

# Treating Traumatized Children: When and How



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*No conflict of interest to declare*



## Overview

- Trauma exposure
- Normal reaction to adversity, ASD, or PTSD
- ASD as guidelines
- Best practice: Treating symptoms
  - When and How
- Clinical Cases
- Conclusion

## Trauma exposure

- Prevalence of Trauma Exposure
  - Depends on definition
  - Majority of people are exposed to trauma once in a lifetime
  - 25% of children
- Risk factors for Trauma Exposure
  - Young people (highest rate for 16-20 years old)
  - History of prior exposure
    - Symptomatology
    - Preexisting personal characteristics

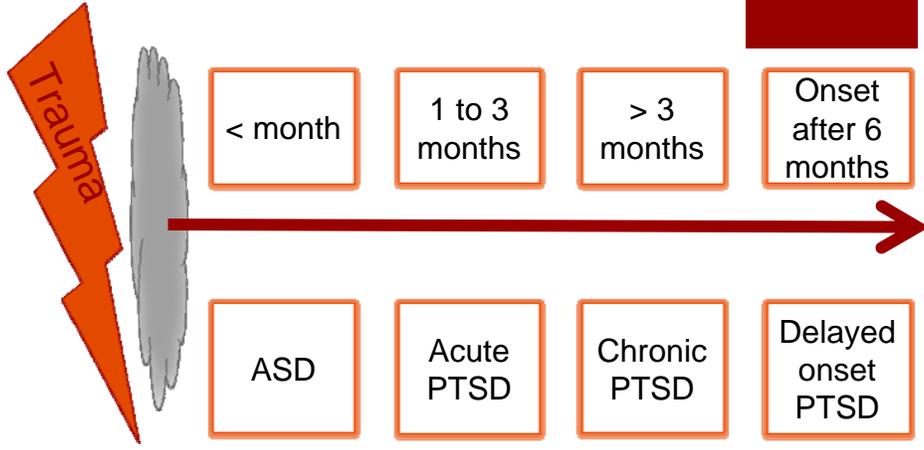
## Normal Reaction to Adversity, ASD or PTSD

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- Normal reactions to adversity
  - Extreme distress is not unexpected
- ASD:
  - Criteria G:
    - Symptoms last at least 2 days and may not last beyond 4 weeks, and occur within 4 weeks of event
- PTSD:
  - Criteria E:
    - Duration of disturbance is more than 1 month

# From Trauma to PTSD

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## Acute Stress Disorder (ASD)

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- Controversial diagnosis
- Most individuals do not develop ASD
  - Many children do not develop any significant emotional problems
- Prevalence of ASD
  - Not known; in few available studies 14% to 33%
  - Fairly new diagnosis (DSM-IV; 1994)
- Risk, protective, and maintaining factors for ASD

## Diagnostic Criteria for Acute Stress Disorder

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- A. The person **has been exposed to a traumatic event** in which **both of the following were present**:
  - the person experienced, witnessed, or was confronted with an event or events that involved **actual or threatened death or serious injury**, or a **threat to the physical integrity of self or others**
  - the **person's response involved intense fear, helplessness, or horror**

## Diagnostic Criteria for Acute Stress Disorder

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- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following **dissociative symptoms**: (specific to ASD)
  - a subjective sense of numbing, detachment, or absence of emotional responsiveness
  - a reduction in awareness of his or her surroundings (e.g., "being in a daze")
  - De-realization
  - depersonalization
  - dissociative amnesia (maybe a protective factor)

## Diagnostic Criteria for Acute Stress Disorder

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- C. The traumatic event is **persistently re-experienced** in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

## Diagnostic Criteria for Acute Stress Disorder

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- D. **Marked avoidance** of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- E. Marked **symptoms of anxiety or increased arousal** (e.g., difficulty sleeping, irritability, poor concentration, hyper-vigilance, exaggerated startle response, motor restlessness).

## Diagnostic Criteria for Acute Stress Disorder

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- F. The disturbance causes **clinically significant distress or impairment** in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
- G. The disturbance lasts for a **minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.**

## Diagnostic Criteria for Acute Stress Disorder

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- H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.  
**(differential diagnosis)**

## Treating symptoms: When

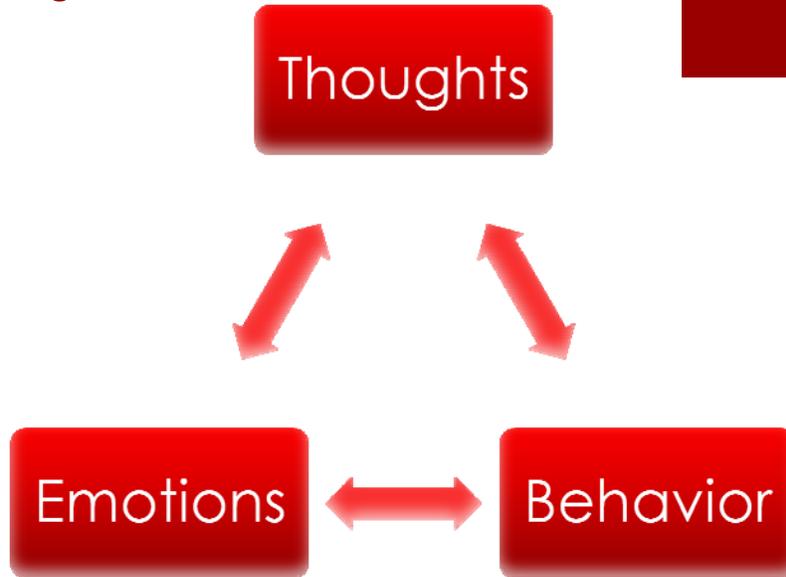
- Identifying symptoms:
  - During admission
  - After discharge
- Look for altered functioning

