TRAUMA- AND STRESSOR-RELATED DISORDERS

Acute Stress Disorder • Post-Traumatic Stress Disorder
Adjustment Disorders • Attachment Disorders of Early Childhood

OVERVIEW

Trauma is a lasting adverse effect on an individual caused by an event that involves a threat or danger. Events are not traumatic simply because they involve violence; instead, an individual's perception of threat or danger is what can cause trauma. Trauma can result when an individual directly experiences an adverse event, witnesses that event, or learns about it from others.

Exposure to trauma is very common. For instance, one study found that about 60 percent of children experience at least one trauma each year, with about 22 percent of these youth experiencing four or more different types of traumas.[1] Certain events can be more likely to trigger trauma- and stressor-related disorders, including being the victim of or witness to physical or sexual abuse, violence, accidents, and natural disasters, or being diagnosed with a life-threatening illness. However, the likelihood of an adverse outcome is determined by both the nature of the stressor(s) and the characteristics of the child, family, and post-stressor environment, as well as what interventions are offered after the traumatic event.

The primary trauma- and stressor-related disorders that affect children and adolescents are presented in Table 1. Each disorder has different treatments and will be discussed in its own section of this chapter. Recognizing that your child is struggling is the first and most difficult step. It may be difficult to acknowledge that trauma has taken place, because it may evoke guilt in a caregiver. Caregivers must keep in mind the occurrence of trauma does not necessarily mean they have failed in their caregiving responsibilities.

Experiencing trauma can lead to a broad range of potential psychological outcomes, many of which are presented in Table 2. However, it is important to note that, while these factors may be consequences of trauma, they do not always occur following trauma.

Families should take care, as thoughts or attempts of suicide may occur with trauma- and stressor-related disorders. Information about suicide is provided in the "Youth Suicide" section of the *Collection*. If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

Trauma-Informed Care

A new form of care is emerging that takes into consideration trauma that individuals experienced in the past. Trauma-informed care programs are based on recognition that trauma survivors are vulnerable and potentially

[1] Finkelhor, D., Turner, H., Ormrod, R., & Hamsby, S. (2009) Violence, abuse and crime exposure in a national sample of children and youth. *Pediatrics*, 1124, 1-13.

have triggers that may be aggravated by traditional service approaches. Trauma informed care programs seek to avoid those triggers and prevent the trauma from reoccurring.

The treatments for trauma-informed care are similar to treatments for PTSD. Because such a large proportion of children have had an experience that can be classified as a traumatic experience, trauma-informed care is appropriate. Such care avoids situations wherein undue stress is inadvertently placed upon a child. These triggers are thought to have negative short-term effects on emotional health, as well as long-term effects on physical and cognitive health.

Table 1
Disorders Affecting Children and Adolescents Exposed to Trauma

Disorder		Description
Acute Stress Disorder		Dissociative, re-experiencing, avoidance, and hyper-arousal symptoms following a traumatic event that are diagnosed after lasting three days to 1 month after trauma.
Post-traumatic Stress Disorder (PTSD)	PTSD	Re-experiencing, avoidance, and hyper-arousal symptoms following a traumatic event that are diagnosed at least 1 month after trauma exposure.
	Preschool Subtype	Recreating trauma in play; ongoing dreams or nightmares related or unrelated to the traumatic event; avoiding activities or places that trigger memories of the trauma; fear, guilt, and sadness; or withdrawing from friends and activities. Symptoms present for at least one month.
	Dissociative Subtype	Symptoms of PTSD combined with depersonalization, ongoing feeling of detachment from the body or mind, and derealization (regularly feeling that one's surroundings are unreal, dreamlike, or distorted).
Adjustment Disorders		Emotional and/or behavioral symptoms in response to an identifiable stressor, such as termination of a relationship or a persistent painful illness (discussed in a separate chapter in the *Collection*). Symptoms occur within 3 months of the onset of the stressor and do not persist for more than 6 months after the stressor or its consequences have terminated.
Attachment Disorders of Early Childhood	Disinhibited Social Engagement Disorder (DSED)	This disorder is diagnosed only in children. Children with DSED exhibit overly familiar and comfortable behavior with relative strangers, including a willingness to go off with strangers with minimal or no hesitation. The child rarely checks back with caregivers, even in unfamiliar situations.
	Reactive Attachment Disorder (RAD)	This disorder is diagnosed only in children. RAD affects infants and very young children. A child with RAD has a pattern of showing disturbed and developmentally inappropriate attachment behaviors. The child rarely or minimally turns to an attachment figure for comfort, support, protection, and nurturance.

