Posttraumatic Stress Disorder

How can children with posttraumatic stress disorder be identified?

- Children with posttraumatic stress disorder (PTSD) are most easily identified if caregivers and child care and early education professionals are aware that they have experienced a significant trauma in their past, including a motor vehicle crash, significant medical procedure, house fire, natural disaster, sexual or physical abuse, or exposure to family interpersonal violence or neighborhood violence.
- Children with PTSD can also be identified by looking for observable signs and symptoms described herein.
- It is important to realize that some of the symptoms are subtle and might not seem as obvious if the child care or early education professional is not aware of trauma exposure, either because the parents are not aware or because the family has not shared the information.
- Children with PTSD can be identified by using standardized mental health screenings, such as the Early Childhood Screening Assessment, Preschool Pediatric Symptom Checklist, Pediatric Symptom Checklist for school-aged children, or a specific trauma-focused measurement tool.

How common is it?

- Among preschoolers, fewer than 1% of children have PTSD at any one point; by adolescence, about 5% of children will have had PTSD at some point.[1,2]
- About 16% of children who are exposed to potentially traumatic events will develop PTSD, with the highest rates occurring among girls who are exposed to interpersonal trials (32%).[3]
- Even more children who are exposed to potentially traumatic events will develop non-PTSD mental health problems, such as sleep problems, anxiety, mood disorders, attention-deficit/hyperactivity disorder (ADHD), or disruptive behavioral problems.

What are the behaviors usually seen?

- The behaviors seen most are fear that occurs with reminders of the trauma and avoidance of those reminders.
  - Reminders may include talking about the trauma or the people involved, specific sounds (including tone of voice), smells, particular kinds of touch or closeness to others, specific kinds of people (based on sex, race, or build), places, or thoughts.
  - Signs of fear can be
    - Obvious emotional distress (eg, sadness, anger, fear, appearing frozen)
    - Body signals (eg, faster breathing and heart rate, sweating, stomach distress, pupils enlarging)
- Signs of repetitive, uncontrollable thoughts about the trauma may also be observed.
  - Older children with PTSD may talk about the trauma or related topics, even when the conversation isn't about that.
  - Younger children with PTSD may play out the trauma with toys or people (including being aggressive toward another child, if that was the traumatic event they were involved in).
  - Nightmares may occur.
- Negative emotions and social withdrawal may be observed in children with PTSD.
- Children with PTSD may display emotional reactivity and the following signs of being "on alert":
  - Keeping track of where everyone is and whether they are safe or under control
  - Sleep problems
  - Irritability
  - Having a highly reactive "startle" response to sudden, unexpected noises or movements
  - Reduced concentration

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When should a more concerning issue be suspected?

- If a child has a known chronic or new exposure to trauma, monitoring the child for these kinds of patterns is recommended.
- It is not uncommon for child care and early education professionals to not be aware of a child's exposure to trauma—and sometimes, parents are not aware of the trauma either. In these cases, red flags should include new development of these symptoms in a child or the presence of a number of these symptoms in a child who is new to the class or the child care program.
- Full-blown PTSD does not resolve without specialty treatment, so if these patterns are observed and last longer than 2 weeks, the teacher or child care professional should alert caregivers and encourage them to follow up with a mental health professional or the child's pediatrician.

What are typical management strategies in the behavioral support plan?

