# Children and Trauma

## Update for Mental Health Professionals

2008 American Psychological Association
Presidential Task Force on Posttraumatic
Stress Disorder and Trauma in Children
and Adolescents

**Children and Trauma**
Update for Mental Health Professionals

**APA Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents**

Annette M. La Greca, PhD *University of Miami*
Beth A. Boyd, PhD *University of South Dakota*
Lisa H. Jaycox, PhD *RAND Corporation*
Nancy Kassam-Adams, PhD *Children's Hospital of Philadelphia*
Anthony P. Mannarino, PhD *Allegheny General Hospital*
Wendy K. Silverman, PhD, ABPP *Florida International University, Miami*
Farris Tuma, ScD, MHS *National Institute of Mental Health*
Marleen Wong, PhD *University of Southern California*

**APA Staff**
**Public Interest Directorate**
**Children, Youth, and Families Office**

Mary Campbell, Director
Efua Andoh
Nancy Smith-Crawford

Government Relations Office
Diane Elmore, PhD, MPH

# CHILDREN AND TRAUMA

## Update for Mental Health Professionals

We live in an era in which many children, adolescents, and their families in American society are exposed to traumatic life events. Mental health professionals are, of course, deeply concerned about the impact of traumatic exposure on children and how these children and their families can best be helped. The Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents is a presidential initiative of 2008 APA President Alan E. Kazdin, PhD. The primary goals of the task force are to identify "what we know" and "what we need to know" regarding the development and treatment of posttraumatic stress disorder (PTSD) in youth and to present current knowledge and information, as well critical gaps in knowledge, about this important area.

Much of our knowledge about PTSD is based on studies of adults. As evidenced by the birth of new scientific disciplines (e.g., developmental translational neuroscience), it is clear that what we learn from research involving adults may not necessarily be applicable to children and adolescents. Indeed, the field of child and adolescent PTSD and trauma is relatively young, although the knowledge base has increased substantially over the past 2 decades. Moreover, task force members recognize that mental health professionals may have many different perspectives on child and adolescent trauma, particularly in regard to the specific nature of its effects and what interventions may be most effective in reducing negative outcomes and enhancing adaptive functioning. Although we attempt to summarize here what is currently known about child and adolescent PTSD and trauma, we welcome ongoing discussion and novel perspectives, which help to advance the field.

The task force understands that the United States is a highly diverse society comprising many different racial and ethnic groups. There is no doubt that because of poverty and discrimination, racial and ethnic minority youth and families are more likely to be subjected to traumatic events, and immigrant youth and families may be particularly at risk. Cultural context and background, as well as membership in a minority group, will affect how individuals perceive a traumatic event and its impact and how the community can assist in recovery. Mental health professionals must be sensitive to this array of issues and provide help in a culturally responsive manner.

## WHAT WE KNOW

### Many children are exposed to traumatic life events

A significant number of children in American society are exposed to traumatic life events. A traumatic event is one that threatens injury, death, or the physical integrity of self or others and also causes horror, terror, or helplessness at the time it occurs. Traumatic events include sexual abuse, physical abuse, domestic violence, community and school violence, medical trauma, motor vehicle accidents, acts of terrorism, war experiences, natural and human-made disasters, suicides, and other traumatic losses. In community samples, more than two thirds of children report experiencing a traumatic event by age 16. However, estimates of trauma exposure rates and subsequent psychological sequelae among children and youth have varied depending on the type of sample, type of measure, informant source, and other factors.

- Estimated rates of witnessing community violence range from 39% to 85% —and estimated rates of victimization go up to 66%.
- Rates of youths' exposure to sexual abuse, another common trauma, are estimated to be 25 to 43%.
- Rates of youths' exposure to disasters are lower than for other traumatic events, but when disasters strike, large proportions of young people are affected, with rates varying by region and type of disaster. Children and adolescents have likely comprised a substantial proportion of the nearly 2.5 billion people affected worldwide by disasters in the past decade.