Table 2
Symptoms and Consequences Related to Trauma in Children and Adolescents

Domain	Potential Symptoms or Consequences
Physical/Physiological	• Hypersensitivity to physical contact • Numbness • Problems with coordination and balance • Unexplained physical pain (e.g., headaches, stomachaches)
Medical/Mental Health	• Asthma • Autoimmune disorders • Pseudoseizures • Sleep disturbances and/or nightmares • Disordered eating • Dissociation (feeling that the self or world is not real) • Depression • Anxiety disorders • Substance abuse • Attention-deficit/hyperactivity disorder (ADHD) or ADHD-like symptoms • Suicide
Cognitive	• Poor attention • Problems with planning and goal-oriented behavior • Problems with learning • Lack of sustained curiosity • Problems processing new information • Difficulties with language • Impairments in auditory, visual, or spatial perception and comprehension
Attachment/ Relationships	• Distrust of and/or uncertainty about those around them • Problems attaching to caregivers and/or fearing separation from caregivers • Difficulties with boundaries • Interpersonal difficulties
Behavioral	• Poor impulse control • Self-destructive behavior • Aggression • Difficulty complying with rules • Oppositional behavior • Excessive compliance • Inappropriate sexual behaviors
Emotional	• Problems regulating emotions • Amnesia • Low self-esteem • Shame or guilt • Disturbances of body image

ACUTE STRESS DISORDER

Acute stress disorder is diagnosed when trauma-induced symptoms last for at least three days after the trauma. Any other symptoms that are resolved within three days do not meet the criteria for acute stress disorder. The manifestation of the disorder differs in every individual, but symptoms can mirror many of the symptoms of PTSD (which is discussed in the next section). Typically, symptoms consist of anxiety that includes some form of re-experiencing the trauma, or reactivity related to the trauma.

KEY POINTS

- **Characterized by problematic symptoms of trauma that last between three days and four weeks after the traumatic event.**
- **Half of youth with acute stress disorder later develop PTSD.**
- **Treatment involves therapies that restore a sense of safety and assist youth with processing the event.**

If symptoms persist past 1 month, the youth may then be diagnosed with PTSD. However, it is important to note that a youth may be diagnosed with PTSD without having been previously diagnosed with acute stress disorder. Approximately 50 percent of individuals with acute stress disorder may later develop PTSD. Recognizing acute stress symptoms in children and adolescents is a critical first step in the path towards preventing PTSD.

TREATMENT FOR ACUTE STRESS DISORDER

There are no standard treatments for acute stress disorder. The goal of intervention is to restore a sense of safety and assist in the processing of the traumatic event. In the days and weeks after a traumatic event, crisis intervention can involve elements of cognitive-behavioral therapy, supporting therapy, psychoeducational therapy, group and family therapy, and other age-appropriate therapies.

POST-TRAUMATIC STRESS DISORDER (PTSD)

PTSD is diagnosed when problematic symptoms related to trauma last longer than 1 month following a traumatic event. Children with PTSD show symptoms including, but not limited to, angry outbursts, insomnia, worrying about dying, and acting younger than their ages. The manifestation of PTSD can be different in every child or adolescent. Some youth experience PTSD through fear-based re-experiencing, while others have dysphoric mood states. PTSD can also manifest as arousal and reactive-externalizing symptoms. Symptoms of PTSD have the following components:

KEY POINTS

- **Characterized by symptoms such as re-experiencing the event, hypervigilance, avoidance, and negative thoughts.**
- **Symptoms in young children can include recreating the trauma in play, reoccurring nightmares, and fear, guilt, or sadness.**
- **Trauma-focused cognitive behavioral therapy (TF-CBT) has the most support as an evidence-based treatment.**

