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National Workforce Centre for Child Mental Health

Common severe stress reactions to a traumatic event

Note: The following information describes some of the possible difficulties children may demonstrate following exposure to various traumatic events. While every effort is made to ensure the accuracy of the material contained in this guide, the following information is not a substitute for independent professional advice or assessment and is not intended to be used to diagnose mental health difficulties.

Academic performance

Over time, some children may demonstrate a decline in academic performance. Although this could be due to a number of reasons, changes in academic performance can be linked to difficulties following exposure to a traumatic event.

Changes in academic performance following trauma may occur due to:

- difficulties completing homework tasks as a result of changes or problems in the home environment (e.g. some children may not have returned to their home, may be staying with relatives, may have not been able to replace schoolbooks and resources, etc.)
- ongoing family difficulties (e.g. financial stressors, family conflict)
- ongoing medical issues resulting from the natural disaster which prevent the young person from completing schoolwork or attending school
- difficulties sleeping (due to post-traumatic stress or anxiety) which interferes with the child's ability to concentrate at school; or
- depressed mood or anxiety resulting from the trauma. Children who experience ongoing depressed mood or anxiety will find it difficult to concentrate and will find it hard to motivate themselves to complete schoolwork. Some children may require additional motivation and reinforcement.

Social or interpersonal difficulties

Following trauma, children may experience difficulty interacting socially and maintaining friendships. This may be caused in part by other difficulties such as depression and anxiety but can also be directly linked to traumatic events. Children who have experienced trauma (particularly multiple events) may find it difficult to cope with interpersonal stress. For example, when faced with a difficult interpersonal situation (e.g. fighting with a friend, teasing, bullying), a child who has experienced something traumatic may simply find it more difficult to cope with this situation. These children may respond

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differently to such situations (e.g. cry, withdraw) than they would have previously (e.g. using appropriate social skills to manage the situation).

Over time, children may:

- start to withdraw from friends and peers
- get less enjoyment out of social activities
- fight more with friends
- react negatively to minor interpersonal incidents; or
- use inappropriate social skills or interaction patterns.

Post-Traumatic Stress Disorder (PTSD):
Post-traumatic stress symptoms or Post-Traumatic Stress Disorder (PTSD) can develop after exposure to an extremely traumatic event in which the child experiences intense fear, horror or helplessness.

Children under 6 years

Children who are **under the age of six** and experience PTSD may experience some or all of the following symptoms:

Intrusive symptoms

Recurrent, involuntary and intrusive distressing memories of the traumatic event.

- Recurring and upsetting dreams about the event.
- Flashbacks or other dissociative responses, where the child feels or acts as if the event were happening again.
- Strong and long-lasting psychological distress after being reminded of the event or after encountering trauma-related cues.
- Strong physical reactions to trauma-related reminders (e.g. increased heart rate, sweating).

Avoidance symptoms

- Avoidance or attempted avoidance of activities, places or physical reminders that arouse recollections of the traumatic event.
- Avoidance or attempted avoidance of people, conversations or interpersonal situations that serve as reminders of the traumatic event.

Negative alterations in thoughts and moods

- More frequent negative emotional states, such as fear, guilt, shame or sadness.
- Lack of interest or participation in activities that used to be meaningful or pleasurable, including limited or repetitive play.
- Social withdrawal.
- Persistent reduction in the expression of positive emotions.

Changes in arousal or reactivity

- Increased irritable behaviour or angry outbursts. This may include extreme temper tantrums.
- Reckless or self-destructive behaviour.
- Hypervigilance, which consists of being on guard all the time and unable to relax.
- Exaggerated startle response.
- Difficulties concentrating.
- Problems with sleeping.

Children over 6 years

Children who are over the age of six and experience PTSD may experience some or all of the following symptoms:

Intrusive symptoms

- Recurrent, involuntary and intrusive distressing memories of the traumatic event.
- Recurring and upsetting dreams about the event.
- Flashbacks or other dissociative responses, where the child feels or acts as if the event were happening again.

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- Strong and long-lasting psychological distress after being reminded of the event or after encountering trauma-related cues.
- Strong physical reactions to trauma-related reminders (e.g. increased heart rate, sweating).

Avoidance symptoms

- Avoidance or attempted avoidance of distressing memories, thoughts or feelings about or associated with the traumatic event.
- Avoidance or attempted avoidance of activities, places or physical reminders that arouse recollections of the traumatic event.
- Avoidance or attempted avoidance of people, conversations or interpersonal situations that serve as reminders of the traumatic event.

Negative alterations in thoughts and moods

- Inability to remember an import aspect of the traumatic event.
- Persistent and exaggerated negative beliefs around death and danger to oneself, others or the world.
- Persistent distorted thoughts about the cause or consequences of the traumatic event that result in self-blame or blame of others.
- Persistent negative emotional states, such as fear, shame or sadness.
- Increased lack of interest in activities that used to be meaningful or pleasurable.
- Social withdrawal.
- Persistent reduction in the expression of positive emotions.

