Post Traumatic Stress Disorder
Cognitive Therapy with Children and Young People

Patrick Smith, Sean Perrin, William Yule and David M. Clark

“These authoritative, yet practical books will be of interest to all professionals who work in the field of child and adolescent mental health” - Alan Carr
Post Traumatic Stress Disorder

Post traumatic stress disorder develops after exposure to one or more terrifying event that has caused or threatened to cause the sufferer grave physical harm. This book discusses how trauma-focused cognitive therapy can be used to help children and adolescents who suffer from post traumatic stress disorder.

Cognitive therapy is frequently used to treat adults who suffer from PTSD with proven results. *Post Traumatic Stress Disorder* provides the therapist with instructions on how CT models can be used with children and young people to combat the disorder. Based on research carried out by the authors, this book covers:

- assessment procedures and measures
- formulation and treatment planning
- trauma-focused cognitive therapy methods
- common hurdles.

The authors provide case studies and practical tips, as well as examples of self-report measures and handouts for young people and their parents, which will help the practitioner to prepare for working with this difficult client group.

*Post Traumatic Stress Disorder* is an accessible, practical, clinically relevant guide for professionals and trainees in child and adolescent mental health service teams who work with traumatised children and young people.

**Online resources:**
The appendices of this book provide worksheets that can be downloaded free of charge to purchasers of the print version. Please visit the website www.routledge mentalhealth.com/cbt-with-children to find out more about this facility.

**Patrick Smith** is a Lecturer in Psychology at the Institute of Psychiatry, King’s College London, and Consultant Clinical Psychologist at the South London and Maudsley NHS Foundation Trust.

**Sean Perrin** is a Lecturer in Psychology at the Institute of Psychiatry, King’s College London, and team leader for the Child Traumatic Stress Clinic at the South London and Maudsley NHS Foundation Trust.

**William Yule** is Emeritus Professor of Applied Child Psychology at the Institute of Psychiatry, King’s College London; Consultant Clinical Psychologist; and Founding Director of the Child Traumatic Stress Clinic.

**David M. Clark** is Professor of Psychology at the Institute of Psychiatry King’s College London; and Director of the Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Foundation Trust.
The CBT with Children, Adolescents and Families series, edited by Professor Paul Stallard and written by a team of international experts, meets the growing need for evidence-based treatment manuals to address prevalent psychological problems in young people. These authoritative, yet practical books will be of interest to all professionals who work in the field of child and adolescent mental health.' – Alan Carr, Professor of Clinical Psychology, University College Dublin, Ireland

Cognitive behaviour therapy (CBT) is now the predominant treatment approach in both the NHS and private practice and is increasingly used by a range of mental health professionals.

The CBT with Children, Adolescents and Families series provides comprehensive, practical guidance for using CBT when dealing with a variety of common child and adolescent problems, as well as related family issues. The demand for therapy and counselling for children and adolescents is rapidly expanding, and early intervention in family and school settings is increasingly seen as effective and essential. In this series leading authorities in their respective fields provide detailed advice on methods of achieving this.

Each book in this series focuses on one particular problem and guides the professional from initial assessment through to techniques, common problems and future issues. Written especially for the clinician, each title includes summaries of key points, clinical examples, and worksheets to use with children and young people.

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Post Traumatic Stress Disorder

Cognitive Therapy with Children and Young People

Patrick Smith, Sean Perrin, William Yule and David M. Clark
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Introduction

Cognitive therapy for PTSD with children and young people

Since publication of Beck’s seminal key text (Beck et al. 1979) on cognitive therapy for depressed adults, there has been rapid development of cognitive therapies for a range of disorders across a range of ages. This growth of effective treatments has come about in part because treatment approaches are theoretically based. That is, the careful evaluation of cognitive behaviour therapy (CBT) in randomised controlled trials has been preceded by equally careful evaluation of the cognitive models on which they are based.

The development of CBT for children and adolescents has lagged behind that for adults, but the overarching approach has been the same. Theoretical models of the disorder(s) specify maintaining factors; these are empirically tested in naturalistic or experimental studies; interventions aimed at reversing key maintaining factors are piloted; and finally, comprehensive CBT programmes which incorporate a variety of techniques to target key maintaining factors are tested in controlled trials.

