# Exposure to Trauma or Loss/ PTSD

We can stop Toxic Stress.

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Advertising Disclaimer

## Bereavement Fact Sheet

**Prevalence**

The vast majority of children will experience the death of a family member or friend sometime during their childhood. Five percent of children will experience the death of a parent by age 16.

**Risk Factors for Complicated Grief**

- Sudden and unanticipated death (especially if traumatic or violent, or the result of suicide or homicide) or death after a very long illness
- Perception of death as being preventable
- Death when the child is less than 5 or during adolescence
- Other losses in the child's life or ongoing stressors
- Angry, ambivalent or dependent relationship between the child and deceased
- If parent remarries and there is an unsupportive relationship between the child and stepparent
- Pre-existing mental health problem in the child
- Inadequate support within the family or community for the child

**How Can Pediatricians Provide Assistance?**

Pediatricians can draw upon their established relationship with the child and family in order to:

- Actively listen to the child and be with the child/family while they express their grief
- Provide guidance on normal reactions to grief
- Identify and address guilt reactions and misconceptions
- Provide concrete advice on how to support children, such as issues relating to funeral attendance
- Identify and address somatization
- Screen for rare but more serious reactions, such as depression
- Provide referrals to community resources (e.g., children's bereavement support groups)
- Provide follow-up - contact children after time has passed to see how they are doing

**Examples of Comments to Avoid**

**DO NOT** try to cheer-up children who are actively grieving (e.g., "I know it hurts very much right now, but I know you will feel better within a short period of time"). Allow children to grieve.

**DO NOT** encourage the child or parent to cover up their emotions (e.g., "You need to be strong for your mother/son. You don't want them to see you crying, do you?").

**Do** express your own feelings and demonstrate empathy (e.g., "I realize this must be extremely difficult for you" or "I can only begin to imagine how painful this must be"), but AVOID statements such as:

"I know exactly what you are going through" (You cannot know this.)
"You must be angry" (Let the individual express his/her own feelings. Do not tell him/her how to feel.)
"Both my parents died when I was your age" (Do not "compete" with the survivor for sympathy.)

**Advice to Give to Parents on Funeral Attendance**

Children, just as adults, often benefit from participating in the funeral and other ceremonies. Explain to children concretely what to expect and invite them to participate to the level they feel comfortable. Do not coerce children to do something that makes them uncomfortable (e.g., kissing the deceased). Identify a "partner" to guide the child and monitor reactions throughout the event. He/She can answer the child's questions and allow the child to leave temporarily or permanently if the child so desires. He/She should be well known to the child, understand the child's developmental needs and preferably not be actively grieving so as to be able to attend to the child's needs.

**Remember**... Notify families that you are interested in learning about important events that may impact their child's life, such as the death of a family member or friend. Otherwise they may not contact you for support at such times.

Help parents find support for themselves, so they are better able to support their children.

Be sure to follow-up with families over time since grieving is a long-term process.

View the Case Summary

## When to be concerned about grief

Children who are having serious problems with grief and loss may show one or more of these signs:
•an extended period of depression in which the child loses interest in daily activities and events
•inability to sleep, loss of appetite, prolonged fear of being alone
•acting much younger for an extended period
•excessively imitating the dead person
•believing they are talking to or seeing the deceased family member for an extended period of time
•repeated statements of wanting to join the dead person
•withdrawal from friends
•sharp drop in school performance or refusal to attend school

# Childhood trauma

- 22% of children in national study exposure to 4 or more types of trauma in their life (Tuner et al 2010)
- Telephone survey of 4000 children 0-17 – 15% experienced maltreatment by caregiver (5% physical abuse) 5.8% witnessed domestic violence. 2% girls experiences sexual abuse (Finkelhor et al 2015)
- Feliti et al in adverse childhood experience study of 9000. ¼ reported 2 categories of childhood trauma.

# Acute stress disorder

A. Exposure to actual or threatened death, serious injury, sexual violence in one or more of the following ways

1. Directly experiencing the traumatic events
2. Witnessing, in person, the events as it occurred to others, (does not include witness in only electronic media, television, movies or pictures.
3. Learning that the traumatic events occurred to a close family member or friend (in the case of the actual or threatened death of a family member or friend the events must have been violent or accidental)
4. Experiencing repated or extreme exposure to aversive details of the traumatic events (first responders collecting human remains, police officers repeatedly exposed to details of child abuse)

B. Presence of 9 or more of the following from any of the five categories of intrusion, negative mood, dissociation, avoidance and arousal, beginning or worsening after the traumatic event occurred.

