traumaclinic
counselling

Diagnostic issues with survivors of trauma: An introduction

Debra Kaminer, M.A. (UWC) Ph.D. (UCT), Senior lecturer at the Dept. Psychology, University of Cape Town.

Debbie.Kaminer@uct.ac.za

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Course outcomes:

When you have completed this course you will have an understanding of:

- the diagnostic criteria for PTSD in adults
- acute stress disorder
- different common comorbid disorders of PTSD
- the different effects of prolonged trauma
- how trauma manifests in children
- ~~the diagnostic symptoms for PTSD in children~~

~~**Course facilitation and interaction:**~~

~~Direct interaction with the course presenter/author by email is encouraged. Interaction with other experts and colleagues is also a valuable resource. Our blog facilitates discussion with colleagues all over the world.~~

~~**Course assessment and accreditation:**~~

~~Once you have completed your reading you can register for the multiple-choice evaluation to earn your credits.~~

~~When you are ready …~~

1. ~~send an email to info@traumatrainingonline.com.~~
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Diagnostic issues with survivors of trauma: An introduction.

A note on the learning and teaching approach

This course is built on the principles of supported open learning pioneered by the UK Open University and developed by South African Institute for Distance Education (SAIDE) and The SACHED Trust. Course participants (Students) are asked to do all the tasks as they appear in the text in order to take full value from the course. There are two kinds of tasks:

Fact check – to memorise key knowledge items

Reflection and analysis – to take time to actively engage with the ideas in the course

OVERVIEW

Responses to traumatic events are many and varied. Practitioners working with survivors of trauma may be confronted with a wide range of clinical presentations, and need to be able to make decisions about which of these are serious enough to require an intervention. While some symptoms of anxiety and distress are common in the days or weeks after experiencing a traumatic event, most survivors of single traumas do not develop any lasting difficulties – spontaneous recovery from trauma appears to be the norm (Bonnano, 2004). However, a significant minority of trauma survivors go on to suffer severe and ongoing symptoms that cause substantial distress and restrict their ability to function. When trauma responses reach this level, a psychiatric disorder may be present. Post-traumatic stress disorder (PTSD) is the most widely publicised trauma-related psychiatric disorder and will therefore be a major focus of this module, but there are several other psychiatric diagnoses that are also commonly associated with traumatic events. In addition, in recent years some potential new diagnostic categories have been proposed to account for clinical observations of the complex psychological effects of prolonged abuse at the hands of another person. Finally, special considerations need to be taken into account when assessing and diagnosing post-traumatic disorders in children.

1. PTSD

Some feelings of distress in the aftermath of a traumatic event are expectable, as part of the process of adapting to what has happened. Some commonly reported reactions include feelings of anxiety and mild depression, having distressing thoughts and memories of the traumatic event, difficulty sleeping, and feeling hyper-alert to any signs of danger. In order to avoid causing themselves more distress, it is possible that many trauma survivors may wish to avoid talking about what happened, may withdraw from contact with other people, and may feel emotionally numb when they think about the trauma (O'Brien, 1998). These reactions can last for a few days, weeks or even months after the traumatic event and then

gradually fade, without severely impacting on the survivor's ability to continue with their normal daily functioning.

However, some trauma survivors continue to experience these symptoms intensely, without any gradual reduction over time. Furthermore, these symptoms result in significant impairment in their work and social roles – they may not be able to concentrate at work or school, may struggle to look after their children, become easily angry with family members or colleagues, feel too anxious to leave the house to go shopping for food, or even battle to get out of bed each morning. Post-traumatic stress disorder or PTSD is a psychiatric diagnosis that has been developed to describe such an ongoing response to trauma. PTSD was first introduced as a psychiatric disorder in 1980 (American Psychiatric Association, 1980) and since then the diagnostic criteria for PTSD have been further refined through systematic clinical research, largely based in North America. North American surveys indicate that between 10% and 25% of all trauma survivors develop PTSD (Breslau, 1998), and about 8% of the population in the United States has met a diagnosis of PTSD during their lifetime (Kessler et al., 1995). However, rates of PTSD tend to vary quite widely across different countries and contexts (possibly because of differences in the methods used to assess PTSD, or limitations in the applicability of methods to different contexts) and it is difficult to pin-point a more 'global' average prevalence of PTSD.

