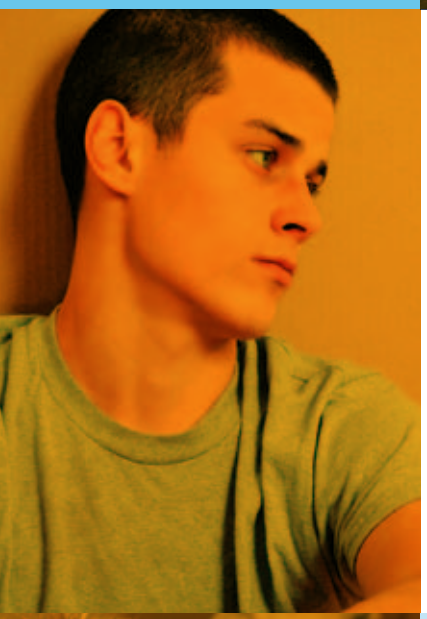
PHOENIX AUSTRALIA
Centre for Posttraumatic Mental Health

Promoting recovery after trauma



Acute Stress Disorder & Posttraumatic Stress Disorder in Children & Adolescents

A Practitioner Guide to Treatment

This guide provides an overview of important points to consider in the assessment and treatment of PTSD and ASD in children and adolescents.

The practitioner checklist later in this document can help to guide assessment and treatment planning.

What is a traumatic event?

Any event in which the child or adolescent is exposed to actual or threatened death, serious injury, or sexual violence has the potential to be traumatic. Exposure to such events can occur in different ways:

Children aged 6 years or younger

- Directly experiencing the event
- Witnessing, in person, the event as it occurred to others, especially primary caregivers
- Learning that the event occurred to a parent or caregiver

Children/adolescents older than 6 years

- Directly experiencing the event
- Witnessing, in person, the event as it occurred to others
- Learning that the event occurred to a close family member or close friend

These types of events are relatively common; by the age of 16 years more than two thirds of children will have experienced at least one traumatic event.

Not all young people exposed to such events will develop significant psychological problems. The use of the term potentially traumatic events (PTEs) has been advocated to highlight this point.

Common mental health and behavioural problems after trauma

All ages

- Sleep problems
- Irritability, anger, aggression
- Concentration and memory problems
- Hypervigilance
- Depression
- General anxiety
- Separation anxiety
- Development of specific trauma-related fears (link may not always be obvious)

Preschool-aged children

- Temper tantrums
- Oppositional behaviour
- Regression in/ loss of previously mastered developmental skills (e.g., speech, toileting)
- New fears not associated with traumatic event (e.g., fear of going to the toilet alone)

Primary school-aged children/ adolescents

- New awareness of own mortality
- Survivor guilt
- Substance use

DSM-5 Acute stress disorder criteria

- Exposure to traumatic event (see above)
- Presence of multiple symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal
- Persistence of symptoms for 3 days to 1 month after trauma exposure

ASD affects approximately 8-20% of children and adolescents exposed to trauma.

DSM-5 Posttraumatic stress disorder criteria

- Exposure to traumatic event (see above)
- Persistence of symptoms for at least 1 month after trauma

In children aged 6 years or younger

- Presence of one intrusive symptom, one symptom of avoidance or negative alteration in cognition, and two arousal symptoms

In children/adolescents older than 6 years

- Presence of one intrusive symptom, one avoidance symptom, two symptoms of negative alterations in mood or cognitions, and two arousal symptoms

For full DSM-5 criteria, refer to Appendix 5 of the full Guidelines, available at www.phoenixaustralia.org

About PTSD in children and adolescents

PTSD prevalence

- Up to 6% of children and adolescents in the general population
- Up to a third of those exposed to trauma

Key risk factors for PTSD

Preschool-aged children

- Mother's mental health
- Family social support
- Maternal-child attachment

Primary school-aged children and adolescents

- Low social support
- Pre-trauma fear
- Perceived threat to life
- Social withdrawal
- Psychiatric comorbidity
- Poor family functioning
- Use of coping strategies such as distraction and thought suppression

PTSD course and prognosis

In preschool-aged children, symptoms of PTSD tend to be persistent over time. PTSD in very young children may also be associated with a range of poor developmental outcomes.

Among older children and adolescents with PTSD, approximately one third will recover spontaneously within a year, while one third will respond well to treatment. A more chronic course of PTSD will affect the remainder of those exposed, many of whom may still be affected several years after trauma exposure.

