Trauma & Anxiety in Children

Caroline Elder Danda, PhD
Licensed Psychologist, Kansas City Center for Anxiety Treament, PA
Volunteer Research Assistant Professor, KUMC
drdanda@kcanxiety.com

February 19, 2007

Objectives

- Distinguish between fears and anxiety
- Provide Specific Information about Post-Traumatic Disorder & Case Examples
- Discuss First Aid for Trauma in Schools
- Overview of Psychological Treatments
- Discuss School Refusal/Avoidance
- Resources

Childhood Fears

	Age							
Fear	1	2	3	5	7	9	12	14
Separation	X	X			X			
Noises		X			X			
Falling	X				X		X	
Animals/insects	X		X	X				
Toilet training	X	X						
Bath	X	X						
Bedtime		X	X		X			
Monsters/Ghosts			X	X				
Divorce				X				
Getting lost			X	X				
Loss of Parent				X				
Social rejection						X		
War						X		
New situations						X		
Adoption						X		X
Burglars							X	X
Injections								X
Sexual relations								X

Childhood Fears

- Key questions
  - Does child's fear interrupt daily schedule more than three times per day?
  - Can anyone recall a specific trigger?
  - How do you (parents) respond?
- Fears
  - Respond to reassurance, often have plausible event as cause, child can be distracted, and does not impinge on child's play and development

Don’ts of Childhood Fears

- Use fear as a threat
- Humiliate child or belittle fear
- Be indifferent to distress
- Be unrealistic about child’s ability to master fear
- Be overprotective

Do's of Childhood Fears-

- Respect child's inclination to withdraw
- Support child to develop mastery over feared object/situation
  - Initial avoidance
  - Discussions about fear (not lectures)
  - Gradual introduction to fear
  - Modeling
- Take concrete action

Anxiety Disorders

- Most common psychiatric disorder
- 42.3 billon annual medical costs
- Lifetime prevalence 28.8%
  - 3 of every 100 children and adolescents ages 9 to 17
  - Girls more affected than boys

