

Assessing Trauma in Children: A Review of The Evidence

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ABSTRACT

The civil courts require lawyers and experts to be very diligent in assessing trauma or potential trauma in children. Nearly all young people are likely to experience some psychological distress following trauma. This paper reviews the evidence and common factors in childhood single-event trauma and emphasizes the importance of a robust and comprehensive approach to assessment.

KEYWORDS

Trauma; Diagnosis; PTSD; NICE.

CASE REPORT

Immediately following a traumatic event almost all children will experience acute psychological distress. Some of these reactions are mild and/or transient and can be considered a normal response to trauma, and some (particularly when they last a long time or interfere significantly with social, family life or education) may meet the criteria for a clinically significant psychological diagnosis (as outlined in the DSM 5) and may require psychological intervention.

Commonly Seen Symptoms Following Trauma

Research and clinical experience suggest that almost all children have sleep disturbance following trauma (fear of being alone, fear of the dark, nightmares) and this usually lasts for several months[1]. It is not unusual for the psychological reaction of children following a traumatic event to include one or more of the following[1, 2]:

- Separation difficulties/"clinginess" (which may include sleeping in parental bed for the first few weeks)
- Concentration difficulties and memory problems
- Intrusive thoughts
- Not wanting to talk about their feelings
- Heightened alertness to dangers – wary of transport, affected by reports of disasters

- Foreshortened future – lost trust in long term planning, wanting to live "each day to the full"
- Depression
- Anxiety and panic
- Afraid of things that remind of the accident
- Crying and fearful clinging
- Aches and pains (tummy/head)
- Regressive behaviour (including bedwetting, thumbsucking, baby talk)
- Aggressive/reenacting play
- Confusion about the trauma and its meaning
- Worried/confused about death
- Concentration problems
- Worries about family safety
- Shame/guilt
- Worrying about the future ("if I grow up")
- Worry about how parents reacted to trauma

These difficulties often present themselves differently de-

pending on the child's age and developmental stage in the following ways.

Toddlers and Pre-School

- Bed wetting
- Sleep disturbances and bed hopping
- Hyperactivity
- Temper tantrums
- Separation anxiety
- Phobic reaction
- Loss of skills
- Increased perception of danger/clinginess/separation anxiety.

School Aged Children

- Oppositional behaviour
- Social problems
- Hyperactivity
- Feelings of guilt and shame
- Somatic problems such as stomach aches and headaches
- Concentration difficulties
- Depression

Adolescence

- Relationship difficulties
- Chronic separation anxiety
- Social withdrawal
- School failure or suspension
- Self-injury
- Suicidal ideation
- Substance abuse

These difficulties may last for a few weeks or even a few months, but if they continue beyond this time and interfere with the child's ability to attend school, socialise or cause significant disruption to family life, it may be indicative of a more clinically significant psychological problem.

There can also be high rates of additional psychological disorders running alongside the trauma related difficulties such as: depression, anxiety, substance misuse, dissociation, dysphoria and aggressive behaviour. These additional difficulties are more likely if the child has prolonged or repeated exposure to severe stressors.

Predicting Reactions to Trauma in Children

Studies suggest that exposure to potentially traumatic events in children and adolescents is common [3]. Figures show that between 62-68% of children in the studies conducted have

been exposed to a major traumatic event in their lives with half of this number having more than one. (Numbers are higher in developing nations).

It is difficult to predict whether a child's psychological reaction will be significant following a trauma. However, it has been well established in research that while short term psychological consequences are common. After 4-7 months following a trauma, parents often still consider their children to be having a moderate reaction (33%) and a further 11% considered their child to be severely affected [3].

Other studies have shown that 9% children develop Acute Stress Disorder following a trauma (short term but significant emotional response to a trauma), with 23% showing lower levels but still some symptoms, and 16% developing Post-Traumatic Stress Disorder. Those most at risk of a significant or long term reaction appear to be [4-7]:

- Younger children
- Those who have not fully recovered from the physical effects of the accident
- Those who had a parent involved in or who witnessed the accident.
- The severity of a father's PTSD
- The "personal meaning" of the trauma to the child (including appraisal of threat to life)
- Female gender

Unsurprisingly, children exposed to chronic and pervasive trauma are especially vulnerable to the impact of subsequent trauma. Sleep disorders in children following a Road Traffic Collision (RTC) have been found to be related to the severity of the mother's PTSD symptoms, as well as, again, female gender [8]. These studies highlight the need for medico-legal expert witnesses to consider the role of parental involvement in the index event, as well as the severity of PTSD symptoms in the parent and any ongoing physical effects when assessing children following trauma.

Help Seeking Following A Trauma

Despite many children experiencing moderate to severe symptoms following an RTC [4] it has been found that less than 50% of the parents of affected children appear to seek help of any form (including from friends) for their child (and only 20% of affected parents seek help for themselves). The National Institute for Health and Care Excellence (NICE) [9] notes that children – especially those under 8 years of age – may not complain directly of PTSD symptoms (but notes the prevalence of sleeping problems in this client group) but does guide A&E staff to inform parents of the potential problems their child may display after a traumatic event and suggest

that if symptoms continue beyond 1 month then help should be sought from the child's GP.

Treatment Provision

Unfortunately, research and clinical experience show us that well-meaning parents and carers may exacerbate or prolong psychological trauma symptoms; it is not uncommon to see family "accommodation" in relation to anxiety. Accommodation is where family members (usually parents) attempt to reduce distress by changing their own behaviours (overly reassuring, removal or avoidance of feared situations, allowing child to sleep in their bed when this would not usually occur, making special arrangements with siblings/teachers, repeating ritualistic behaviours to reduce anxiety (using the same routines or same words to comfort) [10]. These things shield the child from fully experiencing and thus habituating themselves to his/her symptoms of anxiety. In many cases where mild psychological symptoms continue at the time of a medico-legal assessment (often between 6 and 18 months post trauma) giving advice on reducing this accommodation is successful in eradicating these residual symptoms within 3 months.

Where significant PTSD symptoms have been ongoing for more than 3 months after a trauma, the NICE guidelines suggest that children should be offered a course (8-12 sessions, once a week) of trauma-focused cognitive behavioural therapy (TF-CBT) adapted appropriately to suit their age, circumstances and level of development. At present no good evidence for the efficacy of widely-used forms of treatment of PTSD such as play therapy, art therapy or family therapy exists. For children whose difficulties are predominately anxiety based, rather than PTSD, research has suggested that psychological treatment should be up to 16 sessions of cognitive behavioural therapy (CBT) [11].

Reporting on Mild Symptoms

New guidance that is currently being written regarding diagnosis discusses a new definition of a milder response to trauma which is called an Acute Stress Reaction. This is not defined as a mental disorder and is mainly focusing on shock and confusion as an understandable milder response to the trauma.

CONCLUSION

Children react differently to trauma depending on a multitude of factors, and it can be very difficult to predict whether their symptoms will develop into a diagnosable mental health condition, although there are some factors common in cases where longer term or significant difficulties have arisen. While it is important not to pathologise early distress or psychological reactions, a significant minority of children who have experienced trauma will have significant symptoms that interfere with life for a prolonged period of time, and are likely

to benefit from psychological therapy. This underscores the importance of a robust and comprehensive approach to the assessment of trauma in children, addressing medico-legal areas of reliability, truthfulness, causation and attribution in many ways which stand scrutiny and debate and which are independent and assist the court in its final decision [12].

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