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ABSTRACT

Literature exists to support the statement that children suffer from Post Traumatic Stress Disorder (PTSD). The diagnosis is not one that is commonly made in children and is generally considered occurring in returning war veterans or adult victims of trauma, including incest. The American Psychological Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM)-III-Revised defines post-traumatic stress disorder, an anxiety disorder, as distinguished by the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience. An improved method of diagnosing PTSD, especially in children, would be the inclusion of acute versus chronic differentiation. Consider that a prolonged, or painful, event in a child's life can meet the criteria for experiencing PTSD in children. Too often children are viewed as passive recipients of life experience when they are instead dynamic consumers of all the experiences that come their way, whether good or bad. PTSD in children can result in aggression and precocious sexuality, alterations in a child's sense of security and perceived vulnerability, challenge self-esteem, create or escalate stress in intrafamilial and peer relationships, and change future orientation. Improved diagnosis can effect treatment considerations and assist a child experiencing PTSD to an improved level of functioning. (ABL)

Post-Traumatic Stress Disorder and Childhood Trauma: A Proposed Addition to the APA DSM-IV-R

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Running head: POST-TRAUMATIC STRESS DISORDER AND CHILDHOOD TRAUMA

Abstract

The emotional lives of children and their development impact the subsequent adult life they will lead. Children who suffer, and the effect this has on their development, has not been adequately addressed in the current literature. This paper discusses the effects of trauma in children, the potential for the development of post-traumatic stress disorder, and proposes the inclusion of a new diagnostic criterion in the American Psychological Association Diagnostic and Style Manual, 4th Edition-Revised (DSM-IV-R).

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Adlerian Views on Child Development

Adler contended that the truly overriding motive in human development was a *will to power,* a striving for superiority. He wrote that "whatever premises all our philosophers and psychologists dream of---self-preservation, pleasure principle, equalization---all these are but vague representations, attempts to express the great upward drive" (Adler, 1930, p. 398). What becomes of this upward drive in children who suffer? Does undergoing prolonged and/or painful procedures change the way children develop? If so, to what degree is their subsequent development impaired and are the effects temporary or permanent? The impact of prolonged or severe suffering on a child's development will be examined.

Adler described the family constellation as constituting the primary social environment for the growing child whose situation is comparable to an immigrant in a foreign country-unable to comprehend the language and unable to be understood. Until a child learns what is expected of her she is relatively helpless, incompetent, and inferior. Children observe their environment, make evaluations, and arrive at various conclusions regarding self, worth, and the environment. In the process of becoming a socialized human being, the child forms' conclusions based on her subjective experiences, whatever they may be (Corsini, 1984). The child

develops a cognitive map from which she views the world and her place in it. Use of the cognitive map assists the person in movement through the life span. Consider children who, for whatever reason, undergone prolonged and painful experiences. How do they then view the world that has inflicted suffering on them?

Childhood Trauma

Definition

In response to a recognizable stressor (e.g., experiencing or witnessing life threat, injury, or threat of harm), children have been reported to have symptoms of re-experiencing the event, persistent numbing, avoidant behavior, and signs of increased states of arousal (Pynoos et al., 1987). The infiltration of traumatic phenomena into a child's life may be evidenced by traumatic play, behavioral reenactments, intrusive thoughts and images, dreams, and psychological reactivity to reminders of the event (Nader & Pynoos, 1991). Children vary widely in their attempts to interpret these events and their symptoms, to regulate their emotions, and to search for meaning, information, and assistance. They often manifest avoidance behaviors and anxiety associated with specific traumatic reminders (Nader & Pynoos, 1991).

Occurrences

Some studies have focused on age differences in children's responses to traumatic events (Pynoos & Nader, 1990). Carey-Trefzer (1949) found that as a rule, the older the child, the more the sight of destruction

aroused anxiety. Younger children were more likely to reflect adults' reactions to war conditions: neurotic reactions occurred for them only if personally endangered. Other researchers (Glesser, Green, and Winget, 1981) found that school-age children exposed to a flood exhibited more severe psychic impairment than did preschool children. Symptoms found in adolescents were more likely to include a premature entrance into adulthood or premature closure of identity formation; feelings of shame, embarrassment, and betrayal; as well as post-traumatic acting-out behaviors.

Little systematic data has been presented regarding the effects of disaster or other traumatic experiences on child development. Posttraumatic stress phenomena may influence a number of characteristics that affect the developmental process including: cognitive functioning, initiative, personality style, self-esteem, outlook on life, and impulse control (Pynoos 7 Nader, 1990). Traumatic avoidant behavior can lead to inhibitions or altered interests in life that may persist bevond childhood.

Studies of children who have experienced trauma consistently reveal a marked change in orientation toward life, including negative expectations, a sense of a foreshortened future, and altered attitudes toward marriage, children, and a career (Pynoos & Nader, 1990). Children hospitalized or treated for physical ailments, like adults, often display symptoms remarkably similar to those noted in traumatized soldiers in wartime.

Such symptoms include: night terrors, fear of the dark, anxiety symptoms, obsessions, hysteria, and negativism (Levy, 1945). Nir (1985), studied childhood cancer patients and noted that life-threatening or other unexpected aspects of their illness tended to elicit feelings of helplessness and vulnerability.

Post-Traumatic Stress Disorder

Definition

The APA's DSM-III-R (APA, 1987) defines post-traumatic stress disorder, an anxiety disorder, as distinguished by the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience. It may be argued that a child has not had the length, or breadth, of experience that an adult possesses and, therefore, a child's range of usual human experience is brief. Children, especially those of pre-school age, typically lead a life that revolves around family and family activities. They do not possess the range of extrafamilial contact that an adult does in the everyday maintenance of a career, family, home, friends, and leisure activities.