Changes in arousal or reactivity

- Increased irritable behaviour or angry outbursts. This may include extreme temper tantrums.
- Reckless or self-destructive behaviour.
- Hypervigilance, which consists of being on guard all the time and unable to relax.
- Exaggerated startle response.
- Difficulties concentrating.
- Problems with sleeping.

It is important to understand that many children exhibit some of these signs immediately after they're exposed to a traumatic event. If these signs persist or worsen over time however, they can be an indication of something more serious. If the signs remain evident after a month, it is possible the child may require additional assistance to manage their difficulties.

Anxiety Disorders

All children and adults experience anxiety. Anxiety is a normal and helpful response to threatening situations and helps prepare us for action. However, for some children, ongoing anxiety may interfere with social and/or academic functioning. Below are descriptions of some common anxiety reactions that children may demonstrate.

Separation anxiety

It is normal for children to want to be close to their family and friends. However, after a traumatic event, some children may experience significant distress and fear when they are separated from loved ones, which can impact on their social and academic functioning. Children may also worry about the safety of loved ones or fear that something bad might force them to be separated. These worries can develop immediately following the traumatic event or appear at a later date. Children may display symptoms such as being distressed on arrival to school; refusing to attend school camps, excursions or external activities; or complain of physical symptoms (e.g. nausea, headache) when separated from loved ones. These symptoms can persist over time and can develop into Separation Anxiety Disorder.

Although concerns over separation from loved ones and home are often expected immediately following traumatic events, these behaviours may begin to

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interfere with the child's and family's functioning if they continue. Separation concerns can be developmentally appropriate (e.g. for younger children); however, one sign that the young person might need further assistance is if their distress becomes inappropriate for their developmental level or age, or if it prevents them from engaging in age-related activities. For example, an 11-year-old boy who would not leave his mother to go to a friend's house for two hours may be missing out on having fun, building friendships, and seeing that he can safely be separated from his parents.

Sometimes it can be difficult to determine if the child's emotional responses are developmentally appropriate and consistent with the type of separation they are experiencing (e.g. first school camp), or an emotional response to trauma. Professional assessment and intervention can help to distinguish between trauma-related and normal emotional responses and improve anxiety management.

Generalised anxiety

Children may develop or demonstrate more generalised forms of anxiety following exposure to traumatic events. Generalised Anxiety Disorder (GAD) is characterised by excessive and uncontrollable worry or anxiety, in which the young person overestimates the likelihood of negative consequences. For example, after hearing a weather forecast predicting rain showers, a young person may worry that there will be so much rain that the town will be flooded.

To some degree, all children who have experienced natural disasters will be on alert and occasionally may expect the worst when similar circumstances arise. This is a natural reaction, but children who develop GAD will experience such worry on a daily basis, often in the absence of direct evidence of a threat. Further, such children often tend to worry about a number of issues, and the worry persists over time (often over six months). Notably, these worries are not always related to the traumatic event the child has experienced.

Topics that children with GAD may worry about include:

- schoolwork
- being good enough at sports or other activities
- friends and social situations
- their own health or a family member's health
- finances, housing issues and family relationships
- new situations; and
- world events (including natural disasters, terrorism, news stories).

Children with GAD may also experience some somatic or physical complaints including muscle aches, tension, concentration difficulties, irritability, fatigue and difficulty sleeping. A lot of these symptoms overlap with signs of other psychological difficulties, such as Attention Deficit Hyperactivity Disorder (ADHD) or Post-Traumatic Stress Disorder (PTSD). One way of distinguishing between these difficulties is to find out what is causing the symptoms. For example, in the case of GAD, children may have trouble concentrating or sleeping because they are distracted by their worries, not because they are unable to concentrate or sit still (as with ADHD).

A distinctive feature of GAD is difficulty controlling their worry and excessively seeking reassurance from others, often by asking a lot of 'What if....' questions. Over the course of a day, a child with GAD might ask their parents, educators and other adults many questions like 'What if I am late to class?', 'What happens if it rains at lunch time?' or 'What if my mum is late picking me up?' Children with GAD might also be worried about others in their class and how they might be affected by others' behaviours.

Panic attacks and agoraphobia

Panic attacks and agoraphobia are generally less common in childhood than adulthood. However, some children may develop panic attacks following exposure to a traumatic event, which can cause the child and their family significant distress.

Panic attacks are characterised by a sudden onset of intense fear or discomfort, which is often accompanied by a sense that something bad is about to happen. Typically, such panic attacks occur without a specific trigger (i.e. outside of anxiety-provoking situations) and can occur anywhere, any time. Children may report

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such feelings as non-specific anxiety about suddenly becoming ill, or fears of suddenly vomiting that are difficult to control.