The current diagnostic criteria for PTSD include 1) a definition of the type of traumatic event that the person must have experienced in order to qualify for the diagnosis, 2) three different symptom clusters (re-experiencing, avoidance and hyperarousal) and 3) requirements regarding the minimum duration and the degree of impact of these symptoms (American Psychiatric Association, 2000). Each will be discussed below.

1.1. Type of traumatic event

In order to qualify for a diagnosis of PTSD, the person must have experienced, witnessed or been confronted with a traumatic event that involved some form of physical threat. Historically, as well as in current everyday usage, the term 'trauma' has been used to refer to a wide variety of experiences, including emotionally stressful experiences. However, research has repeatedly shown that the specific syndrome of PTSD is linked to physically threatening experiences, rather than emotionally damaging experiences that lack any perceived physical threat (Kilpatrick et al., 1998). Importantly, this criterion acknowledges that many people can develop PTSD from witnessing physically traumatic events or being confronted with them in other ways, such as hearing about a physically threatening event that happened to someone they are close to.

Currently, in order to qualify for a diagnosis of PTSD, the physically threatening event must have elicited in the person a reaction of intense fear, helplessness or horror. This acknowledges that the degree of threat involved in a potentially traumatic event cannot always be decided objectively by someone who is assessing the mental state of a trauma survivor. Rather, the survivor's subjective response to the event (how frightened they felt) provides an important indication of the degree to which the event was experienced as threatening. For example, one person may be in a minor car accident and sustain only a few scratches, while another may be seriously injured in an accident in which another passenger was killed, but the first accident victim may feel subjectively more frightened and helpless

during and after the event than the second accident victim. However, this requirement for the diagnosis has recently been challenged due to the lack of evidence to show that subjective responses of fear, helplessness or horror actually predict the development of PTSD (Stein et al., 2009).

1.2. Symptom clusters

The first symptom cluster of PTSD encompasses different forms of re-experiencing the traumatic event, through thoughts, images and memories that the trauma survivor is unable to voluntarily control. For example, the survivor may find that throughout the day images and thoughts about the trauma continually intrude into their consciousness, even when they try to focus on something else. At night, this intrusion may occur in the form of nightmares about the trauma. Whenever the person encounters something that reminds them of the trauma (known as a traumatic 'trigger'), they feel intense emotional distress. They may also experience a strong physical fear response to such 'triggers', including increased heart rate, muscle tension and sweating. This physical reaction is similar to the 'fight or flight' reaction, which is the body's natural response to danger (Yehuda, 2000), but in PTSD the 'fight or flight' symptoms are often activated by something that resembles or symbolises the past traumatic event rather than by any real threats in the current environment. For example, someone who has survived a serious car accident may feel intense distress and fear every time they have to sit in a car, and possibly in other forms of transport as well. A soldier on leave from active duty may respond to the sound of a car backfiring with the same fear response that he experienced when being confronted with gunshots in a combat situation. A final form of re-experiencing the trauma is flashback episodes, which are usually activated when the person encounters a traumatic reminder or trigger. Flashbacks differ from normal memories as they involve intense sensory re-experiencing of the trauma (smelling the same smells, hearing the same sounds, feeling the same sensations on the skin, and seeing the same sights), rather than just an image or thought about the event. Through these re-experiencing symptoms, the survivor finds themselves perpetually returning to the moment of the trauma. At least one of the above forms of re-experiencing the trauma must be present in order to consider a possible diagnosis of PTSD.