This book is a reflection of the last stage in that process. It has its origins in a therapist guide which was used in a preliminary randomised controlled trial to evaluate cognitive therapy for young people with post traumatic stress disorder (PTSD, Smith et al. 2007), treatment being firmly based on Ehlers and Clark’s (2000) cognitive model of PTSD, suitably adapted for children (Meiser-Stedman 2002). The book is intended as an accessible, practical, clinically relevant guide for professionals working with traumatised children.

Who is this book for?

The book is aimed primarily at professionals and their trainees who work with traumatised children in child and adolescent mental health service (CAMHS) teams. This will include clinical psychologists, psychiatrists,
social workers, nurses, occupational therapists, family therapists, and others. Most will be gained from this book by those who have some prior CBT experience, although formal post-qualification CBT training is not required. Regular supervision will be helpful in implementing this treatment approach. It is hoped that this will be a useful resource for those who are experienced in working with children with PTSD, but also as a guide for less experienced trainees. The important point is that this treatment should be implemented by trained and qualified mental health workers in the context of a safe and professional approach to working with children and families – usually within a CAMHS setting.

CBT should be provided by suitably trained and supervised mental health practitioners.

Who can benefit from cognitive therapy for PTSD?

The model on which this treatment is based has empirical support for the 7 to 16 years age group, while the randomised controlled trial evaluating its effectiveness was carried out with 8 to 18-year-olds. Participants in the trial – and those in most of the basic research testing the applicability of the cognitive model – had developed PTSD as a result of single-incident traumatic events such as road traffic accidents and exposure to violence. Primarily then, the approach described here is intended for 7 to 18-year-olds who have developed PTSD as the primary disorder following a one-off trauma.

However, with some adaptation, this treatment is helpful for a broader range of young people. First, it may be used with those who have developed PTSD symptoms relating to more than one traumatic event, following multiple traumatic exposure. In this case, the same principles of treatment will apply, but additional sessions are usually needed in order to process multiple trauma memories. Second, the principles of this treatment approach may be used with children younger than seven years old, including pre-schoolers. Adaptations include more family involvement, less reliance on verbal processing of trauma memories, and a more behavioural approach to working with traumatic reminders.

What is cognitive therapy for PTSD?

The form of cognitive therapy for PTSD described in this book shares many characteristics with the wider family of CBT interventions that are used successfully across a range of disorders and ages. The approach is based on
Ehlers et al. (2005) cognitive therapy treatment programme for adults. Treatment components overlap to some extent with other CBT approaches, but differ in a number of key respects.

Cognitive therapy is theory based. The central idea in cognitive theories is that feeling, thinking and behaviour are all interrelated; changes to thoughts will influence feelings and behaviour. Put another way, idiosyncratic appraisals of events (the meaning we give to things) are critical in the regulation of affect and behaviour (Bolton 2005). The cognitive theory of PTSD (Ehlers and Clark 2000) is a detailed and elaborated, disorder-specific example of this central idea, and is described in Chapter 2. When working clinically, cognitive models or theories enable formulations to be developed: presenting problems are understood and explained using the overarching framework of the model. As described in some detail in Chapter 4, this cognitive formulation is a ‘working hypothesis’, subject to change or refinement as further information is gathered. It is also individualised for each client – it is a unique way of understanding each particular young person’s problems. Thorough knowledge of the model is therefore crucial to understanding a client’s problems, and in developing strategies to help. That is, CT for PTSD is far more than a collection of techniques. Cognitive models are sometimes construed as ‘roadmaps’. The model, or map, may suggest many different starting points or routes to change – but it is not prescriptive about how one gets there, about the means of transport. Cognitive theory shows the way, while cognitive therapy uses all sorts of ways to get there, pragmatically encompassing a wide variety of helpful techniques, some of which overlap with, or are drawn from, different therapeutic traditions. The important point to bear in mind here is that therapists must have a thorough grounding in the principles and models of the disorder, as well as skills in implementing the various treatment components with young people, if they are to effectively help their young patients.

CT for PTSD is based on a clear theoretical model which informs the intervention.