Relational PTSD patterns

If parents or caregivers are also affected by PTSD, this may adversely affect their parenting in three ways:

- **Withdrawn/unresponsive/unavailable**

  The adult's own trauma-related symptoms may make him or her less available to the child. The ability to read, recognise and respond sensitively to the child can be significantly compromised.

- **Overprotective/constricting**

  Parents may become overprotective, which can send negative messages to a child, including, 'the world is not safe', and 'there is still something to be frightened of'.

- **Re-enacting/endangering/frightening**

  A traumatised adult may become preoccupied with reminders of the traumatic event and attempt to discuss the event repeatedly with their child.

For young children experiencing posttraumatic stress, the mental health of caregivers should be attended to first, or at the same time.

Common comorbid conditions

Preschool-aged children

- Oppositional defiant disorder
- Separation anxiety disorder
- Attention deficit hyperactivity disorder
- Major depression
- Specific phobia

Primary school-aged children

- Anxiety disorders
- Major depression
- Attention deficit hyperactivity disorder

Adolescents

- Anxiety disorders
- Major depression
- Suicidal ideation or self-harm
- Substance dependence

Treatment recommendations

Interventions for children and adolescents with PTSD

C For children and adolescents of school age with PTSD, developmentally appropriate trauma-focussed cognitive behavioural therapy should be considered.

GPP Given that retention in therapy and the effectiveness of trauma-focussed cognitive behavioural therapy with children and adolescents both require strong parent and/or caregiver involvement, an initial phase of trauma-focussed cognitive behavioural therapy with this group is engagement of the parent(s) to improve their understanding and support of this treatment modality.

Individual versus group therapy

C For children with PTSD, individual psychological interventions should be considered in preference to group interventions.

Cohen's Protocol for Child TF-CBT (PRACTICE)*

- **Psychoeducation:** about the type of traumatic event experienced, common trauma reactions, and the TF-CBT approach, as well as parenting skills
- **Relaxation:** e.g., controlled breathing, progressive muscle relaxation
- **Affective modulation skills:** identification of feelings, positive self-talk, thought stopping, positive imagery, problem-solving, and self-regulation of negative affective states
- **Cognitive coping and processing:** monitoring and changing inaccurate, unhelpful thoughts
- **Trauma narrative development and processing:** creating a narrative of the child's trauma experience and helping the child to correct cognitive distortions related to this experience
- **In vivo exposure:** gradual exposure to feared, trauma-related stimuli
- **Conjoint parent/child sessions:** in which the child shares their trauma narrative with their parent(s), and other family issues are addressed
- **Enhancing safety/future development**

*This is one example of implementing trauma-focussed cognitive behavioural therapy (TF-CBT) with children and adolescents (Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: Guilford Press).

School-based interventions

C For children exposed to trauma with symptoms of PTSD, where they were exposed to the same event, a school-based trauma-focussed cognitive-behavioural intervention aimed at reducing symptoms of PTSD should be considered.

GPP An integrated model between education and health providers that facilitates appropriate support and referral is recommended. It is recommended that schools provide a facilitative function in intervening with children following trauma, especially after large-scale traumas.

Pharmacological interventions

D For children and adolescents with PTSD, pharmacotherapy should not be used as a routine first treatment over trauma-focussed cognitive behavioural therapy.

D For children and adolescents with PTSD, pharmacotherapy should not be used routinely as an adjunct to trauma-focussed cognitive behavioural therapy.

GPP Prescription of antidepressants in children should be guided by specific practice guidelines on depression, and practitioners should be aware of age-related side effects.

Treatment recommendations

What about early interventions?

B	For children exposed to a potentially traumatic event, psychological debriefing should not be offered.
GPP	Psychological first aid may be appropriate with children in the immediate aftermath of trauma, however if it is used there must be access available to infant, child and adolescent mental health specialists if and when required.
CP	Trauma-focussed cognitive behavioural therapy may be useful as an early psychological intervention for children with a diagnosis of ASD in the initial four weeks after the traumatic event, based on the positive evidence for cognitive behavioural therapy in children with PTSD. However, the effectiveness of this approach with ASD in children is not yet established.
D	For children exposed to a potentially traumatic event, pharmacotherapy **should not** be used as a preventive intervention for all those exposed.