Other acute and potentially traumatic events also affect large numbers of children. In 2006, 7.9 million U.S. children received emergency medical care for unintentional injuries (from motor vehicle crashes, falls, fires, dog bites, near drowning, etc.), and more than 400,000 for injuries sustained due to violence. Race and ethnicity, poverty status, and gender affect children's risk of exposure to trauma. For example, significantly more boys than girls are exposed to traumatic events in the context of community violence, and serious injury disproportionately affects boys, youths living in poverty, and Native American youths.

It is more common than not for children and adolescents to be exposed to more than a single traumatic event. Children exposed to chronic and pervasive trauma are especially vulnerable to the impact of subsequent trauma. When children, adolescents, and families come to the attention of helping professionals, the identified trauma may not be the one that is most distressing to the child. For this reason, gathering a thorough, detailed history of trauma exposure is essential.

### After exposure to a traumatic life event, short-term distress is almost universal

Children and adolescents vary in the nature of their responses to traumatic experiences. The reactions of individual youths may be influenced by their developmental level, ethnicity/cultural factors, previous trauma exposure, available resources, and preexisting child and family problems. However, nearly all children and adolescents express some kind of distress or behavioral change in the acute phase of recovery from a traumatic event. Not all short-term responses to trauma are problematic, and some behavior changes may reflect adaptive attempts to cope with a difficult or challenging experience.

Many of the reactions displayed by children and adolescents who have been exposed to traumatic events are similar or identical to behaviors that mental health professionals see on a daily basis in their practice. These include:

- the development of new fears
- separation anxiety (particularly in young children)
- sleep disturbance, nightmares
- sadness
- loss of interest in normal activities
- reduced concentration
- decline in schoolwork
- anger
- somatic complaints
- irritability

Functioning in the family, peer group, or school may be impaired as a result of such symptoms. Therefore, when working with children who may display these types of reactions, the clinician must make a careful assessment of possible exposure to trauma.

### Over time, most children return to their prior levels of functioning

The majority of children and adolescents manifest resilience in the aftermath of traumatic experiences. This is especially true of single-incident exposure. Youths who have been exposed to multiple traumas, have a past history of anxiety problems, or have experienced family adversity are likely to be at higher risk of showing symptoms of post-traumatic stress. Despite exposure to traumatic events and experiencing short-term distress, most children and adolescents return to their previous levels of functioning after several weeks or months and resume a normal developmental course. This resilience typically results in a reduction in both psychological distress and physiological arousal.

Research has provided evidence about predictors of trauma recovery, although there are no perfect predictors. Recovery can be impeded by individual and family factors, the severity of ongoing life stressors, community stress, prior trauma exposure, psychiatric comorbidities, and ongoing safety concerns. Also, poverty and racism can make this recovery much more difficult. Caretakers are affected by children's exposure to trauma, and their responses affect children's reactions to trauma. On a positive note, individual, family, cultural, and community strengths can facilitate recovery and promote resilience. Social, community, and governmental support networks are critical for recovery, particularly when an entire community is affected, as when natural disasters occur.

### Most children with distress related to trauma exposure and in need of help do not receive psychological treatment, and those who do receive a wide variety of treatments

Although most return to baseline functioning, a substantial minority of children develop severe acute or ongoing psychological symptoms (including PTSD symptoms) that bother them, interfere with their daily functioning, and warrant clinical attention. Some of these reactions can be quite severe and chronic. Most children and adolescents with traumatic exposure or trauma-related psychological symptoms are not identified and consequently do not receive any help. Even those who are identified as in need of help frequently do not obtain any services. This is especially true for children from ethnic and racial minority groups and for recent immigrants, who have less access to mental health services. Even when children are seen for mental health services, their trauma exposure may not be known or addressed. For those children who do receive services, evidence-based treatment is not the norm.

Many of the treatments that traumatized children and adolescents receive have not been empirically studied. Although it is possible that some of these unexamined treatments could be helpful, it is also possible that some pose a risk for those who receive them. Despite the fact that diverse samples are included in many studies, there has been little work to understand the way in which culture affects the experience of trauma and the impact of treatment.

Cognitive–behavioral therapy (CBT) techniques have been shown to be effective in treating children and adolescents who have persistent trauma reactions. CBT has been demonstrated to reduce serious trauma reactions, such as PTSD, other anxiety and depressive symptoms, and behavioral problems. Most evidence-based, trauma-focused treatments include opportunities for the child to review the trauma in a safe, secure environment under the guidance of a specially trained mental health professional. CBT and other trauma-focused techniques can help children with cognitive distortions related to the trauma, such as self-blame, develop more adaptive understanding and perceptions of the trauma.

