

## BEHAVIORAL CONSULT

## Helping Children With PTSD

Different forms of trauma can cause posttraumatic stress disorder in children, whether from an objective event like a car crash or sports injury to trauma involving loved ones, such as domestic violence, abuse, or neglect.

Pediatricians can help by routinely screening for dysfunction and by asking questions at annual well-child visits. Overt symptoms include fear related to the trauma such as avoiding the traumatic setting or activity. Less specific symptoms include anxiety, avoidance, social isolation, depression, and low self-esteem.

If a standard screen such as the Pediatric Symptom Checklist or another instrument reveals psychosocial dysfunction, you have to determine the cause of dysfunction, and PTSD should certainly be considered.

Is there family discord leading to violence in the home? If you suspect PTSD, ask a child what happened and why he or she thinks it happened. Determine if the child is blaming himself or herself in any way. Is the child grieving following a permanent injury and/or loss of a loved one? How have the parents discussed any traumatic event with the child? Do the parents feel traumatized by the child's experience?

If PTSD is a possibility, ask if the child is experiencing flashbacks, intrusive thoughts, and/or any related anxiety.

Some symptoms are expected after a traumatic event or following cancer or critical care treatment experienced as traumatic. Most children and adolescents overcome the fear of riding in a car or playing the sport that resulted in the trauma.

However, symptoms that persist for a month or more, with avoidance and associated anxiety, are core to the diagnosis of PTSD. The anxiety can build and be self-reinforcing so as to interfere with daily functioning. At this point, consider referral to a mental health specialist,

preferably one with some experience in PTSD treatment. A specialist can help the patient overcome his or her anxiety and return to functioning through cognitive and behavioral techniques such as reframing the events, dealing with any guilt, and staged exposure to the anxiety.



MICHAEL S. JELLINEK, M.D.

If one of your patients experienced a car crash or other major trauma, you will likely know about it, already be treating the child, and should be planning to monitor them for signs of PTSD. In contrast, detection of subtle PTSD is more challenging, particularly if the trauma is unknown or occurred years ago. Trauma related to domestic violence or sexual abuse first requires con-

sideration of this possibility and then gentle, empathic, and persistent questioning.

Triggers for reliving/reexperiencing the trauma also can be straightforward. For example, a child who gets into a car with a similar interior design years after a crash can immediately experience and emotionally return to the trauma. Other triggers are less obvious, such as a teenage girl who was held down and forced to have sex against her will, who later feels constrained by tight clothing and immediately relives the fear and anguish.

Like many presentations in pediatrics, management of PTSD depends on the developmental stage of the child, including his or her cognitive abilities and emotional state. For example, infants or toddlers might not be able to make much sense of what is happening when they witness domestic violence. Terror, fear, and confusion are their most likely reactions.

School-age children aged 5-8 years would not fully understand either, but they will try to make some sense of the domestic violence. Assuming no one reassures them otherwise, they also may feel that something they did sparked or contributed to the violence. For example, if they overhear arguments around issues in

the family and hear their name mentioned, they may quickly assume that they are the cause of the domestic violence. This can lead to feelings of guilt, self-criticism, and unworthiness.

Adolescents will experience some of the same reactions as younger children. They will still experience shock, even if they are better equipped to conceptualize the domestic violence. Some will feel powerless because they cannot end the strife, particularly at a time when they are supposed to have more control over the real world. Teens might feel they have not lived up to expectations and perceive some blame. Others may choose to flee, find support through friends, and/or may deal with their feelings using substances.

Act when you encounter a patient who feels very guilty about parental fighting or who justifies abuse because he feels worthless or was told repeatedly he was a bad child. Help him realize he was not responsible for the conflict and that no one deserves abuse. Discuss other, more realistic possibilities for the family paradigm.

These are not easy conversations. Some pediatricians will feel comfortable working at this depth, others will prefer to refer.

Healing from PTSD related to family violence, sexual abuse, or criminal activity is a several-step process. As one's sense of guilt diminishes, other emotions such as anger at not being better protected or valued need to be addressed. Finally, there needs to be some grieving for what was lacking and some acceptance of what was possible. This is not a simple process; however, it is worthwhile because if their PTSD remains untreated, there is a greater likelihood they will continue to relive traumatic memories as adults.