INTRUSION SYMPTOMS

1. Recurrent, involuntary and intrusive distressing memories of the traumatic events (In children, repetitive play may occur in which themes or aspects of the traumatic event are expressed.
2. Recurrent distressing dreams in which the content and or affect of the dream are related to the traumatic events (In children there maybe frightening dreams without recognizable content)
3. Dissociative reactions (flashbacks) in which the child feels or acts as if the traumatic events are recurrent (such reactions may occur on a continuum, with the most extreme expression being complete loss of awareness of present surroundings) In children such trauma-specific reenactment may occur in play
4. Intense or prolonged psychological distress at the exposure of the internal or external cues that symbolize or resemble an aspect of the traumatic event

NEGATIVE MOOD

5. Persistent inability to experience positive emotions (inability to experience happiness, satisfaction or loving feelings)

DISSOCIATIVE SYMPTOMS

6. An altered sense of the reality of one's surrounding or oneself (e.g. seeing oneself from another's perspective, being in a daze, time slowing
7. Inability to remember an important aspect of the traumatic event (typically due to dissociative amnesia and not other factors due to head injury, alcohol or drugs)

# Acute Stress Disorder

**AVOIDANCE SYMPTOMS**

8. Efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic events
9. 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 events.

**Arousal symptoms**

10. Sleep disturbance (difficulty falling or staying asleep, restless sleep
11. Irritable behavior or angry outburst (little or no provocation), typically expressed as verbal or physical aggression towards people or objects
12. Hypervigilance
13. Problems with concentration
14. Exagerrated startle response

C. Duration of the disturbance is 3 days to 1 month after the trauma. (symptoms typically begin immediately after the trauma but persist for at least 3 days and up to a month)

# Post Traumatic Stress Disorder

The following criteria apply to adults, adolescents, and children older than 6 years.

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 events
   2. Witnessing, in person, the events as it occurred to others.
   3. Learning that the traumatic events occurred to a close family member or close friend. In the cases of actual or threatened death of a family member or firend the events must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic events

   The criterion DOES NOT apply to exposure through electronic media, television, movies or pictures unless exposure is work related.

B. Presence of one or more of the following intrusion symptoms associated with the traumatic events beginning after the traumatic events occurred
   1. Recurrent, involuntary and intrusive distressing memories of the traumatic events
   2. Recurrent distressing dreams in which the content and or affect of the dream are related to the traumatic events
   3. Dissociative reactions (flashbacks) in which the child feels or acts as if the traumatic events are recurrent (such reactions may occur on a continuum, with the most extreme expression being complete loss of awareness of present surroundings)
   4. Intense or prolonged psychological distress at the exposure of the internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. Marked psychological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event

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).

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").

   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).

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).

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.

# PTSD criteria for Children 6 and under

A. Exposure to actual or threatened death, serious injury, sexual violence in one or more of the following ways
   1. Directly experiencing the traumatic events
   2. Witnessing, in person, the events as it occurred to others, **especially primary caregivers** (does not include witness in only electronic media, television, movies or pictures.
   3. Learning that the traumatic events occurred to a **parent or caregiver figures**

B. Presence of one or more of the following intrusion symptoms associated with the traumatic events beginning after the traumatic events occurred
   1. Recurrent, involuntary and intrusive distressing memories of the traumatic events **(spontaneous and intrusive memories my not necessarily appear distressing and my be expressed as play re-enactment**
   2. Recurrent distressing dreams in which the content and or affect of the dream are related to the traumatic events **(it may not be possible to ascertain that the frightening content is related to the traumatic event)**
   3. Dissociative reactions (flashbacks) in which the child feels or acts as if the traumatic events are recurrent (such reactions may occur on a continuum, with the most extreme expression being complete loss of awareness of present surroundings) **Such trauma-specific reenactment may occur in play**
   4. Intense or prolonged psychological distress at the exprosure of the internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. Marked psychological reactions to reminders of the traumatic events

# PTSD criteria for Children 6 and under

C. One or more of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic events or negative alterations in the cognitions and moods associated with the traumatic event must be present, beginning after the event or worsening after the event