The second symptom cluster of PTSD is avoidance symptoms. In an attempt to manage the highly distressing re-experiencing symptoms described above, the trauma survivor may attempt to avoid any reminders of the trauma. For example, the person may make a conscious effort to avoid places or situations that are associated with the trauma. A hijack victim may try to avoid having to drive anywhere alone, a child who has been mugged outside his school may refuse to go back to school afterwards, and a woman who has been raped while walking to her bus stop may feel unable to walk that route again. This avoidance may not be restricted to the trauma-specific situation, but may also generalise to the point where the person avoids leaving their home at all, or only goes out when absolutely necessary and this may restrict their participation in their usual activities. Trauma survivors may also wish to avoid talking to others about the trauma, as this makes them feel anxious and distressed all over again. Survivors may also find that they attempt not to think about the trauma at all, forcing themselves to think about something else if a thought about the trauma enters their mind. In some cases, the survivor may have amnesia for some aspects of the traumatic experience. In addition, they may try to avoid the distressing feelings associated with the trauma by numbing themselves emotionally; resulting in feeling cut-off or

emotionally deadened much of the time. Other avoidance symptoms that trauma survivors may manifest include withdrawal from their usual activities, feelings of isolation and disconnection from others, and a sense that they have no long-term future. At least three of the above avoidance symptoms must be present in order to consider a possible diagnosis of PTSD.

The final symptom cluster of PTSD is an increased level of physical arousal compared with before the trauma, known as hyperarousal. This physical arousal entails an ongoing state of the body's 'fight or flight' response, and involves difficulty sleeping, difficulty concentrating on daily activities, being constantly on the look out for signs of threat and danger (known as hypervigilance), startling very easily in response to loud noises or sudden movements, and becoming easily irritable or angry in response to minor frustrations or perceived hostility from others. At least two of these symptoms must be present in order to consider a possible diagnosis of PTSD.

1.3. Duration and impact

As noted earlier, it is normal to experience many of the symptoms of PTSD for a while after the trauma, and their presence is not sufficient to diagnose PTSD. To meet the diagnosis, the re-experiencing, avoidance and hyperarousal symptoms must be present for at least one month after the trauma and they must cause the person extreme distress or interfere significantly with the person's ability to function at work or in their social roles. The duration and impact of the symptoms is crucial in deciding the boundary between normal trauma responses and a diagnosis of PTSD that requires some form of intervention. With regard to the course of PTSD over time, research indicates that about half of the people who develop PTSD will recover within three months (this is called Acute PTSD), for others the symptoms will come and go for months or years after the trauma (this is called Chronic PTSD), and still others may only develop PTSD six months or more after the actual trauma (this is called Delayed PTSD) (American Psychiatric Association, 2000; Kessler, 1995).

Case study of PTSD

Jennifer is a 19 year old university student who lives in the university residence. One evening, while walking from the university library towards her residence, she was sexually assaulted and robbed by two men carrying knives. She immediately reported the incident to campus security, and they were able to apprehend the perpetrators. Since the assault, Jennifer is fearful to walk around on campus, even if there are other people around, as she experiences frequent flashbacks of the assault. During these flashbacks, she can hear the perpetrators shouting instructions to her, smell their perspiration, and feel the sensation of a knife-blade at her throat. She is constantly on her guard when walking outside, and startles easily when someone brushes against her in passing. She is only able to attend classes if accompanied by a friend, and refuses to go back to the library, even in the daytime. She struggles to fall asleep at night if her room-mate is not there, and frequently awakens after having nightmares that she is being attacked. She is unable to concentrate in class due to repeated thoughts and memories about the assault, and has failed two recent tests even though she was previously one of the top students in her class. She has withdrawn from socialising with her friends as she does not want to have to speak about the assault to other people, and no longer feels interested in attending the campus societies that she previously participated in.

Fact check 1

Question 1.

What are some of the common and expected feelings or reactions of distress in the aftermath of a traumatic event?

Question 2.

PTSD is a diagnosis that has been developed to describe

…….to trauma.

Question 3.

In the diagnostic criteria in order to qualify for a diagnosis of PTSD, the physically threatening event must have elicited in the person a reaction of:

Question 4.

A trauma survivor may re-experience the traumatic event, through involuntary thoughts, images and memories. These can manifest during the day and night, for example:

Day: ……

Night: ……..

What is:

Acute PTSD- …….

Chronic PTSD- …….

Delayed PTSD- ……

Reflection and analysis

Question 5.

Using the above case study, list and briefly explain the symptoms for PTSD, according to the American Psychiatric Association 2000, that Jennifer is displaying (Write your answer in the box below).

