severe reactions were related to being female, knowing someone injured or killed, and bomb-related television viewing and media exposure[2,3].

Below are some common reactions that children and adolescents may display[4,5].

Young Children (1-6 years)

- Helplessness and passivity; lack of usual responsiveness
- Generalized fear
- Heightened arousal and confusion
- Cognitive confusion
- Difficulty talking about event; lack of verbalization
- Difficulty identifying feelings
- Nightmares and other sleep disturbances
- Separation fears and clinging to caregivers
- Regressive symptoms (e.g., bedwetting, loss of acquired speech and motor skills)

- Inability to understand death as permanent
- Anxieties about death
- Grief related to abandonment by caregiver
- Somatic symptoms (e.g., stomach aches, headaches)
- Startle response to loud or unusual noises
- "Freezing" (sudden immobility of body)
- Fussiness, uncharacteristic crying, and neediness
- Avoidance of or alarm response to specific trauma-related reminders involving sights and physical sensations

School-age Children (6-11 years)

- Feelings of responsibility and guilt
- Repetitious traumatic play and retelling
- Feeling disturbed by reminders of the event
- Nightmares and other sleep disturbances
- Concerns about safety and preoccupation with danger
- Aggressive behavior and angry outbursts
- Fear of feelings and trauma reactions
- Close attention to parents' anxieties
- School avoidance
- Worry and concern for others
- Changes in behavior, mood, and personality
- Somatic symptoms (complaints about bodily aches and pains)
- Obvious anxiety and fearfulness
- Withdrawal
- Specific trauma-related fears; general fearfulness
- Regression (behaving like a younger child)
- Separation anxiety
- Loss of interest in activities
- Confusion and inadequate understanding of traumatic events (more evident in play than in discussion)
- Unclear understanding of death and the causes of "bad" events
- Giving magical explanations to fill in gaps in understanding
- Loss of ability to concentrate at school, with lowering of performance
- "Spacey" or distractible behavior

Pre-adolescents and Adolescents (12-18 years)

- Self-consciousness
- Life-threatening reenactment
- Rebellion at home or school
- Abrupt shift in relationships
- Depression and social withdrawal
- Decline in school performance
- Trauma-driven acting out, such as with sexual activity and reckless risk taking
- Effort to distance oneself from feelings of shame, guilt, and humiliation
- Excessive activity and involvement with others, or retreat from others in order to manage inner turmoil

- Accident proneness
- Wish for revenge and action-oriented responses to trauma
- Increased self-focusing and withdrawal
- Sleep and eating disturbances, including nightmares

TIPS FOR TALKING WITH YOUR CHILDREN ABOUT TERRORISM

- **Create a safe environment.** One of the most important steps you can take is to help children feel safe. If possible, children should be placed in a familiar environment with people that they feel close to. Keep your child's routine as regular as possible. Children find comfort in having things be consistent and familiar.

- **Provide children with reassurance and extra emotional support.** Adults need to create an environment in which children feel safe enough to ask questions, express feelings, or just be by themselves. Let your children know they can ask questions. Ask your children what they have heard and how they feel about it. Reassure your child that they are safe and that you will not abandon them.

- **Be honest with children about what happened.** Provide accurate information, but make sure it is appropriate to their developmental level. Very young children may be protected because they are not old enough to be aware that something bad has happened. School-age children will need help
  understanding what has happened. You might want to tell them that there has been a terrible accident and that many people have been hurt or killed. Adolescents will have a better idea of what has occurred. It may be appropriate to watch selected news coverage with your adolescent and then discuss it.

- **Tell children what the government is doing.** Reassure children that the state and federal government, police, firemen, and hospitals are doing everything possible. Explain that people from all over the country and from other countries offer their services in times of need.

- **Be aware that children will often take on the anxiety of the adults around them.** Parents have difficulty finding a balance between sharing their own feelings with their children and not placing their anxiety on their children. For example, the September 11th attack on the United States was inconceivable. Our sense of safety and freedom was shattered. Many parents felt scared and fearful of another attack. Others were angry and revengeful. Parents must deal with their own emotional reactions before they can help children understand and label their feelings. Parents who are frightened may want to explain that to their child, but they should also talk about their ability to cope and how family members can help each other.

- **Try to put the event in perspective.** Although you yourself may be anxious or scared, children need to know that attacks are rare events. They also need to know that the world is generally a safe place.

WHAT CAN PARENTS DO?
(Excerpted from Monahon [6])

Infancy to two and a half years:

- Maintain child's routines around sleeping and eating.
- Avoid unnecessary separations from important caretakers.
- Provide additional soothing activities.
- Maintain calm atmosphere in child's presence.
- Avoid exposing child to reminders of trauma.
- Expect child's temporary regression; don't panic.
- Help a verbal child to give simple names to big feelings; talk about event in simple terms during brief chats.
- Give simple play props related to the actual trauma to a child who is trying to play out the frightening situation (e.g., a doctor's kit, a toy ambulance).