Like all clinical work, the quality of the therapeutic relationships among therapist, child, and parents/caretakers is the foundation for treatment of trauma. Safe, secure, and trusting therapeutic relationships support recovery processes and encourage children and parents to do the hard work of dealing with the impact of traumatic exposure. Developing these trusting therapeutic relationships is particularly challenging but critical for children and parents from ethnic and racial minority groups. This may stem in part from distrust associated with racism and poverty and also from mental health providers who may not fully understand the child's and family's cultural context. Culturally responsive efforts to engage families in treatment can be effective in meeting those challenges.

## HOW MENTAL HEALTH PROFESSIONALS CAN HELP

Mental health professionals have an important role in facilitating the recovery of children, adolescents, and families when traumatic events occur. Opportunities to help can come about by working with first responders and community organizations that serve families with children, by working with existing clients who experience trauma, and by reaching out to help children and families affected by trauma in their community. Psychologists and other mental health providers can also register with the American Psychological Association's (APA) Disaster Response Network or volunteer their services through their local chapter of the American Red Cross (see p. 7 for contact information). In addition, mental health providers can obtain training in developmentally and culturally appropriate evidence-based therapies for child trauma to effectively treat those children who do not recover on their own.

The opportunity to help is not limited to those who specialize in working with children. Mental health professionals who treat adults have the opportunity to identify and provide support to the potentially trauma-affected offspring of the adults. Mental health professionals can provide consultation to other professionals (in schools, health care settings, spiritual settings, and other service systems) about responding to trauma-exposed children, adolescents, and families. With special training and preparation, mental health professionals can participate in disaster or emergency response teams in their community.

### Support the child, family, and community

By drawing on existing strengths and resources of the child, family, and community, mental health professionals can help to reduce stress and foster the use of existing adaptive coping strategies by children and parents. Specific help in solving problems may be useful for children and their families in order to reduce stress. Traumatic events often lead to other stressors, or secondary traumas, such as police investigations; court proceedings; funerals; disruption of and displacement from school and other routines; housing and custody issues; loss of possessions, friends, and pets; and financial stress. Mental health professionals can help families navigate these real-life challenges and serve as advocates for social justice.

In times of extreme stress, individuals often fail to use their tried-and-true ways of coping. Thus, helping children and families figure out how to apply their existing skills to a new and unfamiliar type of event is in order. Other times, individuals need to build new skills to be able to handle a traumatic event. Training in coping skills and problem solving is often a part of evidence-based treatment. Mental health professionals must be sensitive to providing training that is consistent with children's developmental level and the family's cultural/ethnic background.

### Provide education about trauma reactions and hope for full recovery

Although children are shaped by their life experiences, most children recover from traumatic events. Some even report finding new strengths and skills for coping. Conveying information about common reactions to trauma can often be helpful, not only to the child but also to the people around him or her, including parents, teachers, coaches, clergy, and community leaders. Knowing what to expect and what reactions are most common can relieve adults' worries that the child will not recover or will be damaged forever. This information can also be useful before a traumatic event, and thus can be used in a preventative format. It is important for adults to know that children and adolescents understand and respond to traumatic events based on their developmental level. Parental expectations need to be consistent with what is typical for their child's age. If the individuals in a child's support system understand his or her behavior and distress as normal reactions to abnormal events, they can better support the child during the recovery period. Many useful materials are available on this topic, including those listed at the end of this document.

### Help children, families, and communities return to or create normal roles and routines

Helping children, families, and communities reestablish routines and roles can help return normalcy to a child's life, providing reassurance and a sense of safety. Resuming regular mealtimes and bedtimes, returning to school, renewing friendships and leisure activities, and playing in a safe environment can all help in this regard.