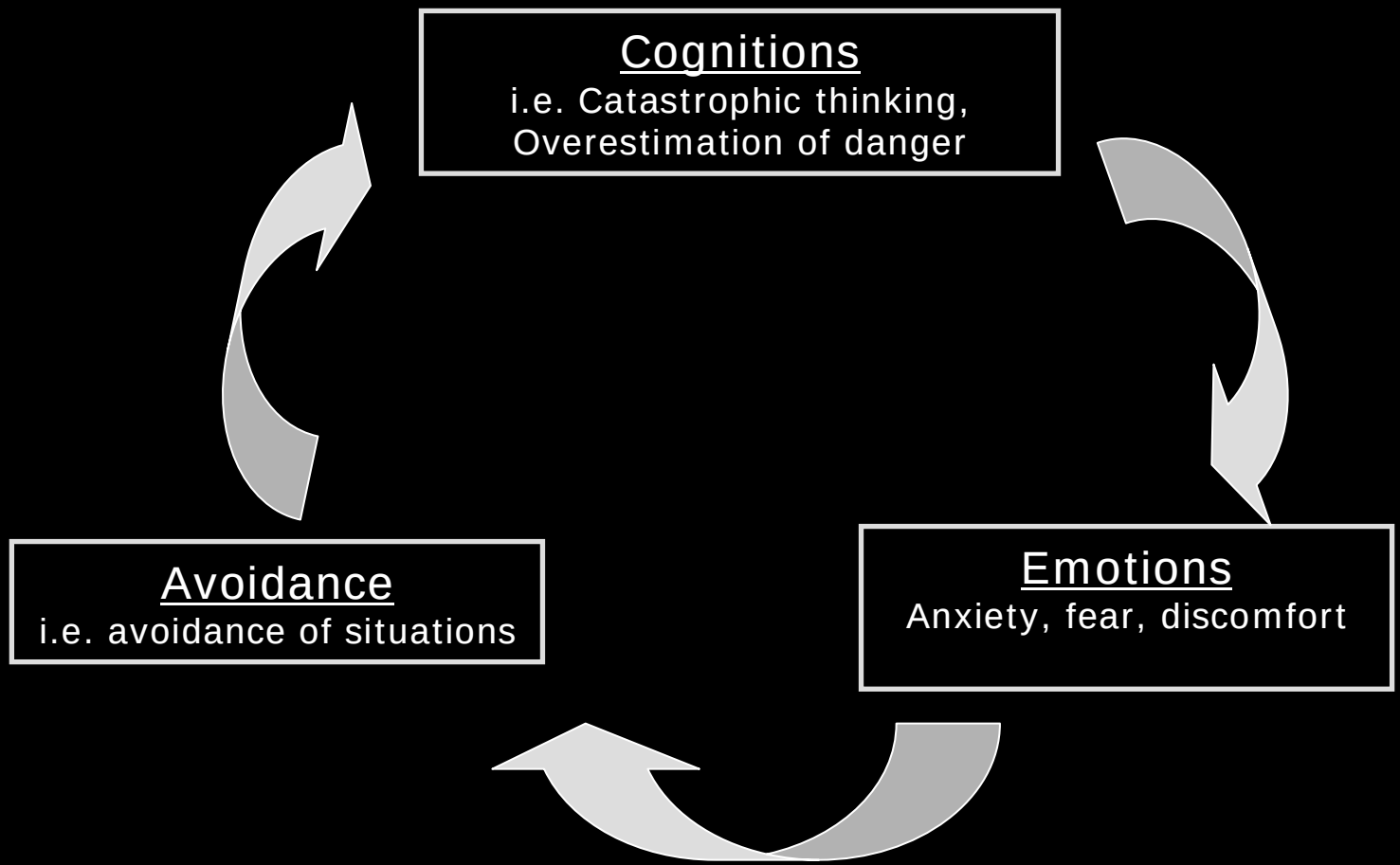
Anxiety Disorders

Specific Phobia	12.5%
Social Anxiety Disorder	12.1%
Post-traumatic Stress disorder	6.8%
Generalized Anxiety Disorder	5.7%
Panic Disorder	4.7%
Obsessive-Compulsive Disorder	3%

Comorbidity

- Anxiety Disorders
  - 1/3 meet criteria for 2 or more anxiety disorders
- Major Depression
  - Estimates range from 28% to 47% to 69%
  - Tend to be older with more severe anxiety symptoms
- ADHD
  - 15-24% of children with SAD or GAD meet criteria for ADHD

Cycle of Anxiety



DSM-IV Criteria for PTSD

A. Person has been exposed to a traumatic event and :

1. Person experienced, witnessed, or was confronted with event that involved actual/threatened death, serious injury, or threat to others
2. Person's response involves intense fear, helplessness or horror

B. The traumatic event is persistently re-experienced in one or more of the following ways

1. Recurrent and intrusive distressing recollections including images, thoughts or perceptions. (In young children repetitive play may occur where themes or aspects are expressed)
2. Recurrent distressing dreams, in children may be dreams without recognizable content
3. Acting or feeling as if the event were recurring, or they are reliving it. In children may be a reenactment
4. Intense psychological distress when exposed to external or internal cues
5. Physiological reactivity on exposure to internal or external cues that symbolize or represent the traumatic event

DSM-IV Criteria for PTSD

C. Persistent avoidance of stimuli associated with the trauma and numbing not present before the trauma – show by three or more of the following:

1. Efforts to avoid thoughts, feelings, conversations about the trauma
2. Efforts to avoid activities, places, or people that arouse recall
3. Inability to recall specific aspect of trauma
4. Markedly diminished interest in activities
5. Feelings of detachment or estrangement
6. Restricted range of affect
7. Sense of foreshortened future

D. Persistent symptoms of increased arousal not present before as indicated by two of following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

- Duration greater than a month (if less Acute Stress Disorder)
- Disturbance causes significant distress or impairment in social, occupational, or other areas of functioning
- Acute (<3 mo) vs. Chronic qualifiers, also with Delayed onset (after 6 months)

PTSD criteria in summary

- Exposure to traumatic event (actual, threatened, or witnessed) resulting in fear, helplessness
- Repeated re-experiencing of event
- Avoidance of stimuli associated with event
- Symptoms of increased arousal
- Often involves somatic complaints

Types of Trauma

- Physical Abuse and Neglect
- Sexual Abuse
- Traumatic Grief
- Domestic Violence
- Community and School Violence
- Complex Trauma
- Medical Trauma
- Refugee and War Zone Trauma
- Natural Disasters
- Terrorism

Behavioral expression of PTSD Preschool

- Thumb sucking, bed wetting,fears, separation and stranger anxiety, clingy, self-stimulation, night terrors or sleeping problems, play reenactment, loss of bladder or bowel control, loss of previously acquired skills, loss of appetite

Behavioral expression of PTSD School aged

- Irritability, whining, regressive behavior, anxiety, depression, fear, lack of emotion, hyper-vigilance, aggression, withdrawal, school avoidance, poor concentration, amnesia for event, lots of bodily or somatic complaints