**Persistent Avoidance of Stimuli**

1. Avoidance of or efforts to avoid activities, places or physical reminders that arouse recollections of the traumatic events
2. Avoidance of or efforts to avoid people, conversation or interpersonal situations that arouse recollections of the traumatic events

**Negative Alterations in Cognitions**

3. Substantially increased frequency of negative emotional states (fear, guilt, sadness, shame, confusions)
4. Markedly diminished interest or participation in significant activities including constriction of play
5. Socially withdrawn behaviors
6. Persistent reduction in expression of positive emotions

# PTSD for children 6 years and younger

D. Alterations in arousal and reactivity associated with the traumatic events, beginning or worsening after the traumatic events occurred, as evidence by two or more of the following

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

E. Duration of > 1 month

# Screening Recommendations

- Mental Health evaluations should routinely include questions about exposure to commonly experience traumatic events
  - Child abuse (physical/sexual)
  - Community violence
  - Serious accidents
- If screen positive – asses for PTSD
  - Juvenile Victimization Questionaire (2 to 17) (free - https://ncvc.dspacedirect.org/bitstream/id/2048/JVA-R2_IR_508.pdf )
  - Children 7+ can self report –
    - UCLA Posttraumatic Stress Disorder Reaction Index (available at no cost through Behavioral Health Innovations – must register to "purchase license" for 25 administrations)
    - Child PTSD Symptom Scale (available online at no cost)
      - https://istss.org/clinical-resources/assessing-trauma/child-ptsd-symptom-scale-for-dsm-5-(cpss-5)–
  - <7 must administer to caregiver
    - PTSD for Preschool Age Children
    - PTSD section of Child Behavior Checklist ( fee for use www.aseba.org)
    - Trauma Symptom Checklist for Children/Trauma Symptom Checklist for Young Children (Fee for use www.parinc.com)

# Instruments available on the ND Mental Health Care Access Program

## Screening and Assessment

- Adverse Childhood Experiences Questionnaire (ACE-Q) Child
  *Center for Youth Wellness*
  Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance.
- Trauma History Questionnaire (THQ)
  *Georgetown University*
  The THQ is a 24-item self-report measure that examines experiences with potentially traumatic events such as crime, general disaster, and sexual and physical assault using a yes/no format. For each event endorsed, respondents are asked to provide the frequency of the event as well as their age at the time of the event.
- Traumatic Stress Screen for Children and Adolescents (TSSCA)
  *University of Minnesota*
  The TSSCA is intended to assist child-serving professionals in using a trauma screening approach with children ages 5 to 18, who have exposure to a known or suspected traumatic event.
- Youth Pediatric Symptom Checklist-17
  *Massachusetts General Hospital*
  The Pediatric Symptom Checklist is a brief questionnaire that helps identify and assess changes in emotional and behavioral problems in children.

If screening indicates PTSD symptoms conduct formal evaluation to determine if PTSD is present, severity of symptoms, Degree of functional impairment – including parents and other caregivers as appropriate

- Child PTSD Symptom Scale rating of functional impairment to allow monitoring of treatment
  - (https://istss.org/clinical-resources/assessing-trauma/child-ptsd-symptom-scale-for-dsm-5-(cpss-5)–

# Treatment

- Trauma Focused CBT
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

- Treat Comorbid Conditions (ADHD, Substance Abuse, Depression, Anxiety)
  - Seeking Safety model of treatment for adolescents with PTSD and Substance use

# Trauma Focused CBT

- PRACTICE acronym
- Psychoeducation about ptsd
- Parenting Skills (effective parenting skills – praise, positive attention, selective attention, time out, contingency reinforcement
- Relxation Skills (focused breathing, progressive muscle relation etc)
- Affective Modulation Skills (feeling identification, thought interruption, positive imagery – enhancing safety, problem solving and social skills. Recognize and self regulate negative affect state
- Cognitive coping and processing (recognizing relations among thoughts, feelings and behaviors
- Trauma Narrative –creating narrative of child's traumatic experiences, correct cognitive disortions about he experience, place in context of childs whole life
- In Vivo mastery of trauma reminder – graduated exposure to feared stimuli
- Conjoint child/parent sessions – share trauma narrative and address family issues
- Enhancing Safety and Development --