There is some controversy as to whether talking through the traumatic event over and over truly helps. Some clinicians feel that a certain amount of supportive discussion in a calm way makes sense, especially early. But solely repeating the details of the event may re-traumatize the child and intensify negative feelings,

especially if the memories are very vivid.

Cognitive and behavioral approaches can help the child reframe their trauma. An example is exposure therapy, where the child is carefully reexposed to the trauma in stages while they learn to reframe and diminish the intensity of the experience. Often, ideas about the trauma come out that can be examined objectively to try to lessen some of those traumatic feelings.

Exposure therapy also can incorporate gradual steps to help the child overcome their fear. If a person survived a plane crash, the first step might be to take him or her to the airport, then to board an airplane without taking off, and so forth. This approach reintroduces the trauma without eliciting a full response. You don't want the brain to go on "red alert" again. In a state of hyperarousal, reliving the trauma may do more harm than good.

The terrified moments that children experience during a traumatic sequence tend to get burned into their memories much more strongly than everyday events. A school-age child might remember nothing about an uneventful trip in the car, but if a traumatic accident happens, often she remembers almost every detail. She recalls descriptive elements of what happened as well as the emotional fright or anguish very vividly.

Sometimes vivid, traumatic memories will enter your patient's mind spontaneously without him knowing why. In other cases, there are triggers. Sometimes these flashbacks arise shortly following trauma and sometimes they take years.

Pediatricians can do their patients and families a service if they are aware of PTSD either after an overt event like a car accident or by considering trauma in an anxious or dysfunctional child. ■

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## Children With Autism Often Manifest Depression, Anxiety

BY MITCHEL L. ZOLER

FROM THE ANNUAL MEETING OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

NEW YORK – Roughly half of all children with autism have depression, and a majority have anxiety or irritability, based on an assessment of 627 pediatric patients.

As a result of these findings, children with autism should routinely undergo screening for depression and anxiety, and should receive treatment if either comorbidity exists, Susan D. Mayes, Ph.D., and her associates said in a poster presented at the meeting.

Depression and anxiety had an increased prevalence in older children with autism, in children with a more severe presentation, and in those with a higher IQ, said Dr. Mayes, professor of psychiatry at Penn State University in Hershey, Pa., and her associates. The prevalence of depression and anxiety showed no apparent relationship with sex, race, or socioeconomic status.

The researchers assessed the prevalence of these comorbidities in 1,607 children aged 1-17, including 667 diagnosed with autism, 853 children diagnosed with another psychiatric disorder (including attention-deficit/hyperactivity disorder, mental retardation, or brain injury), and 187 apparently healthy children. All of the children with autism had both a clinical diagnosis and a score in the autistic range on the Checklist for Autism Spectrum Disorder. The investigators assessed the prevalence of depression, anxiety, and irritability with the Pediatric Behavior Rating Scale.

The prevalence of depression ran 54% in children with high-functioning autism (an IQ of at least 80) and 42% among those with low-functioning autism (an IQ of less than 80). By comparison, 19% of the children without any psychiatric disorder or brain injury met the depression criteria.

The percentage of children with anxiety reached 79% in the children with high-functioning autism and 67%

in the low-functioning group, while irritability was tallied in 88% and 84% of the two autism subgroups. By comparison, 44% of the children without autism or another psychiatric diagnosis met the specified criteria for anxiety as well as for irritability.

Age played an especially strong role in the prevalence of depression and anxiety among the children with autism. In children aged 1-5 years old, the prevalence of depression ran 28% in the high-functioning group and 22% in the low-functioning children with autism. Among those aged 6-10 the rates reached 48% and 35%, respectively, and in those aged 11-17 the prevalence rates of depression rose to 72% in the high-functioning autistic children and 58% in the low-functioning children. The prevalence of anxiety rose from 62% and 36% in the high- and low-functioning children aged 1-5 to 89% and 88% in the two subgroups when they reached 11-17 years old.

Dr. Mayes said that she had no relevant financial disclosures. ■