1. Recurrent experiences of the event, as in memories, dreams, or flashbacks
2. Amplified arousal, including sleep disturbances and reckless behavior

3. Avoiding thoughts, places, and memories about the event
4. Negative thoughts, moods, or feelings

Families should look for the following symptoms:

- Recurring memories of the event, which elicit strong and traumatic feelings
- Bad dreams
- Reenacting trauma during play
- Fear of dying early
- Loss of interest in activities
- Physical symptoms like headaches and stomachaches
- Sudden and extreme emotional reactions
- Dissociation from emotions
- Problems sleeping, both in falling and staying asleep
- Irritability or angry outbursts
- Trouble concentrating
- Acting younger than their age, including thumb sucking, whining, and clinging to an adult
- Increased awareness or alertness to their surroundings
- Repeating behavior that reminds them of the trauma
- Avoiding situations or places that remind them of the trauma

A. PTSD Preschool Subtype (6 Years and Younger)

- Recreating trauma in play/recurrent dreams of the trauma
- Ongoing nightmares with or without recognizable content about the traumatic event
- Avoiding activities or places that remind the child of the trauma
- Exhibiting fear, guilt, and sadness, or withdrawing from friends and activities

These symptoms cause major distress to the child; impair relationships with parents, family members, and/or friends; and affect the child's behavior in preschool or childcare.

B. PTSD Dissociative Subtype

A child or adolescent with PTSD Dissociative Subtype also has symptoms of either depersonalization or derealization. Depersonalization is an ongoing feeling that the youth is detached from his or her body or mind. Derealization is the recurring experience that the youth's surroundings are unreal, dreamlike, or distorted. Some experts believe that dissociation may be a coping response, and it is sometimes seen after sexual abuse.

EVIDENCE-BASED TREATMENT FOR PTSD

Children suffering from PTSD symptoms following a trauma should be treated quickly. The earlier the intervention, the more effective the treatments. The greatest emphasis should be placed on establishing an environment in which the child feels safe. An evaluation by a qualified mental health professional should be sought for any child showing recurring problems handling a traumatic event. Treatments are presented in Table 3.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT has been shown to be effective at improving PTSD, as well as symptoms of depression, shame, and behavioral problems. Parents who participated in treatment with their children have also been shown to have improved parenting skills, in addition to decreased levels of trauma, distress, and depression.

TF-CBT treatment includes core elements that make up the acronym PRACTICE. Each PRACTICE component builds on skills gained in previous sessions:

Psychoeducation is provided to children and parents about trauma and PTSD symptoms, while parents are provided with parenting skills to aid in the management of the child's symptoms.

Relaxation skills are provided.

Affective expression and modulation skills are treatment components.

Cognitive coping skills are provided.

Trauma narrative is developed and processed.

In-vivo mastery of trauma reminders is introduced to differentiate between reminders and dangerous cues in the environment.

Conjoint sessions, where the child and parent focus on having the child share his or her narrative and work on family communication, are also included.

Enhancing safety focuses on safety planning in the future.

These components typically take 12 to 16 sessions to complete. It is important to note that if the youth has complex trauma involving several traumatic incidences, treatment may take longer. Like other cognitive-behavioral treatments, parent involvement and knowledge of skills are important components of treatment. Then, parents or caregivers can help children with the skills outside of the therapy sessions.

TF-CBT is most effective with some degree of caregiver involvement; however, the treatment can still be effective with limited caregiver participation. TF-CBT may not be appropriate when the youth's predominant problems are disruptive behaviors such as defiance, disobedience, aggression, or rule breaking. Similarly, children who are severely depressed or suicidal, or who have active substance abuse, should first receive treatments specific to those conditions.