### Understand the child and family cultural perspective relating to the trauma, reactions to the trauma, and the need for and type of intervention

Because every child reacts to traumatic events in his or her own way, it is important to listen and try to understand children's unique perspectives and concerns, as well as those of the family. Culture plays an important role in the meaning we give to trauma and our expectations for recovery. Thus, trying to understand the child's experience (from the child's own point of view), as well as that of the child's family and community, can help guide intervention efforts. Those unfamiliar with mental health care may be reluctant to seek help and may need time to convey their concerns about treatment before they are ready to seek it. Also, children and families from ethnic and racial minority groups may encounter additional barriers, including limited access to mental health services and insensitivity from the majority culture regarding the impact of racism and poverty on their experience of traumatic events.

In some communities in which trauma exposure is prevalent both currently and historically, particular attention must be paid to the context of the trauma. Engaging community leaders such as clergy and other spiritual leaders, school personnel, health professionals, and caregivers will help everyone to understand the problems faced and the ways in which the community is prepared to handle them.

### Assess need and provide care consistent with the child's level of need and the time elapsed since exposure to the traumatic event

Different strategies are called for at different times and for different levels of symptom severity. For instance, because most children experience distress immediately after a traumatic event, a supportive, problem-focused approach may be useful in the acute phase of recovery. Later on, however, that same level of distress experienced by a child may indicate that a more intensive, trauma-focused approach is needed, such as one that emphasizes both skills training and the opportunity for the child to review the trauma. Similarly, it is useful to differentiate between

universal assistance that is likely to be useful to all trauma-exposed children and families (e.g., basic information on what to expect, support for existing coping resources) and targeted interventions that are appropriate only for those with demonstrated need (e.g., formal psychological intervention).

Although behavioral problems are readily noticed by parents and teachers, children's anxiety and depressive symptoms are not. Thus, it is good practice to assess anxiety and depression by asking children directly and obtaining children's own reports on those symptoms. Routine screening for traumatic exposures upon intake is recommended, and larger scale screening efforts to identify trauma-exposed children who are experiencing problems may also be warranted.

### Respect child and family readiness and willingness for treatment / Keep doors to treatment open

Children and families are not always ready for treatment when it is offered, and some may prefer not to engage in treatment at all. Whether in the immediate aftermath of an acute event or when ongoing trauma exposure or symptoms are initially identified by a professional, the help offered by mental health professionals may not come at the right time for that child or family. Particularly when traumatic events have led to other stressors or secondary traumas, the family may be focused on getting through these problems before they have the energy to turn to mental health needs. It is important to inform children and families about treatment options and let people know that treatment is available to them in the future, in case they are more receptive at a later time. Most important, keep doors to treatment open for the child and family.

### Consider confidentiality and privacy issues

Mental health professionals have extensive training in privacy issues and how to ensure confidentiality of their clients, but it can be challenging to protect confidentiality outside of the traditional office setting when working with children exposed to trauma. For instance, following a natural disaster or schoolwide trauma, mental health professionals may be working with children and families in school or community settings and may not be able to apply normal safeguards to protect privacy. In addition, many children with trauma-related distress may be identified in the juvenile justice or child welfare setting rather than in mental health settings. Mental health professionals must be careful to secure permission from children and parents before conveying information to school personnel or other community members.

### Advocate for trauma-focused treatment for those who do not recover fully

Since treatments such as cognitive–behavioral therapy work for children with persistent PTSD and related symptoms such as anxiety or depression, mental health professionals should advocate for this type of treatment when they encounter a child with such symptoms. Implementation of these treatments can be flexible, allowing for adaptations that are relevant to the child's developmental level and culture, as long as core concepts are delivered with fidelity to these treatment models. In areas where few mental health professionals have this type of training, psychologists can help develop training and supervision opportunities to enhance the community's capacity to deliver such care. Knowing who in the community has trauma treatment expertise can help even nonspecialists be prepared to connect children with the appropriate type of care.

In this rapidly evolving and expanding field, psychologists and other mental health professionals will need to keep up with advances in assessment and treatment to stay informed about new developments and to receive ongoing training in new intervention methods. Mental health professionals must advocate for trauma-informed treatment programs and techniques that have been studied, have empirical support, and can be implemented with children and families from diverse backgrounds and cultural experiences.