# CBITS

- Practice components of TF-CBT
- Teacher component to identify impact of trauma on classroom beahviors
- Group school format (trauma narrative in individual break out sessions)

# Seeking Safety

- Manualized individual or groups therapy for PTSD/Substance use

# EMDR

Eye movement desensitization and reprocessing (EMDR)

Combines imagined exposure, resource development, cognitive change and self control with bilateral sensory stimulation

8 phase program

History and treatment planning

Preparation

Assessment

Reprocessing and desensitization

Installation

Body scan

Closure

Re-evaluation of past present and future

# EMDR

- Does appear to have positive outcomes for adolescent with Dx of PTSD – positive studies in adolescent exposure to trauma but do not meet criteria for PTSD
- No studies re: necessary number/length of treatments
- No studies on Pre-adolescents

# Role of Medications?

- European Guidelines and WHO guidelines do not have a role for medications in children with PTSD (therapy only)
- AACAP treatment guidelines – Medications CAN be considered (there are no FDA approved medications for PTSD in children)
  - Fluoxetine could be considered for treatment of symptoms of PTSD
  - Potential side effects of irritability, poor sleep, or inattention; because these are symptoms of PTSD hyperarousal, SSRIs may not be optimal medications for these children.

- One open study of risperidone resulted in 13 of 18 boys experiencing remission from severe PTSD symptoms. These children had high rates of comorbid symptoms that could be expected to respond positively to risperidone; for example, 85% had coexisting ADHD and 35% had bipolar disorder.
- Both α- and β-adrenergic blocking agents have been used with some success in children with PTSD symptoms.
  - Clonidine has been found in two open studies to decrease basal heart rate, anxiety, impulsivity, and PTSD hyperarousal symptoms in children with PTSD.
  - In a case study, clonidine treatment resulted in improved sleep and increased neural integrity of the anterior cingulate.
  - Propranalol was found in an open study to decrease reexperiencing and hyperarousal symptoms in children with PTSD symptoms.

Table. New World Health Organization mhGAP Recommendations[4]

| Mental Health Condition | Recommendation | Strength of Recommendation[a] |
|---|---|---|
| Acute stress (first month after exposure to a potentially traumatic event) | | |
| Acute traumatic stress symptoms | Cognitive behavioral therapy with a trauma focus should be considered in adults | Standard |
| | Benzodiazepines should not be offered to adults | Strong |
| | Antidepressants should not be offered to adults | Standard |
| | Benzodiazepines and antidepressants should not be offered to children and adolescents | Strong |
| Secondary acute insomnia | Relaxation techniques and advice about sleep hygiene should be considered for adults | Standard |
| | Benzodiazepines should not be offered to adults | Standard |
| | Benzodiazepines should not be offered to children and adolescents | Strong |
| Secondary nonorganic enuresis | Education about the negative effects of punitive responses should be given to caregivers of children | Strong |
| | Parenting skills training and the use of simple behavioral interventions should be considered. Where resources permit, alarms should be considered | Standard |
| Hyperventilation | Rebreathing into a paper bag should not be considered for children | Standard |
| Posttraumatic stress disorder | Individual or group cognitive behavioral therapy with a trauma focus, eye movement desensitization and reprocessing, or stress management should be considered for adults | Standard |
| | Individual or group cognitive behavioral therapy with a trauma focus or eye movement desensitization and reprocessing should be considered for children and adolescents | Standard |
| | SSRIs and tricyclic antidepressants should not be offered as the first line of treatment in adults. SSRIs and tricyclic antidepressants should be considered if (a) stress management, cognitive behavioral therapy with a trauma focus, and/or eye movement desensitization and reprocessing have failed or are not available or (b) if there is concurrent moderate-severe depression | Standard |
| | Antidepressants should not be used in children and adolescents | Strong |
| Bereavement | Structured psychological interventions should not be offered universally to bereaved children, adolescents, and adults who do not meet criteria for a mental disorder | Strong |
| | Benzodiazepines should not be offered to bereaved children, adolescents, and adults who do not meet criteria for a mental disorder | Strong |

Abbreviation: SSRI, selective serotonin reuptake inhibitors.

[a] Strong indicates that the recommendation should be followed in all or almost all circumstances. Standard indicates that there may be circumstances in which the recommendation does not apply.