2. ACUTE STRESS DISORDER

A diagnosis that is closely related to PTSD is Acute Stress Disorder, or ASD (APA, 2000). This diagnosis can be made if symptoms of PTSD are present for less than one month, but there are also several features of dissociation, which may occur either during the traumatic event or afterwards. Dissociation includes a sense of emotional numbing or detachment, a reduced awareness of one's surroundings (for example, feeling as if one is in a daze), amnesia for certain aspects of the trauma, feeling detached from one's body or feeling that the world is unreal or dreamlike. While many trauma survivors may experience some symptoms of dissociation during or immediately after the trauma, the diagnosis of ASD is only made if the symptoms cause significant distress or create a serious impairment in the survivor's ability to function after the trauma. If the symptoms of ASD last longer than one month, the diagnosis may be changed to PSTD if the full diagnostic criteria for PTSD are met.

3. COMMON COMORBID DISORDERS

Research indicates that the majority (some studies suggest as much as 80 – 90%) of trauma survivors who develop PTSD also have other psychiatric disorders (Kessler et al., 1995). The psychiatric disorders that are commonly comorbid with PTSD (in other words, that occur together with PTSD) include mood disorders, substance abuse, and anxiety disorders such as panic disorder and phobias.

3.1. Mood disorders

Mood disorders that often occur together with PTSD include depression and dysthymia. The clinical picture of depression consists of low mood and / or loss of interest or pleasure in regular activities, together with appetite and sleep disturbances, restlessness or agitation, fatigue or low energy, feelings of worthlessness or guilt, loss of concentration, and possibly suicidal thoughts. These symptoms must be present most of the day, nearly every day, for at least two weeks, and must result in significant distress or noticeable impairment in the person's daily functioning (American Psychiatric Association, 2000). Almost half the trauma survivors who have PTSD also have depression (Kessler, 1995). Dysthymia refers to a milder form of depression that lasts for at least two years (American Psychiatric Association, 2000).

3.2. Substance abuse disorders

In North American studies, between 65% and 80% of patients seeking treatment for PTSD also have a substance abuse disorder (Ouimette & Brown, 2003). Substance abuse disorders include the abuse of alcohol, prescription medication or other drugs, to a degree that results in significant distress or impairment in functioning (for example, difficulty fulfilling work or home obligations, or engaging in dangerous behaviours while intoxicated) (American Psychiatric Association, 2000). It is possible that people with PTSD or other post-traumatic symptoms may use substances to try to manage their distress and anxiety. This unfortunately leads to a range of additional difficulties in the person's daily functioning and relationships.

3.3. Anxiety disorders

PTSD is classified as an anxiety disorder. But trauma survivors who meet the diagnosis for PTSD often also have other kinds of anxiety disorders, such as panic disorder or phobias. Panic disorder can be diagnosed when the person experiences repeated panic attacks (which include many of the physical symptoms of the 'fight or flight response') together with anticipatory anxiety about having additional attacks, worry about the implications of the attacks, or avoidance of places or situations that might precipitate an attack (American Psychiatric Association, 2000). Phobias that commonly occur after a trauma include a phobia of specific objects or places (which may be associated with the trauma experience), social phobia (a fear and avoidance of social situations because of anxiety about being evaluated and judged negatively by others) and agoraphobia (fear of being in spaces from which one could not easily escape in the event of having panic-like symptoms, which often leads to an avoidance of leaving home alone for any reason).

There are still some unanswered questions regarding the disorders that seem to commonly occur together with PTSD. Firstly, from the existing research it is difficult to establish the exact nature and time-line of the relationship between PTSD and comorbid disorders. It is not clear whether some trauma survivors have pre-existing mood, anxiety and substance abuse disorders that increase the likelihood of developing PTSD after experiencing a trauma, whether the distressing experience of having PTSD itself results in depressed mood, phobias and substance abuse, or whether PTSD and its comorbid disorders develop separately from each other after a trauma. However, the available information suggests that mood disorders and substance abuse are more likely to develop after the onset of PTSD,