As with CBT in general, the therapeutic relationship in CT for PTSD is characterised by warmth, genuineness and accurate empathy. Maintaining high levels of empathy is crucial in carrying out PTSD work with young people, and therapists should be alert to the possibilities of either becoming overwhelmed by the intense nature of the traumatic material, or hardened to it over time. However, the therapeutic relationship in CT for PTSD goes beyond being empathic and supportive: it also characterised by being active, goal-oriented, highly collaborative, and by taking an empirical, scientific approach to problems. Collaboration starts at assessment. Here, the therapist and young person will agree joint goals which will give a clear direction in treatment. Collaboration continues when developing an
individualised formulation and a treatment rationale which is shared with the young person, at a level appropriate to their development. During the treatment phase, a strong therapeutic alliance is nurtured. The stance taken is one of actively working together as a team towards agreed goals. A trusting relationship is needed. For example, as will be seen in later chapters, the young person’s attempted solution in dealing with PTSD symptoms is often part of the problem, and young people must be able to trust their therapist if they are to drop these old unhelpful habits and test out new ways of responding to difficulties. ‘Collaborative empiricism’ in CT for PTSD refers to the scientific approach that is taken within sessions. That is, a problem is defined and relevant data are gathered (through self or parent report, or from questionnaires); hypotheses or predictions are made and then tested out in behavioural experiments or site visits; data are monitored and hypotheses are revised in the light of the new findings that have been discovered together. Empiricism and experimentation are emphasised throughout. Therapist and young client are working together as a scientific team, jointly discovering new information that will help to alter old unhelpful ways of thinking and behaving.

CT for PTSD is based upon a therapeutic relationship which is empathic, supportive, goal oriented, and promotes collaborative empiricism.

Put this way, CT for PTSD can appear rather cold, level-headed and overly rational. But this sort of therapy, done well, is none of these things. First, children’s level of felt or displayed emotion in sessions may be intense. Therapists are often working with very high affect, especially at the beginning of treatment. Although expression of strong feelings in itself is not necessarily an aim of therapy, the important point in CT for PTSD is that the all-important cognitions, so central to maintaining the disorder, are invariably associated with strong emotions: cognition and emotion go hand in hand. Second, CT for PTSD is active, energetic and at times fun for young people. It is characterised by discovering new information and learning new ways of responding and behaving, hopefully in a manner that is engaging and interesting. Of course it can be hard at times, but the overall attitude in CT for PTSD is a positive one, looking forward and opening up new possibilities for change.

Finally, there is also a strong education element to CT for PTSD with young people. This is apparent first of all in the initial emphasis on psycho-education for children and parents about the nature of PTSD and its treatment. It comes to the fore in some of the behavioural experiments used to demonstrate the unintended consequences of suppressing thoughts and feelings. Education and new discoveries are of course part of the collaborative empiricism that is a theme throughout sessions. There is also some explicit skills learning for particular problems during the course of CT for
PTSD, as described in Chapter 5. Kendall (2006) has thus characterised the role of the therapist in CBT for young people as a coach/educator – someone who is supportive and encouraging, providing opportunities for the young client to try out new strategies, and giving feedback to help them develop new skills. The education element to CT for PTSD is explicit at the final session, where young people are helped to reflect on what they have learned during the course of therapy and to write out a ‘blueprint for the future’, an individualised relapse prevention plan, based on the new discoveries and skills they have learned during therapy.

Psycho-education and learning through doing are core elements of CT for PTSD.

### Developmental aspects to cognitive therapy for PTSD

The cognitive model of PTSD (Ehlers and Clark 2000) was developed with adults in mind, but has empirical support for children as young as seven years old (Bryant et al. 2007). Ongoing work (Meiser-Stedman et al. 2007) suggests that at least some aspects of the model may apply to even younger children. This research, and our clinical experience, shows that while the principles of the cognitive model do indeed apply to young children, the nature of the idiosyncratic misappraisals differ between adults and children. That is, subjective meaning seems to play a central role for children, as it does for adults, although the kinds of attributed meaning will be different. From an individual case consideration, Bolton (2005) is reassuring on this point. Rather than being concerned with general questions about the child’s cognitive developmental level, the therapist needs instead to ask the question: ‘What cognition is involved in the maintenance of the problem in this particular case?’ If cognitions and appraisals are involved in the problem for a particular child, then they will need to be addressed; if not, then there is no need. The emphasis is firmly on the assessment of cognitive factors in individual cases.