## Treating symptoms: How

- CBT has shown repeatedly significant efficacy for symptoms of ASD (or PTSD)
  - Exposure – Essential element
  - Cognitive therapy – restructuring and reframing
  - Breathing and relaxation exercises
  - Eye movement desensitization and reprocessing (EMDR)
  - Combination of treatments

Cognitive Model

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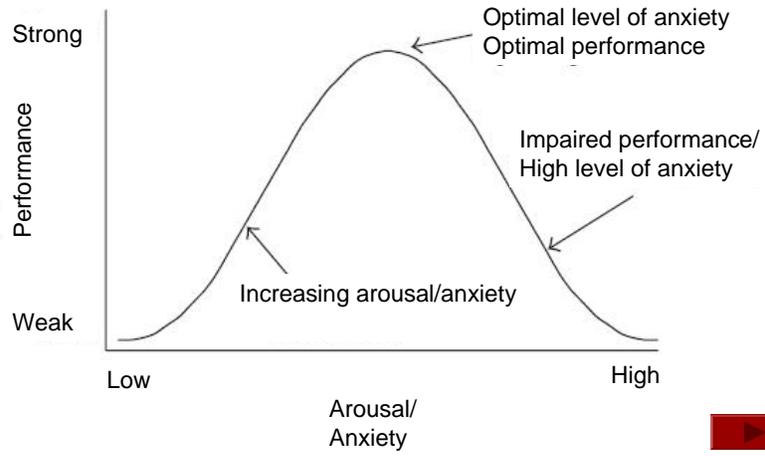


## Step by Step

- Psychoeducation on anxiety and avoidance;
- Normalize symptoms;
- History of Exposure to Trauma;
- Cognitive restructuring;
- Exposure in imagination or in vivo (if necessary or feasible);
- Monitoring anxiety level throughout the process;
- Breathing and relaxation exercises;
- Follow-up

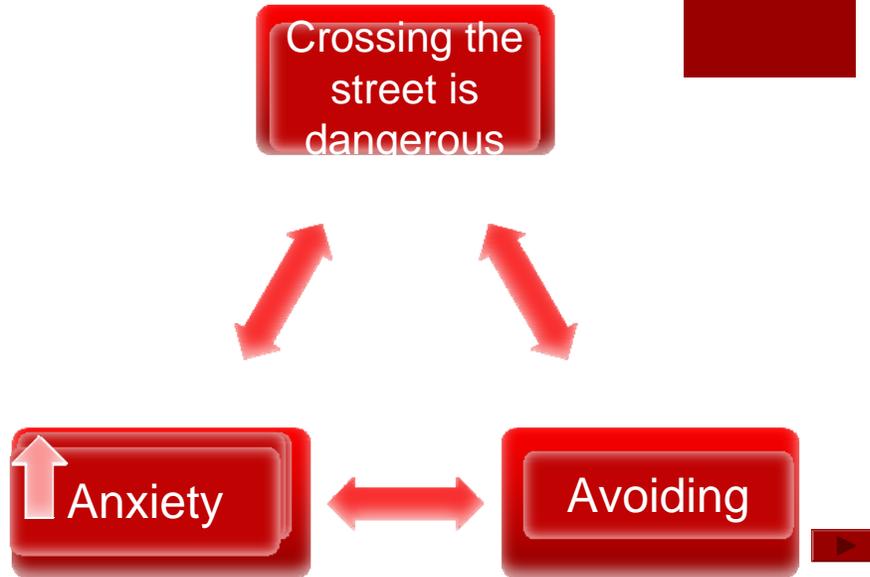
# Anxiety curve

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# Avoidance Model

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## Case 1

- 9 year old boy: Burned with explosion of *fondue* burner
  - Symptoms:
    - Nightmares; Flashbacks; Avoidance
  - Treatment (less than 1 week after event)
    - 8 sessions (family members and patient)
    - Exposure: in imagination and in vivo
    - Cognitive therapy
    - Follow-up at event anniversary



## Case 2

- 3.5 year old boy: Burned falling in fire pit
  - Symptoms:
    - Nightmares; Flashbacks; Avoidance; Hyper-vigilance (would not sleep)
  - Treatment (less than 1 week after event)
    - 6 sessions (family and patient)
    - Exposure: in imagination and in vivo
    - Cognitive therapy



## Case 3

- 2 year old boy: Severe cut in neck in bathtub
  - Symptoms:
    - Reminiscence; Avoidance; Disturbed sleep patterns
  - Treatment (3 months after event)
    - 4 sessions (family)
    - Exposure: in imagination and in vivo
    - Cognitive therapy (family sessions)
    - Intentional ignorance



## Conclusion

- Most individuals do not develop ASD or PTSD;
- Extreme distress is not unexpected;
- Looking for altered functioning;
- Recognizing and treating the symptoms might prevent developing ASD or acute or chronic PTSD;
- CBT is the best known treatment for ASD or PTSD symptoms;
- Psychologist's role.

## A few References

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