while anxiety disorders sometimes (but not always) pre-date PTSD (Kessler, 1995). Secondly, there is a large amount of overlap between the symptoms of PTSD and the symptoms of other anxiety disorders, of depression and of dysthymia (Davidson & Foa, 1991). For example, social withdrawal is one of the avoidance symptoms of PTSD, but also a key symptom of depression, dysthymia, social phobia and agoraphobia. Similarly, concentration and sleep difficulties are symptoms of PTSD but also of depression and dysthymia. In addition, the physiological responses involved in PTSD flashbacks often closely resemble panic attacks. It can therefore be difficult to establish whether other anxiety disorders, depression and substance abuse are in fact distinct and separate disorders from PTSD, and a careful and thorough diagnostic interview conducted by a psychologist or psychiatrist is required in order to identify whether comorbid disorders are present. It is therefore apparent that post-traumatic symptoms often extend beyond those captured by the PTSD diagnosis, creating multiple difficulties and challenges for many trauma survivors. As will be discussed in the next section, survivors of prolonged or early childhood abuse are more likely than survivors of single traumas to develop a range of symptoms that are not captured by the diagnosis of PTSD.

Fact check 2

Question 1.

Define dissociation in PTSD:

Question 2.

Mood disorder is a common comorbid disorder in PTSD. The symptoms include: low mood and / or loss of interest or pleasure in regular activities, together with appetite and sleep disturbances, restlessness or agitation, fatigue or low energy, feelings of worthlessness or guilt, loss of concentration, and possibly suicidal thoughts.

These must be present for

Question 3.

People with PTSD or other post-traumatic symptoms may use substances to

Question 4.

Panic disorder can be diagnosed when the person experiences repeated panic attacks, which include many of the physical symptoms of the 'fight or flight response.' What is the flight or flight response and which part of one's body is responsible for secreting this hormone?

Question 5.

Why is it difficult to establish whether other anxiety disorders, depression and substance abuse are in fact distinct and separate disorders from PTSD?

4. THE EFFECTS OF PROLONGED TRAUMA

Although PTSD is a useful diagnosis for understanding the impact of single traumas such as car accidents or a violent crime, researchers and clinicians have argued that the psychological effects of being in a situation of chronic, repeated trauma at the hands of another person over a long period of time (such as childhood physical or sexual abuse, or abuse by an intimate partner) are often different to the effects of a single trauma. Many survivors of chronic trauma or abuse perpetrated by a loved and trusted person such as a parent figure or an intimate partner present with patterns of difficulties that do not fit with the classic PTSD symptoms (Pelcovitz et al., 1997; Roth, Newman, Pelcovitz, van der Kolk & Mandel, 1997; van der Kolk et al., 1996). The syndromes of 'complex PTSD' (Herman, 1992) and 'disorders of extreme stress not otherwise specified' (DESNOS; American Psychiatric Association, 2000) have been developed to describe the impact of prolonged traumatisation. There is still some debate about whether there is sufficient evidence to confirm that these complex trauma responses represent actual diagnostic syndromes. However, they offer clinicians a potentially useful alternative to diagnosing a survivor of abuse with a mixed bag of many different types of comorbid disorders, or with a range of personality disorders, in an attempt to capture the complex range of symptoms with which they may present. Unlike a diagnosis of a personality disorder or of comorbid depression and substance abuse, these proposed complex trauma syndromes clearly identify experiences of abuse as the root cause of all the symptoms, and can therefore facilitate more focused treatment of the survivor. The symptoms of complex PTSD and DESNOS focus on the way that survivors of chronic trauma feel about themselves (their self-experience), their ways of managing difficult feelings (emotion regulation), and their relationship patterns.

4.1. Self-experience

Survivors of early or chronic trauma often experience a disturbed sense of personal identity, ranging from feelings of fragmentation (for example, experiencing their feelings as being foreign, uncontrollable and frightening), feeling completely detached from themselves, or even feeling that they do not exist. In addition, the survivor might have experiences of alterations in consciousness, including periods of dissociation – that is, 'blanking out' and not being aware afterwards of what he or she said or did while in this state. These experiences of detachment and dissociation develop as internal coping mechanisms to enable the person to psychologically 'remove' themselves from chronically traumatic experiences that they cannot physically escape. Survivors of prolonged trauma, especially at the hands of a controlling abuser, carry feelings of helplessness and passivity, or not being able to take initiative in doing things. In addition, survivors of abuse often blame themselves for the abuse that they suffered. It is much easier to believe that they are bad and deserving of abuse than to believe that a loved one has chosen to hurt them. This may result in powerful feelings of guilt, shame and unworthiness, and the survivor may view himself or herself as unlovable, despicable and weak, and possibly even as evil or contaminated (Herman, 1992).