A related question concerns the developmental level needed to engage in CT for PTSD (Stallard 2002). Reynolds and colleagues specified a number of cognitive abilities needed to engage in a typical CBT programme (such as the ability to distinguish between thoughts, feelings and behaviour; the capacity for logical thinking; memory abilities; a theory of mind). In a series of experiments they found that children as young as five years old show some abilities for many of these tasks (e.g. see Quakley et al. 2003, 2004; Doherr et al. 2005). They conclude that many young children could engage in cognitive therapy when given age-appropriate materials. The materials used in this CT for PTSD programme include handouts and leaflets, worksheets and diaries, and age-appropriate metaphors and experiments.
For very young children, the materials differ, with more use of play, drawing and cartoon strips to reconstruct trauma narratives. While the components of CT for PTSD are often very appealing to children and young people, clinical skill and experience are needed to engage young people and to adapt and implement these sorts of techniques successfully according to the child’s developmental level.

CT for PTSD can be used with children younger than seven years of age if appropriately tailored to the child’s development.

### A course of cognitive therapy for PTSD with young people

Following detailed assessment, a typical course of CT for PTSD with young people will last between 10 and 12 sessions. The first of these is a cognitive assessment, leading to a shared formulation and agreed treatment goals. The final session is a look towards the future, leading to an individualised written blueprint for relapse prevention. The intervening eight to ten sessions will comprise an individually customised treatment package combining some or all of the CT for PTSD components detailed in Chapter 5.

Sessions are generally held weekly. If less frequent, then some of the momentum in therapy is lost – new learning is not consolidated and new skills are forgotten. For this reason, appointments are scheduled well in advance and reminders given the day before. If appointments are missed, then it is helpful to double up appointments for the following week. Sessions vary in length, but are generally around 90 minutes. Longer sessions may be needed when carrying out imaginal reliving, especially in beginning sessions or when doing substantial work with parents.

CT for PTSD typically involves 10 to 12 weekly sessions.

Each session begins with listing the topics to be covered (setting an agenda), usually followed by a brief check in with the child’s symptoms and problems in the preceding week, referring to the Child PTSD Symptom Scale (CPSS) which the young person completes weekly. Homework review is done early in each session. Depending on the progress of homework, some tasks may be carried forward as new homework for the following week. The main topic for the session will fill most of the remainder of the time: this may be, for example, carrying out reliving or writing, continuing with cognitive restructuring, or designing behavioural experiments. In the spirit of collaborative empiricism described above, feedback from the young person is sought throughout. Towards the end of the session, it is useful to summarise
what has been done, and some young people will like to write brief notes as a reminder. The session finishes by setting new homework tasks. These will have arisen naturally from the main topic of the session and will be agreed and set jointly with the young person at the end of the session. The diaries or worksheets that are needed for homework will be handed out, and the young person keeps a note of what they have planned to do before the next session.

Parents or carers will always be seen if available. The varied and important roles that parents and carers may play in CT for PTSD are described more fully in Chapter 5. These may range from supporting the child in attending therapy sessions or completing homework assignments, to being a more active collaborator in treatment (helping to reconstruct trauma narratives, for example), to engaging in separate treatment for themselves. Each CT session will follow a similar format and will typically involve:

- agenda setting
- symptom assessment
- homework review
- main session topic
- agreeing homework task(s).
PTSD in children and young people

Until relatively recently, it was believed that children were largely resilient to the psychological effects of exposure to trauma. However, research over the last 15 years or so has established that the effects of major stressors, such as encountered in disasters, war, or other life-threatening experiences, may be severe and long lasting. Post traumatic stress disorder (PTSD) is just one of a broad range of adverse outcomes. Other potential reactions include depression, other anxiety disorders, and prolonged grief.

Graham was involved in a boating accident just before his twelfth birthday. His father, sister and Graham were rescued after hanging on to the wreckage for several hours, but his younger brother was swept away and drowned. Prior to the accident, Graham was well adjusted and happy. He was seen in clinic four months after the accident. A detailed personal and family history was taken from his parents along with an account of the accident and Graham’s subsequent behaviour.

Graham was seen later on his own. He said he did not know how to describe how low his mood was. Much of the time, he felt that life was not worth living and he had thought of ways of killing himself. He described how it took more than an hour to get off to sleep. He would lie in bed, not reading or listening to music, but thinking about how he and his brother used to be happy. Thoughts of his brother triggered a host of upsetting images of the accident.

