PTSD in Youth

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Question 1

Which of the following statements about PTSD in youth is true?

A) PTSD symptoms only develop in youth over the age of 7 years

B) PTSD can develop by witnessing domestic violence

C) The DSM-IV criteria apply equally well to adults and toddlers

D) PTSD symptoms relent in youth and rarely recur

Question 2

Which of the following treatments have been shown to be effective in the treatment of PTSD in youth?

A) Trauma-focused CBT

B) Hypnosis

C) Valproate

D) Buspirone

Question 3

Which of the following statements is true about play therapy in PTSD in children?:

A) Children with PTSD have normal play

B) Children with PTSD have more imaginative play than those without PTSD

C) Children with PTSD have routinized anhedonic play that symbolized the trauma

D) Children with PTSD never symbolize their trauma in play

Question 4

Which of the following medications may be useful to treat symptoms of PTSD in children?

A) Clonidine, hypnotics, SSRIs

B) Clonidine, valproate, buspirone

C) Hypnotics, carbamazepine, SSRIs

D) SSRIs, clonidine, carbamazepine

Question 5

Which criteria of PTSD is likely to be absent from children?

A) Re-experiencing the trauma

B) Persistent arousal symptoms

C) Persistent avoidance

D) Nightmares

E) Startle reaction

Teaching Points

- PTSD: Often overlooked in youth
- Treatment of choice for PTSD symptoms in youth is trauma-focused CBT
- Since symptoms recur in youth with chronic PTSD, treatment must be tailored to current symptoms

Outline

- DSM-IV diagnostic criteria
- Modifications of criteria for children
- Type1 and Type 2- Terr
- Risk factors
- Epidemiology
- Co-morbidity
- Management of PTSD

PTSD in youth

- Relatively new area of interest-25 years
- Lenore Terr and Chowchilla bus kidnapping sparked interest in 1981
- In 1985, Michael Rutter concluded that children's reaction to trauma were less severe than adults and did not warrant their inclusion within a diagnostic category of PTSD
- In 1987, DSM-III-R first recognized PTSD in youth

Types of Trauma

- Interpersonal: Trauma of human design; include warfare, terrorism, witnessing domestic violence, physical & sexual abuse & neglect
- Non-interpersonal: Natural disasters, accidents, life-threatening illness
- Interpersonal trauma more common in children & adolescents

DSM-IV criteria

- Criteria A: Symptoms follow a traumatic event
- Criteria B: Intrusive re-experiencing of trauma
- Criteria C: Persistent avoidance/numbing of associated stimuli
- Criteria D: Persistent symptoms of increased physiological arousal
- Creiteria E: Functional Impairment
- Criteria F: One month or more duration of symptoms

DSM-IV

Criteria-A

- ✓ Witness or experience an event with threat of death or serious injury to self or others
- ✓ Experience “intense fear, helplessness or horror”

Criteria-B

Need one of the following:

- ✓ Recurrent recollections or image
- ✓ Distressing dreams
- ✓ Flashbacks
- ✓ Intense distress if internal or external cues
- ✓ Physiologic distress if internal or external cues

DSM-IV

Criteria-C

Persistent avoidance of cues /thoughts or numbing; need 3 of the following:

- Avoid thoughts, feelings or talk about event
- Avoid cues of event
- Amnesia for important aspects of event
- Diminished interest in others
- Feeling detached from others
- Restricted range of affect
- Sense of a foreshortened future

DSM-IV

Criteria-D:

Arousal symptoms; two of the following needed:

- Difficulty falling or staying asleep
- Irritable mood or angry outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

DSM-IV criteria modifications

(De Bellis 2005)

- Criteria not sensitive for very young kids
- Also not sensitive to long-term effects of physical or sexual abuse
- Teens more likely to meet adult criteria

Event Criteria for kids: Modifications

- Younger kids may not have “feelings” or behavioral changes at the time of “disorganized or agitated behavior

Re-experiencing criteria in children: Modifications

(De Bellis 2005)

- Recurrent intrusive memories: Younger kids have repetitive play or volitional re-enactments that may be dangerous
- Recurrent dreams of event: May be non-specific
- Flashbacks: Uncommon in very young kids
- Events and symbols of events: Kids have condensation of symbols and sense of danger

Avoidance criteria in kids: Modifications

(De Bellis 2005)