4.2. Emotion regulation

Survivors of chronic trauma may also experience extreme difficulty with regulating or controlling their strong feelings, such as sadness or anger, resulting in unpredictable emotional outbursts and often chronic depression. Survivors of early childhood abuse, in

particular, may have an inability to soothe themselves, and may even struggle to take comfort from supportive others. This often results in potentially harmful strategies for managing feelings of distress or anger, such as substance abuse and self-harm activities like eating disorders, secretly cutting oneself in order to release emotional tension, and attempting suicide (van der Kolk, 1996). In addition, for survivors of abuse emotional distress may often manifest itself bodily in somatic symptoms - that is, physical complaints that have no medical basis. For example, many survivors of childhood sexual abuse experience chronic pelvic pain, gastrointestinal discomfort and numbing or paralysis in different parts of their body, with no medical explanation (Roelofs & Spinhoven, 2007). These symptoms are understood to be the result of a conversion of emotional distress into bodily pain.

4.3. Relationship patterns

The relationship patterns that develop as a result of prolonged traumatisation at the hands of another person tend to further exacerbate the trauma survivor's difficulties in living. The survivor may have extreme difficulty with trusting others, resulting in social isolation and withdrawal. Alternatively, out of a need for love and acceptance, the survivor may trust other people indiscriminately, or become excessively accommodating of other people's needs in order to prevent being abandoned by them (Herman, 1992). Together with their chronic feelings of unworthiness, self-blame and being inherently bad, this can sometimes result in the survivor being repeatedly emotionally or physically abused by others. For example, research has found that women who were sexually abused in childhood are more than twice as likely as women who experienced no childhood sexual abuse to be sexually abused in adulthood (Wyatt et al., 1992).

Case study of complex PTSD

Brenda, a 34 year old woman, was admitted to a psychiatric facility after taking an overdose of sleeping tablets the day after her boyfriend of two months ended their relationship. A clinical history-taking revealed that she has had three previous psychiatric admissions for suicide attempts over the past five years, each one precipitated by an experience of rejection in a close relationship. Brenda explained to the clinician that she attempted suicide because she felt overwhelmed at the prospect of being on her own, and that she experiences unbearable feelings of emptiness and unworthiness when she is not in a romantic relationship. Brenda described a childhood history of protracted sexual abuse by her mother's brother, who lived with the family from the time she was five years old until she was twelve. Her father was an alcoholic who was often absent from the family home, while her mother was physically and emotionally abusive towards both her and her younger brother. Brenda never revealed the abuse to her family as she was sure they would not believe her or would blame her for her uncle's actions. She has suffered from bouts of depression since adolescence, and as a result has struggled to complete any programme of study or to hold down a job for more than a few months at a time. In order to manage her feelings of depression, she binge drinks at least twice a week when socialising with her girl friends. She describes a pattern of falling in love very quickly with men who tell her she is attractive, trying very hard to meet their every need in order to keep them happy, but then being rejected by them for being too needy and clingy.

Fact Check 3

Question 1.

Define and explain DESNOS

Question 2.

Trauma survivors often blame themselves for the abuse that they suffered. It is much easier to believe that they are bad and deserving of abuse than to believe that a loved one has chosen to hurt them. This may result in powerful feelings of

……., …… and ……., and the survivor may view himself or

herself as ……, …… and ……. and possibly even as evil or contaminated.

Question 3.

Explain somatic symptoms and give two examples

Example 1)
Example 2)

Question 4.

Trauma survivors may find it difficult to trust others, this could result in

…….. and……... This could also possibly lead to a phobia

called …….

Question 5.