Zero-to-Three has published excellent guidelines for parents whose very young children (ages 0 to 3) might have been exposed to media or conversations about the September 11th terroristic attacks.

Two and a half to six years:

- Listen to and tolerate child's retelling of the event.
- Respect child's fears; give child time to cope with fears.
- Protect child from re-exposure to frightening situations and reminders of trauma, including scary TV programs, movies, stories, and physical or locational reminders of trauma.
- Accept and help the child to name strong feelings during brief conversations (the child cannot talk about these feelings or the experience for long).
- Expect and understand child's regression while maintaining basic household rules.
- Expect some difficult or uncharacteristic behavior.
- Set firm limits on hurtful or scary play and behavior.
- If child is fearful, avoid unnecessary separations from important caretakers.
- Maintain household and family routines that comfort child.
- Avoid introducing experiences that are new and challenging for child.
- Provide additional nighttime comforts when possible such as night-lights, stuffed animals, and physical comfort after nightmares.
- Explain to child that nightmares come from the fears a child has inside, that they aren't real, and that they will occur less frequently over time.
- Provide opportunities and props for trauma-related play.
- Try to discover what triggers sudden fearfulness or regression.
- Monitor child's coping in school and daycare by expressing concerns and communicating with teaching staff.

Six to eleven years:

- Listen to and tolerate child's retelling of the event.
- Respect child's fears; give child time to cope with fears.
- Increase monitoring and awareness of child's play which may involve secretive reenactments of trauma with peers and siblings; set limits on scary or hurtful play.

- Permit child to try out new ways of coping with fearfulness at bedtime: extra reading time, leaving the radio on, or listening to a tape in the middle of the night to erase the residue of fear from a nightmare.
- Reassure the older child that feelings of fear and behaviors that feel out of control or babyish (e.g., bed wetting) are normal after a frightening experience and that he or she will feel better with time.
- Eleven to eighteen years:
- Encourage adolescents of all ages to talk about the traumatic event with family members.
- Provide opportunities for the young person to spend time with friends who are supportive.
- Reassure the young person that strong feelings-guilt, shame, embarrassment, or a wish for revenge-are normal following a trauma.
- Help the young person find activities that offer opportunities to experience mastery, control, and self-esteem.
- Encourage pleasurable physical activities such as sports and dancing.

HOW MANY CHILDREN DEVELOP PTSD AFTER A TERRORIST ATTACK?

The above symptoms are normal reactions to trauma and do not necessarily mean that a child has acquired a disorder. However, a significant minority of children will develop posttraumatic stress symptoms after a terrorist attack. Findings from Oklahoma City indicate that:
Children who lost a friend or relative were more likely to report immediate symptoms of PTSD than non-bereaved children.

Arousal and fear presenting seven weeks after the bombing were significant predictors of PTSD[2].
Two years after the bombing, 16% of children who lived approximately 100 miles away from Oklahoma City reported significant PTSD symptoms related to the event[2]. This is an important finding because these youths were not directly exposed to the trauma and were not related to people who had been killed or injured.

PTSD symptomatology was predicted by media exposure and indirect interpersonal exposure, such as having a friend who knew someone who was killed or injured.
No study specifically reported on rates of PTSD in children following the bombing. However, studies have shown that as many as 100% of children who witness a parental homicide or sexual assault, 90% of sexually abused children, 77% of children exposed to a school shooting, and 35% of urban youth exposed to community violence develop PTSD.

WHEN SHOULD YOU SEEK PROFESSIONAL HELP FOR YOUR CHILD?

Many children and adolescents will display some of the symptoms listed above as a result of terrorist attacks. Most children will likely recover in a few weeks with social support and the aid of their families. Many of the above suggestions will help children recover more quickly. Other children, however, may develop PTSD, depression, or anxiety disorders. Parents of children with prolonged reactions or more severe reactions may want to seek the assistance of a mental-health counselor. It is important to find a counselor who has experience working with children as well as with survivors of trauma. Referrals can be obtained through the American Psychological Association at 1-800-964-2000.

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HANDOUT 1.1

Trauma Goal Worksheet

Trauma Goal Worksheet By the end of this intervention:				
I want to feel LESS: *(please circle all that apply)*				
Nervous	Scared	Angry	Upset	Sad
I want to feel MORE: *(please circle all that apply)*				
Happy	Calm	Excited	Relaxed	

I want to change the way I do things and think about things: *(please check ✓ all that apply)*	
☐	Calm myself down when I feel upset.
☐	Think about things that happened without feeling upset.
☐	Talk about things that happened without feeling upset.
☐	Stop avoiding things that made me nervous.
☐	Do more of the things that I used to do.
☐	Think more about things before I do them.
☐	Make better decisions.
☐	Have fewer problems with my family.
☐	Have fewer problems with my friends.

I also want to change:		

Parent's Section		
What would you like to see changed in your child by the end of the intervention?		