Trauma in Children by Gary Johnston

Level of trauma can vary from child to child depending on their emotional makeup, diet and pre-existing anxiety levels.

Note: Normal symptomology tests used to identify trauma in adults are not applicable to young children because of their inability to express what is going on for them emotionally.

Causes

- PTSD may be caused by exposure to a severe traumatic stress that threatens death or serious injury or threat to personal integrity, as follows:
    - Rape
    - Sexual and physical abuse
    - Car accidents
    - Fires
    - Experiencing war
    - Receiving a serious medical diagnosis
    - Being subjected to invasive painful treatment of medical problems

- Numerous factors increase the likelihood that a child will develop PTSD in response to a given stress, including the following:
    - Lack of social and parental support
    - Prior exposure to traumatic incidents
    - A preexisting psychiatric disorder
    - Repeated trauma
    - Trauma caused by a person (especially if by a trusted caregiver) rather than resulting from an accident

- Parental reaction is a critical factor affecting the child's reaction. Parents' anxiety and difficulty coping with life as the result of the trauma may overwhelm a child, whereas parental ability to cope and to provide a safe haven for a child may markedly affect the child's ability to deal with the stressor or the propensity to develop protracted PTSD.

- PTSD is particularly likely to develop if a child experiences dissociation at the time of the trauma.

What to look for

- Scheeringa et al (1995) recommend altering the criteria for PTSD when assessing very young children, taking into account their ability to report symptoms and the types of symptoms they are likely to have. The altered criteria do not require that the child be able to report fear, helplessness, or horror in response to the trauma.

    - Diagnosis using the altered criteria requires that the very young child undergo one of the following types of re-experiencing:
        - Posttraumatic play
        - Play reenactment
        - Recurrent recollections
        - Nightmares
        - Episodes with objective features of a flashback or dissociation
        - Distress at exposure to reminders of the event

    - The altered criteria also require only one of the following symptoms of numbing/avoidance (instead of the 3 needed for adults):
        - Constriction of play
        - Relative social withdrawal
        - Restricted range of affect
        - Loss of acquired developmental skills

- Furthermore, only one of the following symptoms of hyperarousal is required:
  - Night terrors
  - Difficulty going to sleep that is not related to fear of having nightmares or fear of the dark
  - Night waking not related to nightmares or night terrors
  - Decreased concentration
  - Hypervigilance
  - Exaggerated startle response

- Scheeringa et al endorse an additional class of symptoms to replace the eased category C and category D criteria. Symptoms of fear and aggression marked by one of the following is required::
  - New aggression
  - New separation anxiety
  - Fear of using the restroom alone
  - Fear of the dark
  - New fears of things or situations not obviously related to the trauma

- Posttraumatic play involves joyless repetitive play with traumatic themes. Children also may reenact what occurred or draw pictures related to the event. Posttraumatic dreams in children generally are vaguely formed dreams that the child may not be able to describe.

- In adolescents, the primary symptoms are likely to include invasive images (which they may not talk about), restlessness and aggression, difficulty sleeping, and difficulty concentrating. Other common symptoms include loss of interest in previously enjoyed activities, withdrawal from family and peers, and changes in significant life attitudes. Adolescents with chronic PTSD arising from repeated or prolonged trauma may suffer primarily from dissociative symptoms, numbing, sadness, restricted affect, detachment, self-injury, substance abuse, and aggressive outburst. When interpersonal abuse is the precipitant, the development of dissociative phenomena, somatic complaints, learned helplessness, loss of affect control, hostility, aggression, eating disorders, sexual acting out, personality change, change in belief system, self-destructive and impulsive behavior, substance abuse, social withdrawal, and impaired relationships are a significant possibility.

Sleep Talk® Therapy for Young Traumatised Children

Very young children do not articulate trauma in the same way adults do. The associations of trauma cannot be easily linked to a wide life experience, so trauma symptoms become very basic and relate to protective knowledge.

1. Traumatised children are best treated immediately after the trauma.
2. Touch is a critical component of early intervention (big hugs and lots of them).
3. If parents are also traumatised, especially mother, they must be treated urgently to avoid additional trauma to the child. In an Australian study the children of PTSD victims are 3 times more likely to suicide than average.
4. Make sure you know the cause of trauma and circumstances surrounding it so that appropriate content can be created for treatment.
5. Be observant of external behaviours such as acting out, drawing styles and content etc. This will give non verbal clues as to the images and kinesthetics being processed by the child, and will provide clues to reframes and Sleep Talk® affirmations required.

- If a child starts drawing dark disturbed picture, intervene and encourage going over the original drawing with brighter colours already determined to be associated with happiness. (Take them for a trip to Bunning's and stand in front of the paint samples wall. Play a game and get them to select colours that are "happy colours" and use these colours in the image reframe paintings)

- Since dream state images, sound and kinesthetic will also be related to the trauma colours and feel, use the "happy" colours in Sleep Talk® affirmations.

- Use affirmations that place funny or cartoon pictures over the dream state pictures or feelings and relate to warmth, safety, love etc.

- Affirmations MUST elicit positive colourful fun pictures, positive feelings, positive sounds.

- NEVER, NEVER, NEVER use negative words of any sort. ie: You will NOT feel sad tomorrow. The unconscious mind cannot process a negative and will produce the exact opposite to what you are trying to achieve.

- Reinforce the SleepTalk® affirmations with behaviour, language and play consistent with the affirmations and colours / kinesthetics / sounds used.

- Ensure lots of comforting physical contact and positive reinforcement

Scheeringa MS, Zeanah CH, Drell MJ, Larrieu JA. Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. J Am Acad Child Adolesc Psychiatry. Feb 1995; 34(2):191-200

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