Research has found that women who were sexually abused in childhood are more than twice as likely as women who experienced no childhood sexual abuse to be sexually abused in adulthood.

True/False

Reflection and analysis

Using the case study, list and explain the symptoms of complex PTSD that Brenda is displaying

5. POST TRAUMATIC SYMPTOMS IN CHILDREN

Research indicates that children can develop PTSD after exposure to a range of traumatic stressors, including violent crime, sexual abuse, natural disasters, and war (March, Feeny, Amaya-Jackson & Foa, 2000). Where relatively standardized assessment methods have been used, the incidence of PTSD among child survivors of specific disasters ranges from 30 to 60% (Yule, 2001), while one quarter to one half of child victims of physical and sexual abuse develop PTSD (Margolin & Gordis, 2000). Community studies of representative samples in the United States have found that between 3% and 6% of adolescents have PTSD (Cuffe et al., 1998; McCart et al., 2007).

The DSM notes that, in children, re-experiencing of the trauma may occur through repetitive play involving trauma-related themes, rather than through intrusive images or flashbacks, while nightmares may have generalized traumatic themes rather than being specific to a particular traumatic event (APA, 2000). However, there are some limitations of the existing PTSD diagnostic criteria when applied to young children.

Firstly, eight of the eighteen PTSD criteria require a verbal description of internal states and experiences, a task that is beyond the cognitive and expressive language skills of most young children (American Academy of Child and Adolescent Psychiatry, 1998). Mental health practitioners must therefore try to infer from behavioural observations of the child whether the child's thoughts and feelings are consistent with PTSD symptoms. Direct reports from parents, teachers and other observers in the child's environment are also an important component of the evaluation, although it should be borne in mind that parents often tend to minimize the child's PTSD symptoms (American Academy of Child and Adolescent Psychiatry, 1998). A comprehensive clinical interview with the primary caregivers, and an individual assessment with the child, should form the basis of assessing for posttrauma psychopathology in children but, if permission is granted by the caregivers, obtaining information from multiple informants (such as teachers or other caregivers who know the child well) can enhance the assessment process.

Secondly, while traumatized children often display the core symptom clusters of adult PTSD, they also commonly present with an array of non-PTSD symptoms, which vary according to the child's developmental stage. In young children, emotional regression is common after a traumatic experience. This is often manifested in symptoms of separation anxiety. For example, a child who had developed some level of independent behaviour prior to the

trauma may become clingy and dependent after the trauma, refusing to sleep alone or to be separated from their parents or primary caregivers for any reason. Children may also revert to bedwetting in the aftermath of trauma. They may also display new fears (related to the traumatic experience or more general imaginary dangers) or the re-activation of old ones from early childhood (such as fear of the dark, or of strangers). Somatic complaints, such as stomach aches and headaches, are also common (Yule, 1995). Additionally, young children may express post-traumatic anxiety through hyperactive, distractible and impulsive behaviour, symptoms that may easily be confused with attention-deficit/hyperactivity disorder. Poor concentration and restlessness in the classroom can result in a marked deterioration in school performance. Another common post-traumatic response in young children is to hold themselves responsible for the traumatic event, to imagine that the trauma could have been avoided if they had acted differently (Terr, 1991).

As with adults, the persistence of PTSD symptoms coupled with an accumulation of post-trauma adversities (such as disruptions to the family structure as a result of the trauma) can also produce a secondary depression in traumatised children. If the traumatic event involved the death of a family member, children can also present with complicated grief and bereavement (Pynoos, Steinberg & Goenjian, 1996). Therefore, while young children who have experienced a trauma may not meet all the diagnostic criteria for PTSD, there may nonetheless be a range of post-traumatic responses that warrant intervention. A significant deterioration in any aspect of the child's functioning (scholastic, social, emotional or behavioural) that persists for more than a few weeks after the trauma is a strong indicator that some intervention may be required to restore the child's equilibrium.

