

Post Traumatic Stress Disorder in Children and Adolescents

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Post-Traumatic Stress Disorder (PTSD) in children and adolescents occurs when a child is exposed to one or more events that are unexpected, uncontrollable, life-threatening, and likely to cause serious harm or injury to himself/herself or someone significantly important to the child. In response, the child experiences fear, hopelessness, or horror and responds with a characteristic set of physiological and psychological reactions, which perpetuates the overwhelming and confusing feelings. Symptoms are characterized into three groups: persistent, intrusive re-experiencing of traumatic recollections; avoidance of reminders/numbing; and increased arousal.

Re-experiencing trauma may occur in the following ways: frequent intrusive memories; feeling as if the event is recurring; or intense distress and physiologic reactivity when exposed to a traumatic cue. Very young children may express traumatic events in their play, reenact the event in drawings, and have generalized nightmares.

Avoidance of stimuli includes efforts to evade thoughts, feelings, activities, places, people, or discussions associated with the event. It also includes having a restricted range of affect and sensing an abbreviated future. Very young children may regress or lose previously acquired developmental skills, such as toilet training.

Hyperarousal symptoms may include difficulty falling to or maintaining sleep, disruptive or disorganized behavior, hypervigilance, trouble concentrating, and a pronounced startle response. In addition, children may have new separation anxiety and fears of the dark.

There are several different types of traumatic experiences children and adolescents endure. They include complex trauma (effect of chronic, multiple stressors), exposure to domestic violence, early childhood trauma, medical trauma, natural disasters, neglect, physical and sexual abuse, refugee and war zone trauma, school violence/bullying, terrorism, and traumatic loss. The experiences can have wide-ranging effects on the child's neurological development as well development of trust, emotional regulation, and social skills.

Scientific descriptions of reactions to stressful situations have been described for centuries in adults mainly as "Battle Fatigue/Shell shock/Combat Neuroses." The Revised Edition of the Diagnostic and Statistical Manual of Mental Disorder, III edition (DSM-III) was the first to include references to trauma in children and use age-specific criteria such as loss of previously acquired developmental skills. Despite acknowledgement of PTSD occurring in this age group, requiring a set number of each group of symptoms (as specified in DSM) may lead to under-diagnosis in children and adolescents.

The lifetime prevalence of PTSD in the general population ranges from 8 percent to 14 percent. However, the incidence and course of the illness differ depending on the type of trauma, closeness to the trigger, and the parent's reaction. For example, the rate of PTSD is as high as 95-100 percent in children who witnessed domestic violence, the death of a parent, or who have been kidnapped. One study examining the rate of PTSD following a sniper attack in school, found 40 percent of children developed PTSD. The fact that not all stress reactions result in PTSD suggests that temperament (the child's baseline emotional reactivity and adaptability) plays a significant role in subsequent development of the disorder. Other factors that influence PTSD development include parental support, the number of trauma events experienced, presence of other psychiatric symptoms, and source of trauma. On its own, PTSD is not a fatal disorder, but can lead to conduct disorder, delinquency, depression, substance abuse, and other risk-taking behavior that can pave the way to substantial hazards.

Assessment of the child or adolescent includes a thorough psychiatric history, from the patient's perspective, as well as collateral information from family, social workers, teachers, mental health care workers, and primary care clinicians. Observation of the patient's behavior, play, and drawings helps to assess the non-verbal child. It is also important to understand the patient's and his or her family's strengths and abilities. Sensitive interviewing may be necessary to help the child speak about traumatic experiences.

Currently there are multiple treatment approaches for children with trauma histories and behavior problems that take into account a variety of factors including a child's developmental stage, cultural background, and treatment setting. A detailed list of treatments is maintained by the National Child Traumatic Stress Network website (www.nctsn.org). Referral of a child with significant PTSD should be to a treater who is skilled in one of the evidence based treatments at this website. The preliminary components of the various treatments are to ensure safety and that basic needs are met, addressing medical issues, nutrition, and sleep. It is important to provide psycho-education about the key behavioral symptoms that are responses to traumatic events and to support and empower caregivers to continually facilitate the child's recovery. The child is encouraged to participate in activities and resume routines to rebuild his or her sense of competency and normalcy.

The goals of treatment are for the child to progress developmentally and adopt positive coping strategies to regulate his or her affect. Ideally, the treatment enables the child to integrate the traumatic event into her/his experience to the extent that s/he is able to retell the event without an increase in distressing feelings. The child is taught relaxation techniques, which can then be used when hyper-arousal symptoms emerge in remembering and retelling the traumatic event. Parents and children should be informed that recurrence of PTSD symptoms can occur following future traumatic experiences, and return to mental health treatment may be helpful.

Although therapy is considered first line in ameliorating PTSD, medication can be used to manage specific symptoms of PTSD and comorbid conditions. Selective Serotonin Reuptake Inhibitors (SSRIs) are used to treat severe anxiety and depressive symptoms. Antihypertensive medication, such as clonidine and guanfacine, can be used to decrease hyperarousal symptoms. There are no medications that are officially indicated for treatment of childhood PTSD.

Childhood PTSD can cause significant impairment in development and overall functioning. Although the manifestations of symptoms differ from those that are described for adults, once recognized, the condition is manageable and can improve through proper treatment and care.