ED460122 2001-09-00 Children and Post Traumatic Stress Disorder: What Classroom Teachers Should Know. ERIC Digest.

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ERIC Identifier: ED460122
Publication Date: 2001-09-00
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Source: ERIC Clearinghouse on Teaching and Teacher Education Washington DC., ERIC Clearinghouse on Counseling and Student Services Greensboro NC.

Children and Post Traumatic Stress Disorder: What Classroom Teachers Should Know. ERIC

Digest.

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Post traumatic stress disorder: development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA, 1996).

School children may be exposed to trauma in their personal lives or, increasingly, at school. Classroom teachers can help prepare children to cope with trauma by understanding the nature of trauma, teaching children skills for responding to an emergency, and learning how to mitigate the after-effects of trauma.

PTSD RELATED TRAUMA

By the very unexpected nature of trauma, one can never totally prepare for it. And because each individual responds differently to emotional upset, it is impossible to predict trauma after-effects. Under certain circumstances, trauma can induce Post Traumatic Stress Disorder (PTSD). Unrecognized/untreated PTSD can have a lifelong negative impact on the affected individual. Teachers, who spend up to eight hours each day with the children in their charge, can influence the outcome of a child's response to trauma stress by creating an environment in which PTSD is less likely to develop to the point of life impact.
Not all emotionally upsetting experiences will cause PTSD. Trauma sufficient to induce PTSD has specific characteristics and circumstances, including situations

* perceived as life-threatening,

* outside the scope of a child's life experiences,

* not daily, ordinary, normal events,

* during which the child experiences a complete loss of control of the outcome, and

* when death is observed.

Disasters, violence, and accidents are just some of the experiences that can lead to PTSD. Preparing children for trauma involves giving them skills and knowledge to survive the experience and emerge with as little potential as possible for developing PTSD.

SKILLS TO SURVIVE TRAUMATIC EXPERIENCES

Survival skills for traumatic experiences are essentially emergency action plans.Carrying out emergency action plans not only helps a child retain some personal control, but increases the potential for a healthy outcome. Children must know how to:

* Follow directions in any emergency (i.e., stay in their classroom during a lock down)

* Get help in any type of emergency (i.e., dial 911 or call a neighbor)

* Mitigate specific emergencies (i.e., take shelter during a tornado)

* Report the circumstances (i.e., tell an adult if a stranger approaches them or touches them)

* Say "no" and mean it (i.e., firmly shouting "no, don't touch me").

Implementing survival skills requires knowing right and wrong. Children must know or be able to recognize:

* Appropriate vs. inappropriate touching (i.e., shoulder vs. genitals).

* Appropriate vs. inappropriate information sharing (i.e., who is at home at what times).

* Presence of appropriate vs. inappropriate people (i.e., the teacher on playground duty vs. a prowling stranger).

SKILLS TO MITIGATE PTSD

While there is no predictability in who will develop PTSD, it is possible to take steps to prepare children ahead of time and by doing so, lessen the PTSD potential. Children need to be taught lessons about trauma. Learning about people who have experienced trauma and gone on to live healthy lives gives children role models and hope for their own future.
During a traumatic experience, children will survive better if they have a structure to follow and can maintain some sense of control. Learning the survival skills will aid in maintaining this control. Children need accurate and specific information about their immediate safety, about what has happened and about what will happen to them next (James, 1989). Knowledge helps them control their thoughts and feelings.

Following a trauma, debriefing is critical. Children will vary concerning their willingness and readiness to talk about their experiences. Some will play out the event, while others may be more comfortable writing or drawing about the event. What is important is the opportunity to communicate. There are different avenues for the child to communicate, including online discussion forums for children (Sleek, 1998).

A child's initial debriefing should be child-centered and nonjudgmental. The adult should recognize that each child did his or her best, no matter what the outcome, and refrain from offering advice. Adults should recognize that no two children will have the same thoughts, feelings, or opinions. All expressions about the trauma are acceptable.

Following a trauma, it is also important to help a child reestablish control. Reviewing survival skills and drills and planning for "next time" reestablishes strength. Allowing a child to make choices reestablishes their governance over their own lives.

IDENTIFYING PTSD

Everyone reacts to trauma. What differentiates normal reaction from PTSD is the timing of the reaction, its intensity, and the duration of the reaction. Trauma includes emotional as well as physical experiences and injury. Even second-hand exposure to violence can be traumatic. For this reason, all children and adolescents exposed to violence or disaster, even if only through graphic media reports, should be watched for signs of emotional distress (National Institute of Mental Health, 2000).
Symptoms lasting more than one month post trauma may indicate a problem. Specific symptoms to look for include:

* Re-experiencing the event (flashbacks),

* Avoidance of reminders of the event,

* Increased sleep disturbances, and

* Continual thought pattern interruptions focusing on the event.

In children, symptoms may vary with age. Separation anxiety, clinging behavior, or reluctance to return to school may be evident, as may behavior disturbances or problems with concentration. Children may have self doubts, evidenced by comments about body confusion, self-worth, and a desire for withdrawal. As there is no clear demarcation between adolescence and adulthood, adult PTSD symptoms may also evidence themselves in adolescents. These may include recurrent distressing thoughts, sleep disturbances, flashbacks, restricted range of affect, detachment, psychogenic amnesia, increased arousal and hypersensitivity, and increased irritability and outbursts or rage.