Behavioral expression of PTSD Adolescent

- Anger, guilt, shame, betrayal, rage, poor impulse control, anxiety, hopelessness, depression, sleep disturbance, appetite disturbance, opposition, loss of interest in peers, agitation or decreased energy, apathy, intrusive flashbacks, somatic complaints

Symptoms and Psychological First Aid Preschool through Second Grade

Response to Trauma	First Aid
Helplessness & Passivity	Provide support, rest, comfort, good, opportunity to play or draw
Generalized fear	Reestablish adult protective shield
Cognitive confusion (e.g., do not understand that the danger is over)	Give repeated concrete clarifications for anticipated consequences; tolerate regressive symptoms in time-limited manner
Difficulty identifying what is bothering them	Provide emotional labels for common reactions
Lack of verbalization – selective mutism, repetitive nonverbal traumatic play, unvoiced questions	Help verbalize general feelings and complaints (so they won't feel alone with their feelings)

NCTSN The National Child Traumatic Stress Network

Adapted from: PynoosRS, NaderK: (1988) Psychological first aid and treatment approach to children exposed to community violence: Research implications. Journal of Traumatic Stress 1: 445-473.

Symptoms and Psychological First Aid Preschool through Second Grade

Response to Trauma	First Aid
Attributing magical qualities to traumatic reminders	Separate what happened from physical reminders (e.g., house, monkey-bars, parking lot)
Sleep Disturbances (night terrors & nightmares, fear of going to sleep, fear of being alone, esp. at night	Encourage them to let parents & teachers know
Anxious attachment	Provide consistent caretaking (e.g., assurance of being picked up from school, knowledge of caretaker's whereabouts)
Anxieties related to incomplete understanding about death	Give explanations about physical relaity of death

NCTSN The National Child Traumatic Stress Network

Adapted from: PynoosRS, NaderK: (1988) Psychological first aid and treatment approach to children exposed to community violence: Research implications. Journal of Traumatic Stress 1: 445-473.

Symptoms and Psychological First Aid Third through Fifth Grade

Response to Trauma	First Aid
Preoccupation with own actions during event: responsibility & guilt	Help express their secretive images about event
Specific fears, triggered by traumatic reminders	Help identify & articulate traumatic reminders & anxieties; encourage them not to generalize
Retelling & replaying of even (traumatic play)	Permit them to talk and act it out; address distortions & acknowledge normality of feelings & reactions
Fear of being overwhelmed by feelings (crying, anger)	Encourage expression of fear, anger, sadness, in your supportive presence

NCTSN The National Child Traumatic Stress Network

Adapted from: PynoosRS, NaderK: (1988) Psychological first aid and treatment approach to children exposed to community violence: Research implications. Journal of Traumatic Stress 1: 445-473.

Symptoms and Psychological First Aid Third through Fifth Grade

Response to Trauma	First Aid
Impaired concentration & learning	Encourage to let teachers know when thoughts & feelings interfere with learning
Sleep disturbances (bad dreams, fear of sleeping alone)	Support them in reporting dreams, provide information about why we have bad dreams
Concerns about own & others' safety	Help to share worries; reassurance with realistic information
Altered & inconsistent behavior (e.g., unusually aggressive or reckless behavior)	Help to cope wit challenge of own impulse control (e.g., must be hard to be so angry)

NCTSN The National Child Traumatic Stress Network

Adapted from: PynoosRS, NaderK: (1988) Psychological first aid and treatment approach to children exposed to community violence: Research implications. Journal of Traumatic Stress 1: 445-473.

Symptoms and Psychological First Aid Third through Fifth Grade

Response to Trauma	First Aid
Somatic complaints	Somatic complaints
Hesitation to disturb parents with own anxieties	Offer to meet with children & parents to help children express feelings to parents
Concern for other victims & families	Encourage constructive activities on behalf of injured & deceased
Feeling disturbed, confused, frightened by their grief responses, fear of ghosts	Help retain positive memories as they work through more intrusive traumatic memories

NCTSN The National Child Traumatic Stress Network

Adapted from: PynoosRS, NaderK: (1988) Psychological first aid and treatment approach to children exposed to community violence: Research implications. Journal of Traumatic Stress 1: 445-473.