Age-specific features noted in the current DSM-III-R classification include a child who may be mute in response to trauma, or refuse to discuss a traumatic event. A child who refuses to discuss an event should not in any way be confused with one who lacks the ability to remember what occurred. Younger children may experience distressing dreams of the traumatic event that, within several weeks post-event,

typically change into more generalized nightmares. Repetitive play seen in young children occurs in response to the child reliving the trauma, in this symptom through some repeated action that has meaning for the child.

Diminished interest is also noted to occur in a child's significant activities as well as constriction of affect. One of the few overt symptoms of PTSD in children may be a marked change in orientation toward the future as a direct result of experiencing a traumatic event. "Omen formation," or a belief in an ability to prophesy future untoward events may be noted by clinicians. Children are also known to exhibit various physical symptoms along with the specific symptoms of generally increased arousal.

Saigh (1989) studied Lebanese children employing scales measuring anxiety, depression, and school conduct. He concluded that PTSD cases significantly exceeded simple phobia and control group scores in all three behavioral areas. Children reared in a war-torn area have been significantly affected by their surroundings, most likely a consequence that will continue throughout their developmental years and early adulthood, if not for the duration of their life.

Children who grow up in situations of constant danger (not only limited to war areas, but also occurring in inner-cities) may experience PTSD although there may be no clear point at which to identify a specific traumatic incident. A diagnosis of PTSD currently requires: a stressful

event or experience that is persistently reexperienced in differing ways; persistent avoidance of stimuli associated with the trauma or general numbing of general responsiveness (not present before the trauma); and persistent symptoms of increased arousal (not present before the trauma).

An improved method of diagnosing PTSD, especially in children, would be the inclusion of an acute vs. chronic differentiation. The definition seen in the DSM-III specified the identification a stressor as well as a numbing of responses to, or reduced involvement with, the external world. Reexperiencing the trauma was required to occur in one of three ways. Distinctions between the DSM-III criteria and the DSM-III-R criteria include the temporal relationship of the symptom to the trauma; whether acute, delayed, or chronic. Reinstitution of the acute or chronic differentiation would better serve to identify a child suffering from PTSD.

Conclusions

Literature exists to support the statement that children suffer from PTSD. The diagnosis is not one that is commonly made in children and is generally considered occurring in returning war veterans or adult victims of trauma, including incest. Consider that a prolonged, or painful, event in a child's life (i.e., bone marrow transplant or cancer treatment) can meet the criteria for experiencing PTSD in children. Too often children are viewed as passive recipients of life experience when they are instead

dynamic consumers of all the experiences that come their way, whether good or bad.

PTSD in children can result in aggression and precocious sexuality, alterations in a child's sense of security and perceived vulnerability, challenge self-esteem, create or escalate stress in intrafamilial and peer relationships, and change future orientation. Improved diagnosis can effect treatment considerations and assist a child experiencing PTSD to an improved level of functioning.

REFERENCES

Adler, A. (1930). "Individual Psychology," in C. Murchinson (ed.), *Psychologies of 1930.* Worchester, Mass.: Clark University Press.

American Psychiatric Association: Diagnostic and statistical manual of mental disorders, Third Edition, Revised. Washington, DC, American Psychiatric Association, 1987.

Block, D., Silber, E., & Perry, S. (1956). Some factors in the emotional reaction of children to disaster. *American Journal of Psychiatry,* 113, 416-422.

Burke, J., Bourus, J., Burns, B., Millstein, K., & Beasley, Charles M.(1982).

Changes in children's behavior after a natural disaster. *American Journal of Psychiatry,* 139, 1010-1014.

Carey-Trefzer, C. (1949). The results of a clinical study of war-damaged children who attended the Child Guidance Clinic, the hospital for sick children, Great Ormond Street, London. *The Journal of Mental Science,* 95, 535-559.

Corsini, R. (1984). Current Psychotherapies. Third Edition. F.E.Peacock

Publishers, Inc., Itasca, IL.

Davidson, J. and Foa, E. (1991). Refining criteria for posttraumatic stress

disorder. *Hospital and Community Psychiatry,* 42(3), 259-261.

Gleser, G., Green, B., & Winget, C. (1981). *Prolonged psychosocial effects of diaster.* New York: Academic Press.

Levy, D.M. (1945). Psychic trauma of operations in children. *American Journal of Diseases of Children,* 69, 7-25.

Nader, K. & Pynoos, R. (1991). Drawing and play in the diagnosis and assessment of childhood post-traumatic stress syndromes. In C. Schaeffer (Ed.), *Play, Diagnosis and Assessment.* New York: Wiley.

Nader, K., Stuber, M., and Pyncos, R. (1991). Posttraumatic stress reactions in preschool children with catastrophic illness: Assessment needs. *Comprehensive Mental Health Care,* 1, (3), 223-239.

Nir, Y. (1985). Post-traumatic stress disorder in children with cancer. In S. Eth and R. Pynoos (Eds.), *Post-traumatic stress disorder in children.* Washington, DC: American Psychiatric Press, Inc.

Pynoos, R., Frederick, C., Nader, K., Arroyo, W., Eth, S., Nunez, W., Steinberg, A., & Fairbanks, L. (1987). Lifethreat and posttraumatic stress in school age children. *Archives of General Psychiatry,* 44, 1057-1063.

Pynoos, R.S. & Nader, K. (1990). Prevention of psychiatric morbidity in children after disaster. In S. Goldston, J. Yaeger, C. Heinecke, & R. Pynoos (Eds.). *Prevention of mental health disturbances in children.* Washington, DC: American Psychiatric Association Press, 1990.

Saigh, P. (1989). A comparative analysis of the affective and behavioral

symptomatology of traumatized and nontraumatized children. *Journal of School Psychology*, 27(3), 247-255.