- The most important strategy for a child with PTSD is to make sure he or she is safe and that the child *feels* safe. In child care and education settings, adults should ensure that the physical space is safe, that adults and children are physically and emotionally safe toward each other, and that there are no threats of violence, especially from adults to any children. Specifically, while research shows that all children are at risk from the damaging effects of corporal punishment and other demeaning adult behaviors, children with exposure to trauma are especially vulnerable to significant emotional damage from corporal punishment or threats of corporal punishment, as well as from forced seclusion and isolation or public shaming.
- Children with PTSD benefit from predicable routines and schedules, including expectations for their behaviors. Emphasis should be placed on giving praise for positive behaviors and communicating routine expectations for their own safe behaviors.
- When a child is safe, an adult can address distress by reminding the child that he or she is safe in this setting and that the adults are working together to keep the child safe.
- Understanding the specifics of the traumatic event that the child experienced can help child care and early education professionals avoid unintentional exposure to reminders of the trauma. For example, children who have been in a traumatic event involving emergency vehicles and their sirens may experience extreme distress during a fire alarm. Similarly, activities focused on weather and predicting storms may exacerbate symptoms in a child who has PTSD related to natural disasters.
- It can be helpful to label children's apparent feelings when they are distressed: "It looks like you got scared when the fire alarm went off. But you are OK. We are all safe, and we're just practicing how to be safe. The grown-ups have a plan for keeping you safe when the alarm goes off."
- It is also useful to teach children relaxation strategies they can use to manage mild distress and body reactions to stress, such as breathing or muscle relaxation.
- Adults should monitor themselves for their own emotional reactions to children's traumatic history, especially if they have had similar experiences that might lead them to overprotect children, withdraw from children, or feel angry around children.

When should I ask for additional support?

- A mental health consultant can help tailor expectations for children with PTSD.
- If a child is suspected of having PTSD, child care staff can recommend that parents discuss the concerns with the child's pediatrician, a developmental and behavioral pediatrician, or a mental health clinician (eg, child and adolescent psychiatrist, psychologist, clinical social worker) who has expertise in this age group.
- Treatment of PTSD in young children begins with therapy called *cognitive behavioral therapy*, in which children learn to name their feeling and the intensity (ie, none, some, a lot), learn relaxation strategies such as diaphragmatic breathing or muscle relaxation, and

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practice being exposed to mild, and then more intense situations that might trigger anxiety and distress about the traumatic event. This is done by measuring their distress level, practicing their relaxation strategy, and then measuring the distress again, with the goal of working up to mastering more intense anxiety triggers (**Figure 1**).

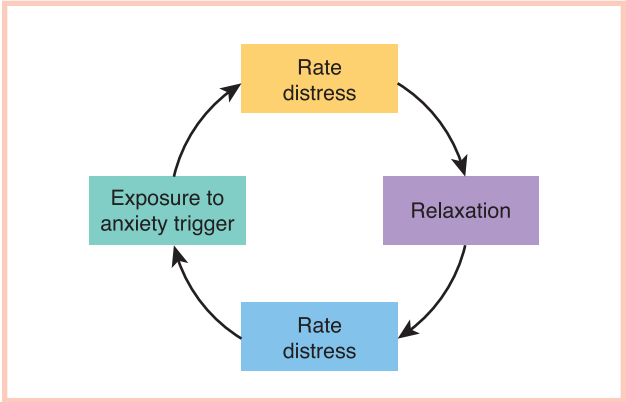

Figure 1. The cognitive behavioral therapy cycle.

- There is no research to indicate that medications are helpful in treating PTSD in preschoolers or school-aged children. There are some occasions when medications may be used to treat other co-occurring conditions, such as anxiety disorders or ADHD (see the Fear and Anxiety and Attention-Deficit/Hyperactivity Disorder Quick Reference Sheets for more details).
- Traumatic events that involve children often include their parents or are frightening for their parents. In treatment, pediatricians and other primary care clinicians will encourage parents and caregivers to monitor their own reactions, take care of themselves, and seek treatment if they are struggling.
- Children's physicians, therapists, or clinicians who treat anxiety disorders may ask teachers to complete questionnaires that ask about the child's symptoms. These questionnaires are helpful in the assessment process, as well as in tracking the effects of the treatment. It is helpful to add written comments to expand on questionnaire responses. Responses can be returned to families without any formal, specific consent process and can be sent directly to the pediatrician with parents' consent. Direct communication with a treating clinician can be invaluable. The more information that is made available to the child's therapist, the more specific the treatment plan can be.

What training and/or policies may be needed?

Training child care staff and educators is important to avoid misinterpreting PTSD symptoms as oppositional or "bad" behaviors, especially if the child is acting out the traumatic events, such as aggressive exposures or sexual acts. Training may also need to be focused on talking about safety with children and practicing coping or relaxation strategies, such as deep breathing, muscle relaxation, or meditation.

Where can I find additional resources?

National Child Traumatic Stress Network (https://www.nctsn.org)

References

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