PostTraumatic Stress Disorder:

Increasing Awareness of the Source of Multiple Possible Reactions to Severe and Chronic Stress

Dr. Justin J. Boseck, Ph.D., L.P., ABPdN, CBIS, NCSP
Board-Certified Pediatric Neuropsychologist,
Fellow of the American Board of Pediatric Neuropsychology,
Licensed Psychologist (ND 490),
Certified Brain Injury Specialist, and
Nationally Certified School Psychologist

NORTH Dakota | Health
Be Legendary.™

OBJECTIVES

1. Outline the types of child abuse and neglect and their potential outcomes
2. Identify diagnostic criteria for Posttraumatic Stress Disorder (PTSD)
3. Identify treatment approaches for PTSD

INTRODUCTION

- Trauma- and stressor-related disorders is a new category in the *DSM-5*
- Includes:
  - Acute Stress Disorder
  - Adjustment Disorder
  - Posttraumatic Stress Disorder (PTSD)
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder

TRAUMA AND STRESS

- Trauma and stressful experiences in childhood or adolescence may involve:
  - Actual or threatened death or injury, or a threat to one's physical integrity.
- Children exposed to chronic or severe stressors, e.g., major accidents, natural disasters, kidnapping, brutal physical assaults, war and violence, or sexual abuse, have an elevated risk of PTSD

HOW STRESS AFFECTS CHILDREN

- Children and youths need a basic expectable environment to adapt successfully
- Stressful events affect each child in different and unique ways
  - Hyperresponsive reactions
  - Hyporesponsive reactions
  - Allostatic load: progressive “wear and tear” on biological systems due to chronic stress

RACIAL/ETHNIC CONSIDERATIONS

- The majority of substantiated maltreated victims are white (44%), African-American (22%), or Hispanic (21%)
- Compared to children of same race or ethnicity in the U.S.
  - Highest rates of victimization are for children who are African-American (15.1/1000), American Indian or Alaska Native (11.6/1000), and multiple race (12.4/1000), white and Hispanic (8/1000), and Asian (2/1000)

POSTTRAUMATIC STRESS DISORDER

(A) Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
(1) Directly experiencing the traumatic event(s).
(2) Witnessing, in person, the event(s) as it happened to others.
(3) Learning that the event(s) happened to a close relative or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
(4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

POSTTRAUMATIC STRESS DISORDER

(B) Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

(1) Recurrent, involuntary and intrusive distressing memories of the traumatic event(s). Note: In young children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

(2) Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.

POSTTRAUMATIC STRESS DISORDER

(3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). Note: In young children, trauma-specific reenactment may occur in play.
(4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
(5) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

POSTTRAUMATIC STRESS DISORDER

(C) Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
(1) Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
(2) Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

POSTTRAUMATIC STRESS DISORDER

(D) Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

(1) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

(2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. “I am bad,” “No one can be trusted,” ”The world is completely dangerous; “My whole nervous system is permanently ruined”).

POSTTRAUMATIC STRESS DISORDER

(3) Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
(4) Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
(5) Markedly diminished interest or participation in significant activities.
(6) Feelings of detachment or estrangement from others.
(7) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

POSTTRAUMATIC STRESS DISORDER

(E) Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
(1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
(2) Reckless or self-destructive behavior.
(3) Hypervigilance.
(4) Exaggerated startle response.
(5) Problems with concentration.
(6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

POSTTRAUMATIC STRESS DISORDER

(F) Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.
(G) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
(H) The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.
Specify if:
With Dissociative Symptoms: The individual's symptoms meet the criteria for post-traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
(1) Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes of body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
(2) Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted).

POSTTRAUMATIC STRESS DISORDER CHILDREN SIX AND YOUNGER

(A) In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more of the following ways):

(1) Directly experiencing the traumatic event(s).

(2) Witnessing, in person, the event(s) as it occurred to other, especially primary caregivers. Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

(3) Learning that the traumatic event(s) occurred to a parent or caregiving figure.

POSTTRAUMATIC STRESS DISORDER CHILDREN SIX AND YOUNGER

(B) Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

(1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be experienced as play reenactment.

(2) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be experienced as play reenactment.

(3) Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: It may not be possible to ascertain that the frightening content is related to the traumatic event(s).

(4) Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). Such trauma-specific reenactment may occur in play.

(5) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

(6) Marked physiological reactions to reminders of the traumatic event(s).

POSTTRAUMATIC STRESS DISORDER CHILDREN SIX AND YOUNGER

(C) One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

(1) Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).

(2) Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

(3) (3) Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).

(4) Markedly diminished interest or participation in significant activities, including constriction of play.

(5) Socially withdrawn behavior.

(6) Persistent reduction in expression of positive emotions.

POST-TRAUMATIC STRESS DISORDER CHILDREN SIX AND YOUNGER

(D) Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

- **(1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums.**
- **(2) Hypervigilance.**
- **(3) Exaggerated startle response.**
- **(4) Problems with concentration.**
- **(5) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).**

(E) The duration of the disturbance is more than a month.

(F) The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or with school behavior.

(G) The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

ASSOCIATED OUTCOMES

- May persist for decades and in some cases for a lifetime (Nader & Fletcher, 2014).
- Children and youth with chronic PTSD may display a developmental course marked by remissions and relapses
- Children exposed to a traumatic event may not exhibit symptoms until months or years later

MOOD AND AFFECTIVE DISTURBANCES

- Symptoms of depression, emotional distress, and suicidal ideation are common among children with histories of physical, emotional, and sexual abuse
- Teens with histories of maltreatment have a much greater risk of substance abuse
- Childhood sexual abuse also can lead to eating disorders, such as anorexia nervosa and bulimia nervosa
- In reaction to emotional and physical pain from abusive experiences, children or adults voluntarily or involuntarily may induce an altered state of consciousness known as dissociation

PREVENTION AND TREATMENT

- Obstacles to intervention and prevention services for maltreating families
  - Those most in need are least likely to seek help
  - They are brought to the attention of professionals after norms or laws have been violated
  - Parents do not want to admit to problems for fear of losing their children or being charged with a crime

THERAPIES

- Exposure-Based Therapy (Psychological First Aid)
  - Following acute stress or trauma, such as motor vehicle accidents, shootings, bombings, and hurricanes
  - Early exposure intervention has reduced acute stress symptoms
  - Many of these interventions are brief, ranging from 1 to 10 sessions
  - Are often delivered in groups to reach as many children as possible.
- Grief and Trauma Intervention for Children
- Trauma-Focused Cognitive Behavioral Therapy

Post-Traumatic Stress Disorder:

Increasing Awareness of the Source of Multiple Possible Reactions to Severe and Chronic Stress

Dr. Justin J. Boseck, Ph.D., L.P., ABPdN, CBIS, NCSP
Board-Certified Pediatric Neuropsychologist,
Fellow of the American Board of
Pediatric Neuropsychology,
Licensed Psychologist (ND 490),
Chief of Psychology,
Certified Brain Injury Specialist, and
Nationally Certified School Psychologist

NORTH Dakota | Health
Be Legendary.™