Table 3
Summary of Treatments for Youth with PTSD

What Works	
Trauma-focused cognitive behavioral therapy (TF-CBT)	Treatment that involves reducing negative emotional and behavioral responses related to trauma by providing psychoeducation on trauma, addressing distorted beliefs and attributes related to trauma, introducing relaxation and stress management techniques, and developing a trauma narrative in a supportive environment.
What Seems to Work	
Family centered treatment (FCT) trauma treatment	FCT trauma treatment provides intensive in-home services and seeks to address the causes of trauma, including parental system breakdown, while integrating behavioral change.
School-based group cognitive behavioral therapy (CBT)	Similar components to TF-CBT, but in a group, school-based format.
Not Adequately Tested	
Child-centered play therapy	Therapy that utilizes child-centered play to encourage expression of feelings and healing.
Medication	Includes treatment with selective serotonin reuptake inhibitors (SSRIs).
Resilient peer treatment	Classroom treatment that pairs withdrawn children with resilient peers with a parent present for assistance.
Eye movement desensitization and reprocessing therapy (EMDR)	Therapy that utilizes visual and physical memory imagery while the clinician creates visual or auditory stimulus to reduce negative memory and increase positive memory.
What Does Not Work	
Restrictive rebirthing or holding techniques	Restrictive rebirthing or holding techniques that may forcibly bind or restrict, coerce, or withhold food/water from children and have resulted, in some cases, in death; not recommended.
Psychological debriefing	An approach in which youth talk about the facts of the trauma (and associated thoughts and feelings) and then are encouraged to re-enter into the present. Recent research suggests this approach is ineffective and potentially harmful.

ADJUSTMENT DISORDERS

For a full discussion of adjustment disorders, see the "Adjustment Disorder" section of the *Collection*.

Adjustment disorders are emotional and behavioral symptoms in response to an identifiable stressor. Examples of stressors include, but are not limited to, experiencing the end of a romantic relationship, experiencing persistent pain with increasing disability, living in a high-crime neighborhood, or experiencing a natural disaster. The diagnosis should be reevaluated if the symptoms persist for more than six months following the termination of the stressor. Adjustment disorders represent a simple response to some type of life stress, which may or may not be traumatic, and they are quite common in children and adolescents.

ATTACHMENT DISORDERS OF EARLY CHILDHOOD

In humans, healthy brain development depends upon forming strong attachments in infancy and early childhood to one or more caregivers. In rare cases, attachment is never established or is severely disrupted. When this happens, a child's ability to form attachments can be severely compromised.

Disinhibited social engagement disorder (DSED) and reactive attachment disorder (RAD) are attachment disorders that manifest in early childhood in situations of profound neglect. These disorders are rare and are only diagnosed in young children.

RAD and DSED are sometimes seen in young children who have come into foster care after having been severely neglected, who have been hospitalized or institutionalized, or who experienced severe neglect in infancy or early childhood in an orphanage or other group care setting.

KEY POINTS

- **Rare disorders caused by a severe disruption in attachment to a primary caregiver in infancy or early childhood.**
- **Characterized by an inability to relate appropriately to caregivers and others (too familiar, too aloof, unable to accept comfort, etc.).**
- **Can indicate severe neglect or severe trauma in infancy or early childhood; sometimes seen in children who have grown up in orphanages or war-torn areas.**
- **No standard treatments have been identified. Treatments should focus on establishing a strong bond with a caregiver.**

A. Disinhibited Social Engagement Disorder (DSED)

DSED is characterized by a pattern of behavior in which a child exhibits inappropriately familiar behavior with strangers. The disorder is characterized by:

- Violations of normal social boundaries
- Unusually familiar behavior (verbal or physical)
- Diminished checking with caregiver when venturing away in unfamiliar settings
- A lack of fear in approaching and interacting with unfamiliar adults
- A willingness to go off with unfamiliar adults

DSED stems from extremely insufficient care of the child. DSED is rare, even in children who have been severely neglected.

Onset for DSED is typically before age five, and it may continue for life unless the child is treated and able to form new attachments. In high-risk populations, including severely neglected children placed in foster care or institutions, approximately 20 percent exhibit signs of DSED.