### Take care of yourself and watch out for burnout

The emotional toll of trauma can wear on professionals as well as the children and families they serve. Some types of traumas affect a whole community, thus affecting the helping professional both directly and indirectly through their clients' experiences. Self-care for professionals is important and includes watching for signs of burnout (e.g., exhaustion, numbing or distancing from others, overinvolvement with trauma survivors). Taking time to take care of yourself, limiting hours spent focusing on trauma, and seeking peer consultation can be effective ways to alleviate this type of stress.

## WHAT WE STILL NEED TO LEARN

Despite many recent advances in the field related to child trauma, there is still much to learn, including the key issues listed below. In all cases, studies are needed that include diverse populations (e.g., with respect to culture, ethnicity, and developmental level), as well as diverse types of trauma.

### Understanding the variety and complexity of children's reactions to traumatic events, and how reactions unfold over time

We need to understand the varied trajectories of children's reactions to, and recovery from, traumatic events. In particular, longitudinal studies are needed that identify risk and resilience factors and that evaluate how these factors interact to shape outcomes. Understanding what occurs biologically, behaviorally, and psychologically after exposure to traumatic events and how and why some children and adolescents recover over time will enable us to better determine who is in need of treatment and how best to deliver such treatment. Understanding the normal trajectories of recovery for children of different ages over time would also help determine the appropriate timing of preventive and treatment interventions. Until we know more about how to work with children who have been traumatized, mental health providers are in the position of ensuring that they "do no harm" and encouraging best practices in their communities.

### Developing practical predictors of psychological outcomes

The limited research to date assessing risk for ongoing distress after trauma exposure has identified some indicators of risk but no reliable way to gauge whether a given child will recover on his or her own or will require some intervention. More research is needed in this area, including the development of well-validated risk assessment tools that can be feasibly implemented in diverse settings and for diverse traumatic events and that will help identify the high-risk youth and families who are in need of clinical services.

### Increasing our repertoire of evidence-based treatments for children and families and knowing which type of treatment is optimal for different individuals or groups

We need to determine whether commonly used treatment and intervention approaches, such as supportive therapy and play therapy, are effective and, if so, for whom. Similarly, the use of medication to address trauma-related symptoms and reactions in trauma-exposed youth is very poorly understood. Progress in these areas would enable us to add more evidence-based treatments to our repertoire. We also need intervention development that targets risk-enhancing and buffering influences on children's trauma reactions. As interventions are developed and evaluated, we need to understand how to match the type, intensity, and duration of the treatment to the needs of children and families over time. Finally, we need to understand whether current treatments can be used with children and families across diverse types of trauma, diverse developmental levels, and in diverse environments and cultural contexts, or whether they need adaptation.

Two particular gaps in intervention are noteworthy. First, we have almost no information on the effectiveness of interventions for the early or acute phase of trauma recovery. Second, there are gaps in our treatments for those exposed to pervasive, widespread, or chronic trauma, where whole communities are affected.

### Disseminating evidence-based treatments for children and families

Finally, we need to determine how to disseminate the evidence-based treatments we already have so that they are readily accessible to mental health professionals across the country. Practical, flexible, and feasible tools that professionals can use to augment their current practice are greatly needed.

## FOR MORE INFORMATION

**American Psychological Association (APA)**
http://www.apa.org/practice/kids.html

**APA, Disaster Response Network**
http://www.apa.org/practice/drnindex.html

**American Academy of Child and Adolescent Psychiatry (PTSD Practice Parameters)** soon to be released
http://www.aacap.org

**American Red Cross—Disaster Services**
http://www.redcross.org

**Centers for Disease Control and Prevention**
http://www.bt.cdc.gov/mentalhealth/general.asp

**Federal Emergency Management Agency—Disaster Preparedness**
http://www.fema.gov/

**National Center for Posttraumatic Stress Disorder**
http://www.ncptsd.va.gov/ncmain/providers

**National Child Traumatic Stress Network**
http://www.nctsn.org

- **Measurement Review Database**
  http://www.nctsnet.org/nccts/nav.do?pid=ctr_tool_searchMeasures
- **Empirically Supported Treatments and Promising Practices**
  http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom

**National Institute of Mental Health**
http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

**SAMHSA–Coping With Traumatic Events**
http://mentalhealth.samhsa.gov/cmhs/traumaticevents/tips.asp