Symptoms and Psychological First Aid Adolescents (Sixth Grade and Up)

Response to Trauma	First Aid
Detachment, shame, & guilt (similar to adult response)	Encourage realistic discussion of event, feelings about it, & realistic expectations of what could have been done
Self-consciousness about their fears, sense of vulnerability, & other emotional responses; fear of being labeled abnormal	Help them understand adult nature of these feelings; encourage peer understanding & support
Post-traumatic acting out behavior (e.g., drug use, sexual acting out, delinquent behaviors)	Help to understand acting out behavior as an effort to numb their responses to, or to voice their anger over, the event
Life threatening re-enactment; self-destructive or accident-prone behaivor	Address impulse toward reckless behavior in acute aftermath; link it to challenge of impulse control associated with violence

NCTSN The National Child Traumatic Stress Network

Adapted from: PynoosRS, NaderK: (1988) Psychological first aid and treatment approach to children exposed to community violence: Research implications. Journal of Traumatic Stress 1: 445-473.

Symptoms and Psychological First Aid Adolescents (Sixth Grade and Up)

Response to Trauma	First Aid
Abrupt shifts in interpersonal relationships	Discuss expectable strain on relationships with family & peers
Desires & plans to take revenge	Elicit actual plans of revenge; address realistic consequences of these actions; encourage constructive alternatives that lessen traumatic sense of helplessness
Radical changes in life attitudes, which influence identity formation	Link attitude change to event's impact
Premature entrance into adulthood (e.g., leaving school, getting married), reluctance to leave home	Encourage postponing radical decisions in order to allow time to work through response to event & grieve

NCTSN The National Child Traumatic Stress Network

Adapted from: PynoosRS, NaderK: (1988) Psychological first aid and treatment approach to children exposed to community violence: Research implications. Journal of Traumatic Stress 1: 445-473.

Multimodal Assessment

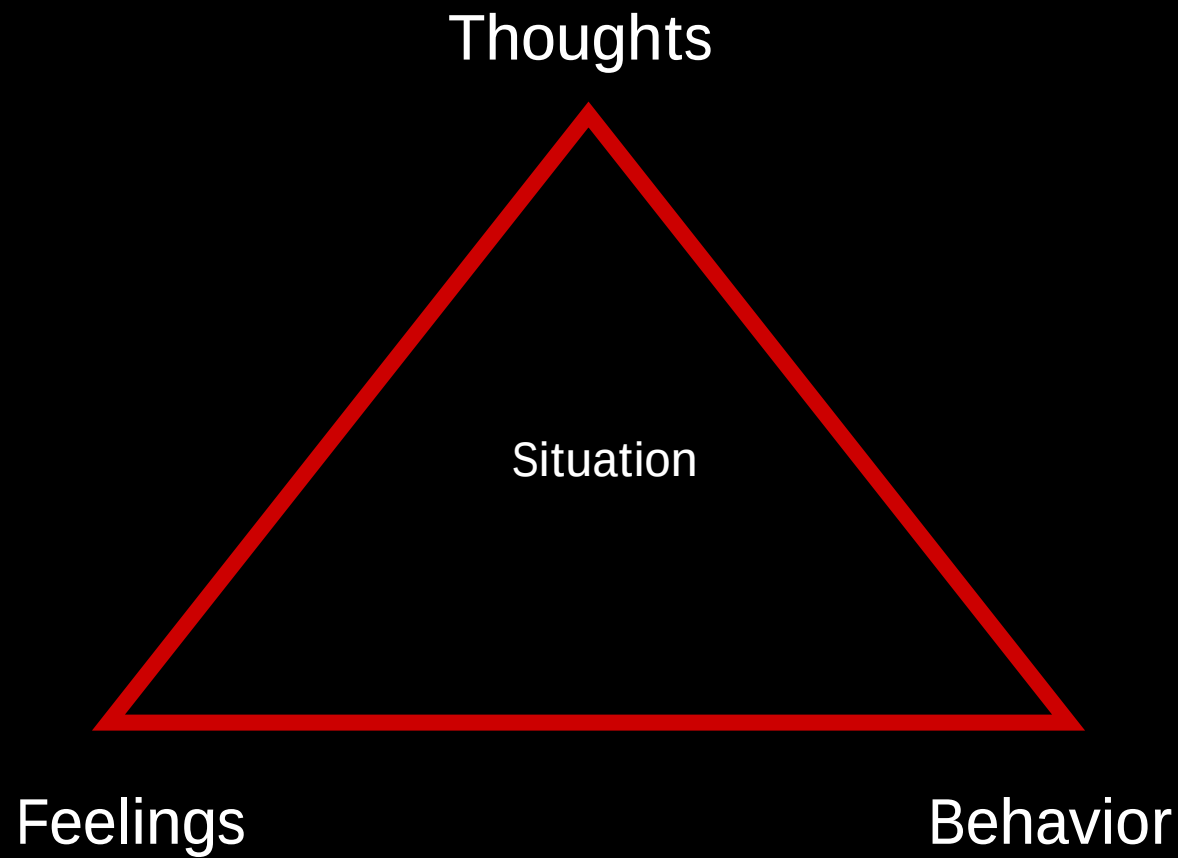
- Onset and development of anxiety symptoms
- Associated stressors/developmental challenges
- Medical history
- School history
- Family psychiatric history
- Mental status examination
- Behavioral observations