On systematic questioning, Graham said that upsetting thoughts and pictures of the accident popped into his head every day. He had bad dreams every night. These woke him up and it then took him a long time to get back to sleep. Graham had occasional flashbacks in which he experienced the ‘up and down’ sensation of being in the water, he became cold and felt as if it were happening all over again. Graham felt that he could not do anything about the intrusive recollections, although he tried very hard not to think about the accident. He avoided talking
about the accident and his reactions to it, but now felt emotionally cut off from close friends and family. He saw less of his friends and had lost interest in hobbies. Graham was much more aware of danger and got scared very easily – he felt jumpy and was snappy with others. He missed his brother and felt bad that he had not helped him more. Graham felt that he would never be happy again.

Graham’s reactions to the dreadful accident are in many ways typical of those of children aged over eight years, although complicated by the grief he felt at the loss of his brother. Clinical experience, surveys and clinical descriptive studies show that children’s reactions to life-threatening traumatic events are broad and diverse. However, characteristic post traumatic stress symptoms tend to cluster, roughly speaking, into three main groups: intrusive recollections, avoidance and emotional numbing, and physiological over-arousal.

Intrusive recollections

Intrusive and distressing recollections of aspects of the traumatic event are the cardinal symptoms of post traumatic stress. Recollections may occur in any sensory modality, but visual images are most common. These may be snapshots (often of the worst moment or ‘hotspot’), or moving images. Children may report auditory intrusions, such as the sound of screaming, or cars crashing, or gunshots. Olfactory intrusions are rare, but usually evoke intense emotion when they occur. Occasionally, children will report what have been called ‘proprioreceptive intrusions’ – i.e. the sense that their body is moving in the same way that it did at the time of the event (as in the example of Graham above). Some children who sustained injury will re-experience physical pain when reminded of the trauma, despite there being no organic cause.

The language that children often use to describe these symptoms suggests that the subjective experience of intrusive recollections is quite different from that of deliberate recall of ordinary autobiographical memories. For example, children might talk of ‘seeing’ (rather than remembering) the event; or of ‘hearing’ the same sounds that were heard at the time of the event. That is, intrusive recollections have a strong here-and-now quality – visual images being particularly vivid and detailed. When asked directly, many children are able to describe this unusual (and frightening) quality to their trauma memories.
Intrusive recollections can occur at any time during the day. Sometimes, there may be very obvious reminders present. At other times, intrusions seem to pop into mind ‘out of the blue’, with no obvious external triggers. As described later, triggers are often very low level sensory cues which are difficult to spot. This can give rise to the subjective experience of out-of-the-blue intrusions. Children often report that they can keep intrusions at bay as long as they remain busy, but that upsetting recollections intrude into consciousness as soon as they relax, such as when trying to drop off to sleep.

When asleep, intrusive recollections may occur in the form of frightening vivid nightmares. Sometimes, these nightmares are straight replays of the event – with the child often waking up at the worst moment. Otherwise, dreams may be variations on what actually happened. The dream might be worse than the events that occurred in reality (for example, a child who survived a non-fatal car crash dreams that her parents were killed in the crash); or they may be events that the child wished had happened (for example, a teenager who was viciously assaulted by a gang of youths dreams that he fought back, rather than running away).

In contrast to other forms of intrusions, flashbacks appear to be less common in children. Some degree of dissociation – in which the young person feels that they have lost touch with their surroundings – occurs during flashbacks. Some care is needed in assessment here, because young people often use the word ‘flashback’ to report what we have described above as intrusive recollections. That is, direct enquiry about the extent of dissociation is usually needed in order to distinguish intrusions from true flashbacks.

Not all children will report intrusions, nightmares or flashbacks. Some children experience intense distress or strong bodily reactions in the face of traumatic reminders. This occurs, for example, when the young person has sustained a head injury which resulted in temporary loss of consciousness at the time of trauma. In this case, although no memory for the events after the loss of consciousness can have been laid down, the young person may show distress and physiological reactivity when encountering cues that were present before the loss of consciousness.