B. Reactive Attachment Disorder (RAD)

RAD is characterized by a consistent pattern of emotionally withdrawn behavior by the child towards his or her caregiver. A child with RAD rarely seeks comfort when distressed and rarely responds to comfort if given. Children with RAD exhibit limited emotional responses, are often bewildered or confused, and have unexplained episodes of sadness and irritability. They may also be unhygienic and have underdeveloped motor coordination.

Symptoms typically occur around age five but may occur at any age. Caregivers usually notice some or all of the following symptoms:

- Severe colic or difficulties feeding
- Failure to gain weight appropriately
- Difficulty accepting comfort or being calmed or soothed by caregiver
- A preoccupied or defiant attitude
- Being inhibited or hesitant in social interactions
- Being disinhibited or inappropriately familiar with strangers

Frequently, these symptoms occur in children who have been physically or emotionally abused and neglected. Often, RAD occurs in children raised in hospitals or institutional settings, those who have experienced traumatic loss, or those whose primary caregiver changes frequently. In high-risk populations, including severely neglected children placed in foster care or institutions, almost 10 percent exhibit signs of RAD.

RAD symptoms are very similar to those exhibited by children with Autism Spectrum Disorder, and children exhibiting these symptoms should be evaluated for both disorders.

TREATMENTS FOR ATTACHMENT DISORDERS OF EARLY CHILDHOOD

There are no standard treatments for attachment disorders that manifest in early childhood. Treatments have been shown to be beneficial when they emphasize the following in the child/caregiver relationship: psychological safety, stability in the time spent with the child, empathy when listening, permanence of an attachment figure, and emotional availability or attentiveness to the child's needs. Treatment can also include individual and family therapy, education, and parenting skills classes. A child with RAD or DSED may take a year or longer to trust a caregiver again.

RESOURCES AND ORGANIZATIONS

Anxiety & Depression Association of America (ADAA)
https://adaa.org/
Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/
Child Welfare League of America (CWLA)
http://www.cwla.org
Georgetown University Center for Child and Human Development
Trauma Informed Care
https://gucchd.georgetown.edu/TraumaInformedCare/
International Society for Traumatic Stress Studies (ISTSS)
https://istss.org/home
Medical University of South Carolina (MUSC)
Trauma Focused-Cognitive Behavioral Therapy
http://tfcbt.musc.edu
National Child Traumatic Stress Network
https://www.nctsn.org
Prevent Child Abuse America
800-CHILDREN (244-5373) or (312) 663-3520
http://preventchildabuse.org/
Society of Clinical Child and Adolescent Psychology
https://sccap53.org/
Substance Abuse and Mental Health Services Administration (SAMHSA)
National Child Traumatic Stress Initiative (NCTSI)
https://www.samhsa.gov/child-trauma

VIRGINIA RESOURCES AND ORGANIZATIONS

Ainsworth Attachment Clinic & Circle of Security
(434) 984-2722
http://theattachmentclinic.org
Child Savers Guidance Clinic & Trauma Response
(804) 644-9590
https://childsavers.org/
Families Forward
https://www.familiesforwardva.org/
University of Virginia Children's Hospital
https://childrens.uvahealth.com/
VCU Health – Children's Hospital of Richmond
Cameron K. Gallagher Mental Health Resource Center
https://www.chrichmond.org/services/mental-health/cameron-k-gallagher-mental-health-resource-center
Virginia Treatment Center for Children (VTCC)
https://www.chrichmond.org/services/mental-health/virginia-treatment-center-for-children
Virginia Child & Family Attachment Center
(434) 242-2960
https://attachmentclinic.org
Virginia Commonwealth University (VCU)
Center for Psychological Services and Development
https://cpsd.vcu.edu/
Virginia Department of Behavioral Health and Developmental Services
http://www.dbhds.virginia.gov/
List of TF-CBT Certified Providers
https://dbhds.virginia.gov/assets/Developmental-Services/children-and-families/november-2018-tf-cbt-providers.pdf
Virginia Tech
Child Study Center
http://childstudycenter.wixsite.com/childstudycenter
Psychological Services Center
https://support.psyc.vt.edu/centers/psc

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