Multimodal Treatment

AACAP (1997) recommended using pharmacological treatment as an adjunct to other treatments

- Education & Support
- Cognitive Behavioral Therapy
- Relaxation Training & Exposure
- Parent Training

Cognitive Behavioral Therapy



Psychological Treatment

- Trauma Focused Cognitive Behavioral Therapy

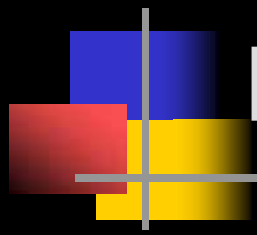
Relaxation Training

- Physiological explanation
- Deep (diaphragmatic) breathing
  - Big sigh
  - Balloon in stomach
  - Blow bubbles
- Progressive Muscle Relaxation
  - Sequence of tensing and relaxing muscles
- Imagery

Cognitive Restructuring

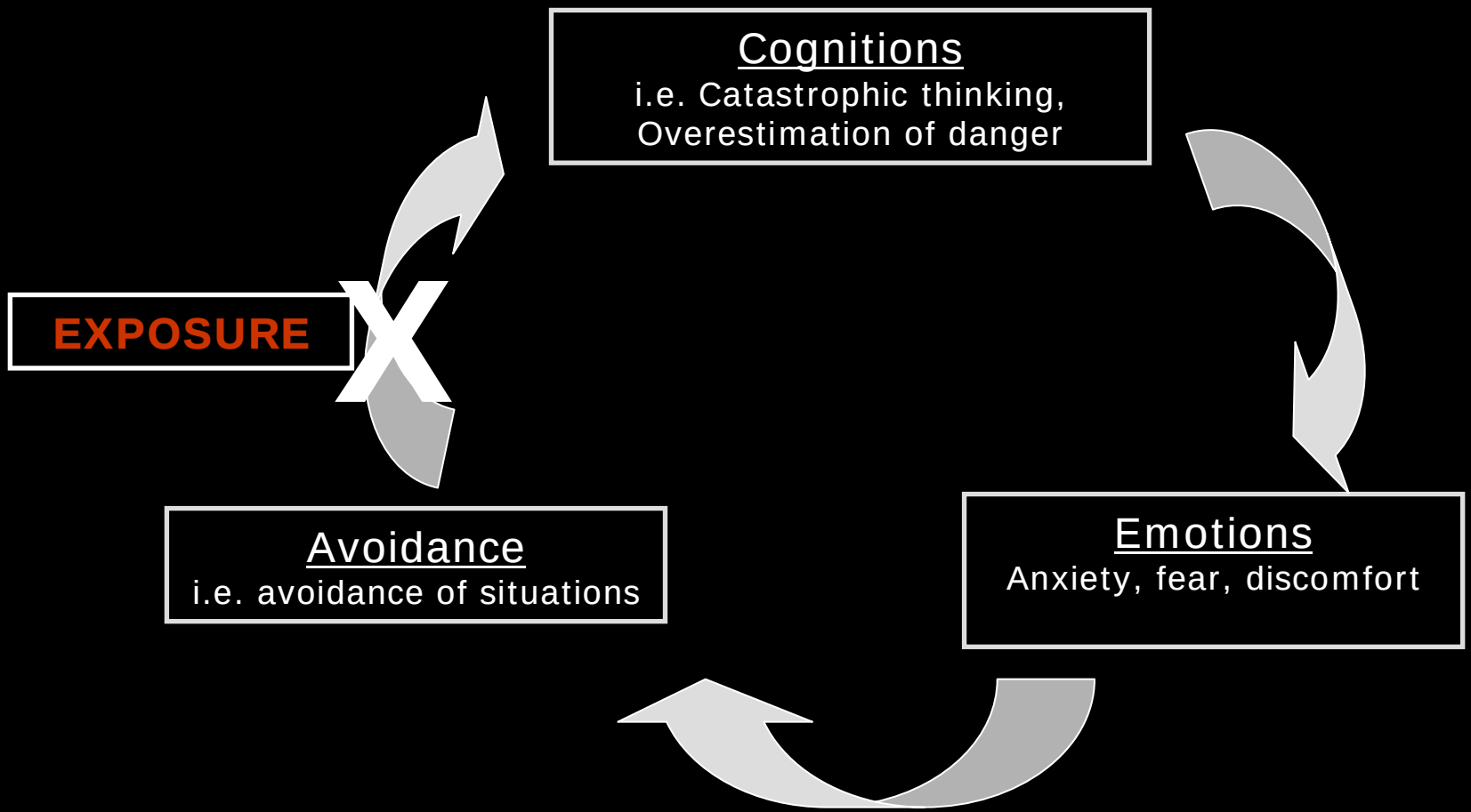
- Changing negative cognitions associated with anxiety
  - Identify negative thoughts
  - Provide alternative ways of thinking
- Thought Stopping/Distraction
- Identifying Feelings