Traumatised adolescents may also present with PTSD symptoms that are found in adults, but other post-traumatic responses are also common at this developmental stage. Some adolescents become increasingly withdrawn and uncommunicative, while others become defiant, oppositional or aggressive in their behaviour (Cook et al., 2005). Given the tendency towards experimentation and risk-taking at this age, a traumatic experience may precipitate substance abuse and other apparently 'delinquent' behaviour in adolescents. Without a careful assessment of the precipitants and the severity of these manifestations, it is all too easy for them to be attributed to 'typical' adolescent behaviour rather than recognised as post-traumatic reactions that require some form of psychosocial intervention.

Case study of a traumatised child

Steven is a six year old boy who was referred to a child and family clinic by his family doctor. Six weeks ago, Steven's paternal uncle, Robert, who lived with Steven's family, committed suicide by hanging himself in his bedroom after several months of severe depression. Steven was the first person to discover his uncle's body, after going into the room to call his uncle for dinner. Prior to this, Steven was a confident, playful and talkative boy, who enjoyed school and socialising with other children in the neighbourhood. However, since his uncle's suicide Steven has become extremely clingy, refusing to be away from his mother or father for any period of time, and has stopped attending school. He is too frightened to sleep alone in his bed and has been sleeping with his parents, but wakes frequently, crying and shouting. He has been eating very little, complaining of a sore tummy. This prompted his parents to take him to the family doctor, who could find no medical cause. Steven has also become very withdrawn, speaking only in a whisper and only to his mother or father. He is unable to sustain any play activities at home as he quickly becomes restless and distracted, and he refuses to play outside with the neighbourhood children. Steven has mentioned to his

mother that he feels ‘bad inside’ because he should have checked on his uncle earlier that day, rather than waiting till dinner time to call him. Steven’s father has been very distressed by Robert’s suicide, and Steven has expressed concerns that ‘daddy is also sad and will want to hurt himself like Uncle Robert’.

Fact check 4

Question 1.

For children, re-experiencing the trauma may occur through ……

Question 2.

What are the ethical issues that a counsellor will need to take into account when

dealing with a child?

Question 3.

What are some of the common regressions in young children after a traumatic

experience?

Question 4.

Some children may have somatic complaints after a traumatic experience. Explain what somatic complaints are, and give two examples

Example 1
Example 2

Question 5.

There are two different ways that adolescents react to trauma. Some may become

…… and ……., while others may become

……., …….. or ……. in their behaviour.

Reflection and analysis

Explain why there are some limitations to the existing PTSD criteria when applied to young children.

6. REVIEW

In this course, you have read about the following topics. Check whether you feel you understand each section by ticking the relevant box. If you feel you need to do more work in the area, re-read the section and do the tasks again., ~~and use the traumatrainingonline blog or contact you're the author facilitator if you need further help.~~

PTSD	( )
TYPE OF TRAUMATIC EVENT	( )
SYMPTOM CLUSTERS	( )
DURATION AND IMPACT	( )
ACUTE STRESS DISORDER	( )
COMMON COMORBID DISORDERS:	
MOOD DISORDERS	( )
SUBSTANCE ABUSE DISORDER	( )
ANXIETY DISORDER	( )
THE EFFECT OF PROLONGED TRAUMA	( )
SELF-EXPERIENCE	( )
EMOTION REGULATION	( )
RELATIONSHIP PATTERNS	( )
POSTRAUMATIC SYMPTOMS IN CHILDREN	( )

End of course self-assessment questions

Use the box below to help you list the criteria under each heading

Common comorbid disorders

Symptom clusters
Diagnostic criteria when applied to young children
Symptoms of complex PTSD and DESNOS

Key:

Common comorbid disorders

Mood disorders

Substance abuse

Anxiety disorders

Symptom clusters

Re-experiencing

Avoidance

Hyperarousal

Diagnostic criteria when applied to young children

Behaviour observation

Direct reports from parents

Individual assessment

Clinical interview with the primary caregivers

Symptom of complex PTSD and DESNOS

Self-experience

Emotion regulation

Relationship patterns

The learning outcomes for the course are:

1) to understand and know the diagnostic criteria for PTSD in adults

2) to discuss acute stress disorder including the different common comorbid disorders

3) to know the different effects of prolonged trauma

4) to understand how trauma manifests in children

5) the diagnostic symptoms for PTSD in children

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