- Must have cognitive ability to link the event with trying to avoid it
- Especially thoughts when quiet or at night
- Sense of foreshortened future in kids very common
- Instead of anhedonia, loss of skills or new fears including separation fears
- Instead of detachment, restricted range of affect

Arousal Criteria in kids: Modification

(De Bellis 2005)

- Startle may be generally present (maturation of inhibition develops at 8-10 years and may be prevented by PTSD)

PTSD: Three stages

- Acute: Symptoms present from 1-3 months
- Chronic: Symptoms present for > 3 months
- Delayed: Minimum of 6 months between the event and symptoms
- If symptoms resolve in one month: Acute Stress Disorder which may go on to PTSD
- Partial symptoms of PTSD may not meet criteria but still needs treatment

PTSD in Early Childhood

(Coates, 2009)

- Very young children's responses to an event trauma also involves reexperiencing, numbing/avoidance, and hyperarousal.
- 3 additional factors differentiate young children's responses to a trauma from those of older children and adults:
  - their cognitive immaturity,
  - their developmental vulnerability,
  - and the relational context of early trauma given young children's dependence on caregivers-also are discussed.

Salient features of PTSD in children

- National Center of PTSD estimates: 15-43% girls & 14-43% boys have experienced at least 1 traumatic event
- North Carolina study: 25% children experienced at least one DSM extreme stressor by age 16
- Current prevalence rate of PTSD among US adolescents: 5%
- Higher rates among females than males; events precipitating PTSD: abuse & violence

Salient features of PTSD in children

- Prevalence in pre-schoolers: 0.1%; prevalence in adolescents: 3-6%
- Difficult to detect hyperarousal, avoidance & re-experiencing before age 4 years; alternative criteria for preschoolers developed
- PTSD symptoms common within 1st month after trauma; gradually fade away after 3 months
- Children with subthreshold & threshold PTSD suffer similar clinical impairment: Need intervention

Terr's Type1 and 2

(Famularo 1996)

- No evidence-based support
- Type 1: From single event; Re-experiencing, avoiding and increased arousal (especially sleep difficulties)
- Type 2: From chronic or prolonged events; Dissociation, restricted affect, sadness and detachment

Risk factors for PTSD development

- Poor social support
- Adverse life events
- Hx childhood maltreatment
- Poor family functioning
- Family Hx psychiatric disorders
- Introversion or extreme behavioral inhibition
- Female gender
- Previous mental illness

Characteristics of PTSD play

(based on Terr, 1981)

- "Terrible sameness"- compulsive repetitiveness-driven quality to play
- Unconscious link with event
- Literalness of play with simple "defense", e.g., identification with aggressor, passive into active, doing and undoing
- Play does not relieve anxiety-contagious quality
- Wide range of ages

Re-enactment

- Potentially dangerous
- Sexual re-enactments
- Re-enactment example: Boy who had seen his father being shot and falls from porch thus repeating this action whenever he heard loud noises.

Epidemiology

- Kids 3-6% in community samples
- 14-25% after MVA (de Vries 1999)
- 20% after visualization of domestic violence (Mertin and Mohr 2002)
- Urban teens 12-36% full criteria
- Maltreatment 39% (Famularo 1992)
- In juvenile detention, 11.2% (Abram 2004)
- Natural disasters low except for more severe ones such as earthquakes or hurricanes 63% (Bradburn 1991)

Remember!

- Rarely does PTSD exist by itself
- Importance of co-morbidity
- If trauma occurs in a developmentally sensitive period with changes in neurotransmitters, then child vulnerable to other conditions (e.g., attachment, social skills, aggression, drug abuse, sexualized behaviors etc)

PTSD Comorbidity

Specific fears around related trauma events or social phobias

- Generalized Anxiety Disorder, later panic attacks
- Survivor guilt
- Complicated bereavement and pathological grieving reactions
- Depression with suicidal ideation, intent, attempts
- Aggression/violence
- For teens, dissociative features, self-injuries behaviors,and especially with girls, substance abuse (Lipschitz 2000)

Diagnostic issue

- Reactive Attachment Disorder (RAD) and PTSD
- Both may have same etiology-maltreatment, but RAD must occur before 5 years
- Child may have had maltreatment and have both or one or none
- RAD refers to “relatedness” : disinhibited or inhibited type and PTSD, the cognitive structures overwhelmed