Very young children may not be able to report the sorts of symptoms described above. Instead, re-experiencing in the young child may be expressed in repetitive and trauma-thematic play. Parents of young children might report that trauma-related activities have increased since the trauma: a child who was involved in a car crash might play with his toy cars much more. Such play may not have the enjoyable, flexible, imaginative flavour that was present pre-trauma; it is instead characterised by being repetitive, sometimes with aggressive themes. For example, the child involved in a car crash may repeatedly smash his toys together, over and over again. This sort of play and drawing may be equivalent to intrusive recollections in older children. Alternatively, it might reflect an attempt by the child to better understand the event or to gain mastery over their recollections. Likewise, while vivid nightmares involving the theme of the trauma are common in children of all ages, younger children may experience an increase in dreams which are not about the traumatic event as such, but which are nonetheless
frightening: dreams involving monsters, being chased, getting lost, or other threats to the self or loved ones. On waking from nightmares, young children may become panicky, run to their parents’ bedroom and find it difficult to describe or recall what has been dreamt. Parents often find that they are unable to get the child back to bed and it is not unusual to learn from the parents that their traumatised child has not slept alone in months or even years.

Intrusive recollections, nightmares and flashbacks are cardinal symptoms of post traumatic stress disorder.

Avoidance and emotional numbing

Unsurprisingly, many children try to cope with these upsetting intrusive recollections by pushing them out of mind, or by staying away from any trauma reminders or triggers. For example, children often report that they try hard to get rid of intrusive memories when they arise, or try to recall pleasant memories instead, or try to keep themselves busy in order not to recall the trauma. Children might also be very clear that they are fearful and avoidant of trauma reminders. Overprotective parents might shield children from reminders, or discourage discussion of the trauma. Some child survivors experience a pressure to talk about their experiences, but paradoxically find it very difficult to talk to parents and peers. Often, they do not want to upset the adults, and so parents may not be aware of the full extent of their child’s suffering. Peers may hold back from asking what happened in case they upset the child further; the survivor often feels this as rejection.

When avoidant coping becomes ingrained or pervasive, children may lose interest in seeing friends, or in continuing with previously enjoyed activities or hobbies. Of course, changes in preferred playmates and activities are part of normal childhood development, and so care needs to be taken if symptoms are being assessed several months or years after the event. Older adolescents may feel that no one else can really understand what they have been through – they feel different to and cut off from peers to whom they were previously close. Survivors have learned that life is very fragile. This can lead to a loss of faith in the future, a sense of foreshortened future or a premature awareness of their own mortality.

Children may try to avoid intrusive trauma memories, talking about the trauma, or events and activities associated with it.
Physiological over-arousal

The third symptom cluster concerns physiological hyperarousal. Arousal symptoms are common in traumatised children of all ages and quite straightforward to assess. Trauma survivors are usually very alert to danger in their environment and continually on the lookout – hypervigilant – for potential threat. Hypervigilance is sometimes evidenced by excessive checking of locks and doors, overprotectiveness of others and frequent reassurance seeking. Children may report feeling continually ‘on edge’, ‘wound up’ or ‘jumpy’ – for example, in response to loud noises. Many children are much more irritable and angry than previously, both with parents and peers. Increases in arguments are common and parents are often bewildered that previously easy and placid children are now snappy and overly sensitive. Difficulties in concentration may occur, especially in schoolwork. Children might experience memory problems at school, both in mastering new material and in remembering old skills such as reading music. Sleep disturbances are very common: fears of the dark and waking through the night are widespread. Not surprisingly, difficulties around bedtime are common in younger children. Parents of younger children often report an increase in somatic complaints such as headaches and stomach pains.

Increased arousal may be demonstrated by hypervigilance, irritability, poor concentration and memory and sleep disturbance.

Diagnostic issues

Historically labelled as ‘traumatic neurosis’, ‘railway spine’ or ‘shell shock’, reactions approximating what we now call PTSD have been documented since before the beginning of the last century (Young 1997).

DSM-IV criteria for PTSD

In its current form, PTSD was first recognised as a distinct disorder in the third edition of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-III) in 1980, in response to the realisation that many young servicemen returning from the horrors of the Vietnam War were presenting with a syndrome that was proving very difficult to treat.

Initially it was thought that children would not present with such symptoms, but by the time of publication of DSM-III-R in 1987 it was recognised that some young people might do so. From the outset, a major problem for child mental health was that the PTSD diagnosis was developed as a result of working with adult patients. Twenty years ago, there were very