HELPING THE CHILD

Making the diagnosis of PTSD requires evaluation by a trained mental health professional. However, regular classroom teachers have a major role in the identification and referral process. Children often express themselves through play. Because the teacher sees the child for many hours of the day including play time, the teacher may be the first to suspect all is not well. Where the traumatic event is known, caregivers can watch for PTSD symptoms. However, traumatic events can involve secrets. Sexual abuse, for example, may take place privately. Sensitive teachers should

monitor all children for changes in behavior that may signal a traumatic experience or a flashback to a prior traumatic experience.
Teachers can help a child suspected of post traumatic stress disorder by: * Gently discouraging reliance on avoidance; letting the child know it is all right to discuss the incident;

* Talking understandingly with the child about their feelings;

* Understanding that children react differently according to age - young children tend to cling, adolescents withdraw;

* Encouraging a return to normal activities;

* Helping restore the child's sense of control of his or her life; and

* Seeking professional help.

Professional assistance is most important since PTSD can have a lifelong impact on a child. Symptoms can lie dormant for decades and resurface many years later during exposure to a similar circumstance. It is only by recognition and treatment of PTSD that trauma victims can hope to move past the impact of the trauma and lead healthy lives. Thus, referral to trained mental health professionals is critical. The school psychologist is a vital resource, and guidance counselors can be an important link in the mental health resource chain.

Although professional assistance is ultimately essential in cases of PTSD, classroom teachers must deal with the immediate daily impact. Becoming an informed teacher isthe first step in helping traumatized children avoid the life long consequences of PTSD.

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National Institute of Mental Health (2000). Helping children and adolescents cope with violence and disasters. Washington, DC: NIMH. Available online at http://www.nimh.nih.gov/publicat/violence.cfm

Sleek, S. (1998). After the storm, children play out fears. APA Monitor, 29(6). Available online at http://www.apa.org/monitor/jun98/child.html.

RESOURCES AVAILABLE FROM ERIC

These resources have been abstracted and are in the ERIC database. Journal articles (EJ) should be available at most research libraries; most documents (ED) are available in microfiche collections at more than 900 locations. Documents can also be ordered through the ERIC Document Reproduction Service (800-443-ERIC).

Demaree, M.A. (1995). Creating safe environments for children with post-traumatic stress disorder. Dimensions of Early Childhood, 23(3), 31-33, 40. EJ 501 997.

Demaree, M.A. (1994). Responding to violence in their lives: Creating nurturing environments for children with post-traumatic stress disorder (conference paper). ED 378 708.

Dennis, B.L. (1994). Chronic violence: A silent actor in the classroom. ED 376 386.

Karcher, D.R. (1994). Post-traumatic stress disorder in children as a result of violence: A review of current literature (doctoral research paper). ED 379 822.

Motta, R.W. (1994). Identification of characteristics and causes of childhood posttraumatic stress disorder. Psychology in the Schools, 31(1), 49-56. EJ 480 780.

Richards, T., & Bates, C. (1997). Recognizing posttraumatic stress in children. Journal of School Health, 67(10), 441-443. EJ 561 961.

OTHER RESOURCES

American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, NW, Washington, DC, 20016-3007, 202-966-7300, http://www.aacap.org

American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005,

202-682-6000; http://www.psych.org

American Psychological Association, 750 First Street, NE, Washington, DC 20002, 202-336-5500, http://www.apa.org

Anxiety Disorders Association of America (ADAA), 11900 Parklawn Drive, Suite 100, Rockville, MD 20852, 301-231-9350; http://www.adaa.org

Disaster Stuff for Kids, http://www.jmu.edu/psychologydept/4kids.htm

Federal Emergency Management Agency http://www.fema.gov/kids

International Society for Traumatic Stress Studies (ISTSS), 60 Revere Drive, Suite 500, Northbrook, IL 60062, http://www.istss.org

National Center for Kids Overcoming Crisis, (includes Healing Magazine online) 1-800-8KID-123, http://www.kidspeace.org/facts

National Center for PTSD, 215 N. Main Street, White River Junction, VT 05009; 802-296-5132; http://www.ncptsd.or

National Center for Post-Traumatic Stress Disorder of the Department of Veterans Affairs http://www.ncptsd.org/

National Institute for Mental Health (NIMH) 6001 Executive Boulevard, Rm 8184, MSC 9663, Bethesda, MD 20892-9663; 301-4513, Hotline 1-88-88-ANXIETY, http://www.nimh.nih.gov

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This digest is co-produced with the ERIC Clearinghouse on Counseling and Student Services.

This project has been funded at least in part with Federal funds from the U.S. Department of Education, Office of Educational Research and Improvement, under contract number ED-99-COO-0007. The content of this publication does not necessarily reflect the views of or policies of the U.S. Department of Education nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

Title: Children and Post Traumatic Stress Disorder: What Classroom Teachers Should Know. ERIC Digest.
Document Type: Information Analyses---ERIC Information Analysis Products (IAPs)

(071); Information Analyses---ERIC Digests (Selected) in Full Text (073);
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Descriptors: Coping, Elementary Secondary Education, Posttraumatic Stress Disorder, Stress Management, Stress Variables, Teacher Role
Identifiers: ERIC Digests, Survival Skills, Traumas
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