Other Good Practice Points

- **Assessment**
  When assessing a child or adolescent for PTSD, healthcare professionals should ensure that they separately and directly assess the child or adolescent for the presence of PTSD symptoms. It is preferable not to rely solely on information from the parent or guardian in any assessment.
- Children, ranging from infants and pre-schoolers to older children and adolescents can be affected significantly by traumatic events, at higher rates than adults. Practitioners need to be conscious of this risk, must be proactive in assessing the range of psychological impacts of trauma, and should be prepared to provide appropriate assistance, including referral to specialist services if needed.
- **Psychoeducation**
  For children exposed to trauma, psychoeducation should be integrated into a stepped-care approach that involves parents and the range of health, education and welfare service providers, and includes monitoring, targeted assessment and intervention, if necessary.
- Information is often provided to assist children following traumatic events. The content, when used, should be of high quality and tailored to the traumatic event type and the target audience. Information given following traumatic events may include: a) information about likely outcomes (most frequently positive); b) reinforcement of existing and new positive coping; c) advice on avenues for seeking further assistance if required; and d) possible indicators of a need for further assistance. Information following traumatic events may also include a recognition of the role of, and impact on, caregivers, siblings and teachers.
- **Managing parent distress**
  Parents and caregivers provide a protective/buffering function against child traumatic stress. Clinicians should be aware of the potential for parents' own distress or other factors to compromise their capacity to provide a protective/buffering function. If distress or other relevant factors are identified, the clinician should respond accordingly.

Guide to recommendation grades

A	Body of evidence can be trusted to guide practice
B	Body of evidence can be trusted to guide practice in most situations
C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
D	Body of evidence is weak and recommendation must be applied with caution
CP	Expert opinion, developed in the absence of evidence (after evidence review)
GPP	Expert opinion, developed in the absence of evidence (without evidence review as evidence known not to exist)

Things I can do to help myself

Use this to help your patient develop a self-care plan.

Things I can do to feel better

1. Talk about my problem with a friend or trusted adult
2. Hang-out with my friends
3. Listen to my favourite music
4. Ask a trusted adult or a friend for a hug
5. Do some exercise with a friend or family member (running, dancing to music, riding my bike, going for a walk)
6. Make something by drawing, painting, sewing, knitting or cooking
7. Have a warm bath
8. Do a quick relaxation exercise
9. Write in my diary
10. Use positive self-talk

Positive self-talk

Sometimes the thoughts in our heads make us feel happy, but sometimes they can makes us feel sad, angry, worried or stressed. Positive self-talk helps to chase these unhelpful thoughts away so we can feel less stressed. If you are thinking about something scary that happened, or are worried that something bad might happen, try using positive self-talk to make you feel better.

I am safe now.

I was strong to survive that.

I have people who can help me.

I have done a lot of things well before - I'm sure I can again!

Quick relaxation exercises

Calm breathing

1. Sit in a chair or lie on the floor
2. Take a breath in through your nose and count to 3 and imagine a soothing colour
3. Breathe out through your mouth and say the word 'calm' to yourself
4. Repeat this 10 times

Imagine a happy place

1. Imagine a calm and happy place
2. Tell yourself what you can see, hear, smell and feel in this happy place
3. Practise your calm breathing whilst you are picturing your happy place

Quick muscle relaxation

1. Hold your arms above your head – feel the tension in them – now drop your arms down by your side and feel them relax
2. Practise tensing and then relaxing muscles in your hands, legs, face, and stomach, and wherever else you feel stress.

Practitioner checklist

Practitioner checklist to help guide assessment and treatment planning.

Exposure	Determine recent or past exposure to a potentially traumatic event
Screen	Screen for diagnosis of PTSD or ASD. Include direct reports from the child as well as parent or carer. See the full Guidelines for recommendations about screening tools.
Assess	If the child screens positive for PTSD or ASD, conduct a comprehensive and developmentally appropriate clinical assessment. *Include direct reports from the child as well as a parent or carer. See the full Guidelines for diagnostic criteria for PTSD and recommendations regarding assessment tools. Assess for comorbid conditions as described on page 2. Assess the wellbeing of parents or carers.*
Safety	Ensure stabilisation and safety. Develop self-care plan with client and parent or carer. *Provide psychoeducation about PTSD and ASD and treatment options when developing a self-care plan.*
Treatment	Either refer for, or provide if appropriately trained, developmentally tailored trauma-focussed therapy. *See full Guidelines for recommended treatments.*
Caregivers	Prioritise engagement of parent or carer as early as possible in therapy and ensure child's correct developmental level is targeted. Include parents or carers and family members as appropriate in treatment. Ensure liaison with school. Determine parent mental health status and manage appropriately.
Care plan	Go through self-care plan (previous page) with your client.

