POST-TRAUMATIC STRESS DISORDER

Post Traumatic Stress Disorder (PTSD) is a psychological disturbance resulting from a person's exposure to a traumatic event, such as inter-personal violence, a natural disaster, a plane wreck, etc. in which the person experienced overwhelming fear and anxiety about his safety. PTSD can also result from child abuse.

This condition is diagnosed when the following symptoms have been present for longer than one month:

- *Re-experiencing* the event through play or in trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma.
- Routine *avoidance* of reminders of the event or a general lack of responsiveness (e.g., diminished interests or a sense of having a foreshortened future).
- Increased sleep disturbances, irritability, poor concentration, startle reaction, and regressive behavior.

Rates of PTSD identified in child and adult survivors of violence and disasters vary widely. For example, estimates range from 2 percent after a natural disaster (tornado), to 28 percent after an episode of terrorism (mass shooting), and 29 percent after a plane crash.[13]

The disorder may arise weeks or months after the traumatic event. PTSD may resolve itself without treatment, but some form of therapy by a mental health professional is often required in order for healing to occur. Fortunately, it is more common for traumatized individuals to have some of the symptoms of PTSD than to develop the full-blown disorder.[14]

As noted above, people differ in their vulnerability to PTSD, and the source of this difference is not known in its entirety. Researchers have identified factors that interact to influence vulnerability to developing PTSD. These factors include:

- Characteristics of the trauma exposure itself (e.g., proximity to trauma, severity, and duration),
- Characteristics of the individual (e.g., prior trauma exposures, family history/prior psychiatric illness, gender; women are at greatest risk for many of the most common assault traumas), and

- Post-trauma factors (e.g., availability of social support, emergence of avoidance/numbing, hyper-arousal and re-experiencing symptoms).

Research has shown that PTSD clearly alters a number of fundamental brain mechanisms. Abnormal levels of brain chemicals that affect coping behavior, learning, and memory have been detected among people with the disorder. In addition, recent imaging studies have discovered altered metabolism and blood flow in the brain as well as structural brain changes in people with PTSD.[15-19]

Treatment

People with PTSD are treated with specialized forms of psychotherapy and sometimes with medications or a combination of the two. One of the forms of psychotherapy shown to be effective is Cognitive Behavioral Therapy (CBT). In CBT, the patient is taught methods of overcoming anxiety or depression and modifying undesirable behaviors such avoiding reminders of the traumatic event. The therapist helps the patient examine and re-evaluate beliefs that are interfering with healing, such as the belief that the traumatic event will happen again. Children who undergo CBT are taught to avoid "catastrophizing." For example, they are reassured that dark clouds do not necessarily mean another hurricane, that the fact that someone is angry doesn't necessarily mean that another shooting is imminent, etc. Play therapy and art therapy also can help younger children to remember the traumatic event safely and express their feelings about it. Other forms of psychotherapy that have helped persons with PTSD include group and exposure therapy. A reasonable period of time for treatment of PTSD is 6 to 12 weeks with occasional follow-up sessions, but treatment may be longer depending on a patient's particular circumstances. Research has shown that support from family and friends can be an important part of recovery.

There has been a good deal of research on the use of medications for adults with PTSD, including research on the formation of emotionally-charged memories and medications that may help block the development of symptoms.[20-22] Medications appear to be useful in reducing overwhelming symptoms of arousal (such as sleep disturbances and an exaggerated startle reflex), intrusive thoughts, and avoidance; reducing accompanying conditions such as depression and panic; and improving impulse control and related behavioral problems. Research is just beginning on the use of medications to treat PTSD in children and adolescents.

There is accumulating empirical evidence that trauma or grief-focused psychotherapy and selected pharmacologic interventions can be effective in alleviating PTSD symptoms and in addressing co-occurring depression.[23-26] However, more medication treatment research is needed.

A mental-health professional with special expertise in the area of child and adolescent trauma is the best person to help a youngster with PTSD. Organizations on the accompanying resource list may help you to find such a specialist in your geographical area.

Recent Research

The National Institute of Mental Health (NIMH), a part of the Federal Government's National Institutes of Health, supports research on the brain and a wide range of mental disorders, including PTSD and related conditions. The Department of Veterans Affairs also conducts research in this area with adults and their family members.

Recent research findings include:

- Some studies show that counseling children very soon after a catastrophic event may reduce some of the symptoms of PTSD. A study of trauma/grief-focused psychotherapy among early adolescents exposed to an earthquake found that brief psychotherapy was effective in alleviating PTSD symptoms and preventing the worsening of co-occurring depression.[27]

- Parents' responses to a violent event or disaster strongly influence their children's ability to recover. This is particularly true for mothers of young children. If the mother is depressed or highly anxious, she may need to get emotional support or counseling in order to be able to help her child.[28-30]

- Either being exposed to violence within the home for an extended period of time or exposure to a one-time event like an attack by a dog can cause PTSD in a child.

- Community violence can have a profound effect on teachers as well as students. One study of Head Start teachers who lived through the 1992 Los Angeles riots showed that 7 percent had severe post-traumatic stress symptoms, and 29 percent had moderate symptoms. Children also were acutely affected by the violence and anxiety around them. They were more aggressive and noisy and less likely to be obedient or get along with each other.[31]

- Research has demonstrated that PTSD after exposure to a variety of traumatic events (family violence, child abuse, disasters, and community violence) is often accompanied by depression.[3,32-35] Depression must be treated along with PTSD, and early treatment is best.

- Inner-city children experience the greatest exposure to violence. A study of young adolescent boys from inner-city Chicago showed that 68 percent had seen someone beaten up and 22.5 percent had seen someone shot or killed. Youngsters who had been exposed to community violence were more likely to exhibit aggressive behavior or depression within the following year.[36,37]

PTSD in Children

For children 5 years of age and younger, typical reactions can include a fear of being separated from the parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions and excessive clinging. Parents may also notice children returning to behaviors exhibited at earlier ages (these are called regressive behaviors), such as thumb-sucking, bedwetting, and fear of darkness. Children in this age bracket tend to be strongly affected by the parents' reactions to the traumatic event.

Children 6 to 11 years old may show extreme withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are also common in traumatized children of this age. Also the child may complain of stomachaches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depression, anxiety, feelings of guilt, and emotional numbing or "flatness" are often present as well.

Adolescents 12 to 17 years old may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. The adolescent may feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

Some youngsters are more vulnerable to trauma than others, for reasons scientists don't fully understand. It has been shown that the impact of a traumatic event is likely to be greatest in the child or adolescent who previously has been the victim of child abuse or some other form of trauma, or who already had a mental health problem.[8-11] And the youngster who lacks family support is at greater risk of a poor recovery.[12]

-- Adapted from the booklet, "Helping Children and Adolescents Cope with Violence and Disasters", at www.nimh.nih.gov/pulicat/violence/cfm