Systematic Desensitization/Exposure



- Graduated exposure to feared object or situation based on fear hierarchy
- Imaginal and in vivo exposure
- Participant modeling

Cycle of Anxiety



School Refusal vs. Truancy

TABLE 1
Criteria for Differential Diagnosis of School Refusal and Truancy

School refusal	*Truancy*
Severe emotional distress about attending school; may include anxiety, temper tantrums, depression, or somatic symptoms.	Lack of excessive anxiety or fear about attending school.
Parents are aware of absence; child often tries to persuade parents to allow him or her to stay home.	Child often attempts to conceal absence from parents.
Absence of significant antisocial behaviors such as juvenile delinquency.	Frequent antisocial behavior, including delinquent and disruptive acts (e.g., lying, stealing), often in the company of antisocial peers.
During school hours, child usually stays home because it is considered a safe and secure environment.	During school hours, child frequently does not stay home .
Child expresses willingness to do schoolwork and complies with completing work at home.	Lack of interest in schoolwork and unwillingness to conform to academic and behavior expectations.

Anxiety-Related School Refusal

- Excessive worry; persistent separation anxiety
- Often complain of physiological signs of anxiety (e.g., stomachache, headache)
- Shy, sensitive temperament
- Often excellent students; no behavior problems
- Girls outnumber boys
- Approx. 20% precipitated by an event

Anxiety Related School Refusal

- Separation-anxious
  - Earlier age of onset; family history of anxiety and/or school refusal
- Phobic
  - More severe school refusal
  - Family history of phobias
- Anxious/depressed
  - More severe emotional symptoms
  - Moderate to severe somatic complaints (autonomic & GI symptoms)

Secondary-Gain Related

- Often follows acute illness
- Get further behind in schoolwork
- May receive sympathy or enjoy rewarding activities at home
- Boys outnumber girls
- Often poor students

Treatment of School Refusal

Primary goal: keep child in school/class

- Graduated exposure if necessary
- Periods of rest available (within reason)
- Ensure child is not overwhelmed by workload, esp. after missing lots of school, or overwhelmed by current workload (e.g., honors classes)
- Education/consultation with parents & school
- Medication

Treatment: Target Maintenance factors

- Negative affectivity
  - Relaxation training
  - Gradual reintroduction (exposure) to school
  - Self-reinforcement and building self efficacy
- Escape from aversive social or evaluative situations
  - Cognitive restructuring of negative self-talk
  - Graded exposure tasks involving real-life situations
  - Social skills training and problem-solving skills training

Treatment: Target Maintenance factors

- Attention-getting or traditional separation anxiety
  - Parent training in contingency management
  - Changing parent commands
  - Establishing routines
  - Use of rewards and punishers for school attendance and school refusal
- Positive tangible rewards
  - Contracting to increase incentive for school attendance
  - Curtail social and other activities for nonattendance
  - Provide family with problem-solving & communication skills strategies to reduce conflict

Resources

- National Child Trauma Stress Network (NCTSN)

http://nctsnet.org/nccts/nav.do?pid=hom_main

- Anxiety Disorders in Children (Fact Sheet)

http://mentalhealth.samhsa.gov/publications/allpubs/CA-0007/default.asp

- Trauma Focused Cognitive Behavior Therapy (TF-CBT) Web Training
- Psychological First Aid

http://nctsnet.org/nctsn_assets/pdfs/edu_materials/psychological_1st_aid.pdf