Panic attacks are also typically accompanied by sudden physical sensations that the child misinterprets as a sign that something is wrong, which in turn increases their anxiety. Physical signs include increased heart rate, chest pain, sweating, trembling, dizziness, breathlessness, nausea and difficulty swallowing. Although physical symptoms are common across the various anxiety disorders, in panic disorder, the symptoms come on quite suddenly and are typically time-limited (e.g. 15-30 minutes). Children with panic disorder may also experience agoraphobia, which occurs when the young person begins to avoid going to places where they believe a panic attack might occur (e.g. a shopping centre).

The difference between avoidance in agoraphobia as opposed to avoidance within PTSD (for example), is that in panic and agoraphobia, the young person is not afraid of the situation itself or the memories associated with it. Rather, they are worried that they will have a panic attack in that situation.

Depression

Depression is one of the most common mental health problems experienced by children and can develop following exposure to a traumatic event. While many children who are involved in natural disasters will feel sad, moody and low at times following the event, some of these children might experience these feelings for long periods of time; experience quite intense depressed moods; or will frequently feel depressed without any reason. Some children may continue to experience depressed moods long after the traumatic event (e.g. a year later).

Children with depression might find it hard to function, have difficulty with their schoolwork, and may stop participating in activities which they previously enjoyed. A depressed mood may be a direct result of the child's experience with the disaster, or it may be due to an accumulation of stressors and events.

Behaviours that might be evident in children with depression:

- Changes in mood, or moodiness that is out of character.
- Increased irritability, especially for teenagers.
- Withdrawal from or difficulty engaging in social interactions.
- Withdrawal from previously enjoyed activities (e.g. not wanting to participate in sports, drama, etc.).
- Alcohol and drug use.
- Staying home from school.
- Failure to complete homework and class activities or reduction in academic performance.
- Changes in concentration levels.
- Changes in sleeping routines; always seems tired, exhausted.
- Presence of negative thoughts; inability to take minor personal criticisms.
- General slowing in thoughts and performance.

Down or depressed moods that have persisted for an extended amount of time may indicate that the young person requires further assessment and assistance.

Behaviour problems

All children experience times when they are disruptive, have difficulty getting along with peers or difficulty following rules. After a traumatic event children may be more argumentative, aggressive, easily annoyed, and/or have difficulty following rules, managing their emotions (e.g. anger) and engaging in appropriate peer relationships (i.e. they may bully/annoy others). Sometimes the young person's behavioural difficulties may be more serious and include activities such as stealing, lying or running away.

For most children, these behaviours are transient and disappear over time. However, for some children these

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behavioural difficulties will persist over time, impact on others (e.g. educators, classmates, friends, siblings) and interfere with the child's social, academic and home life. For some, these problems can become more serious or even present as Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) or Conduct Disorder – which are often referred to as 'externalising' or 'behaviour' disorders.

- **Attention Deficit Hyperactivity Disorder (ADHD)** is characterised by difficulty with attention and concentration. Children with ADHD may also have difficulties with impulsiveness and regulating their behaviour.
- **Oppositional Defiant Disorder (ODD)** is characterised by oppositional, defiant or hostile behaviours towards peers and adults, particularly authority figures.
- **Conduct Disorder (CD)** is a more serious form of externalising disorder and may include overt aggression, difficulties with the law and a disregard for the rights of others.

Although some children may be demonstrating these behaviour disorders, for others, such behaviours may in fact be an expression of trauma-related difficulties.

Sometimes it is unclear whether or not the child's behaviours are reactions to trauma or signs of independent behavioural difficulties (e.g. ADHD). Unfortunately, some of the more common treatments for ADHD, such as medication are unlikely to assist in managing behaviours resulting from trauma.

New difficulties and behaviour problems that arise after exposure to a potentially traumatic event should be investigated. Distinctions between trauma reactions and independent behavioural difficulties can be made through professional assessments and interventions.

Other problem behaviours: A range of other behaviours may also be expressed by children following traumatic events. These include tension-reducing habit disorders such as:

- thumb sucking
- nail biting
- body rocking
- breath holding
- hair pulling
- stuttering; and
- nervous tics.

These behaviours may be a concern for parents, caregivers and educators if they are excessive; if other children notice them; if they seem more typical of a younger child; or if they interfere with the child's ability to function.

Often these habits will resolve with time as the child recovers post-trauma. However, if behaviours persist or cause distress or impairment to the child, family or their peers, seeking professional help may be advised. Behaviours that are still evident some months after the trauma are likely to require assistance.

This tip sheet was originally developed by the Centre of National Research on Disability and Rehabilitation Medicine, University of Queensland as part of the Queensland Government's response to the Queensland Natural Disasters. [Kenardy, De Young, Le Brocque & March. (2011) Brisbane: CONROD, University of Queensland]. The materials and content have been revised and extended for use as part of the Emerging Minds: National Workforce Centre for Child Mental Health Community Trauma Toolkit.

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