Where can I find more information?

Useful information and resources are available through the following organisations.

Trauma and posttraumatic mental health
Phoenix Australia - Centre for Posttraumatic Mental Health provides information and useful resources about posttraumatic mental health, for practitioners and people directly affected, at www.phoenixaustralia.org.

Alcohol and other drugs
The Australian Drug Information Network (ADIN) gives comprehensive information and a list of resources available across Australia at www.adin.com.au.

Asylum seekers and migrants who have experienced torture and trauma
The Forum of Australian Services for Survivors of Torture and Trauma (FASST) has a list of agencies that provide support, advocacy and treatment at www.fasstt.org.au.

Carers
Carers Australia offers information, resources and access to support groups at www.carersaustralia.com.au or call 1800 242 636.

Children and young people
Kids Helpline offers web-based, email, or telephone counselling for children and young people aged 5 to 25 years. Call 1800 55 1800 or visit www.kidshelp.com.au.

Information on a range of mental health and related issues that affect teenagers and young adults is available from ReachOut at www.reachout.com.au.

Information on trauma and mental health, where to get help, and online support is available from headspace, the National Youth Mental Health Foundation. Visit www.headspace.org.au.

Children of parents with a mental illness
The COPMI resource centre provides information, resources and access to services at www.copmi.net.au.

Depression and anxiety
Several organisations offer access to information, resources and services, including *beyondblue* at www.beyondblue.org and the Clinical Research Unit for Anxiety and Depression at www.crufad.org.

Disasters
The Red Cross has information, advice, and resources for kids, teenagers, teachers, and parents. Visit aftertheemergency.redcross.org.au.

Domestic violence and sexual abuse
The Domestic Violence & Incest Resource Centre is a statewide Victorian service that can provide the name and contact details of agencies and support groups throughout Australia at www.dvrcv.org.au.

Immigrant women's domestic violence services
There are several services in each state and territory. See www.iwdvs.org.au or www.speakout.org.au for a list of services throughout Australia.

Parents
Parentline provides telephone counselling to parents and careers of children aged 0 to 18 years. Visit www.parentline.com.au or call 13 22 89.

Information on how to talk to children and teenagers about their problems and where to find help, as well as online and telephone support, is available through headspace at www.headspace.org.au/parents-and-carers

Psychologists
The Australian Psychological Society has a register of psychologists and lists their speciality at www.psychology.org.au or call 1800 333 497.

Sexual assault
The Australian Centre for the Study of Sexual Assault has a list of the main sexual assault services in Australia at www.aifs.gov.au/acssa/crisis. All states and territories have crisis lines listed in the front page of the White Pages.

Veterans and their families
The Department of Veterans' Affairs can provide information and referral advice at www.dva.gov.au or on 1800 555 254. The Department can provide the phone number of the Veterans and Veterans Families Counselling Service in your state and territory.

Victims of crime
A list of victim support hotlines in each state and territory, as well as information about other relevant services throughout Australia, is available at www.victimsupport.org.au.

Vocational rehabilitation
www.crsaustralia.gov.au

Self-care plan and Practitioner checklist

Available as downloadable PDF files for ease of copying for clinician/patient use from **www.phoenixaustralia.org**

This guide is a companion document to the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder.* The Guidelines were approved by the National Health and Medical Research Council, July 2013.

The complete Guidelines, a brief summary booklet, and resources for people affected by acute stress disorder or posttraumatic stress disorder, are available online: www.phoenixaustralia.org

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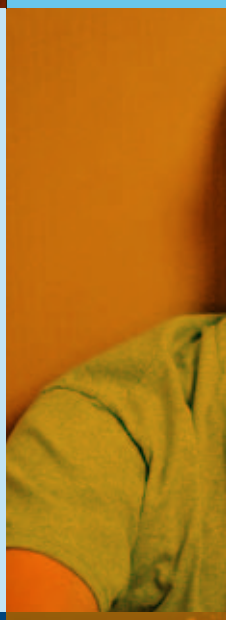
AAP Image/POOL, Herald Sun



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