Emerging Minds.

National Workforce Centre for Child Mental Health

Trauma responses in children aged 0–24 months

Key Messages

- Babies and toddlers aged 0–24 months are vulnerable to the negative effects of trauma.
- There can be tremendous individual variability in trauma responses.
- Child care professionals can play an important role in identifying children experiencing problems, especially if parents and caregivers are also coping with their own grief and loss and would benefit from additional support.
- Post-trauma reactions may interfere with the child's social, emotional, behavioural and academic development.
- Early intervention is recommended.

A commonly held belief is that children under the age of five are immune to the negative effects of trauma. This is not true. In fact, children in this age group may be the most vulnerable to experiencing adverse outcomes as they are undergoing a rapid period of emotional and physiological development, have limited coping skills, and are strongly dependent on their primary caregiver to protect them physically and emotionally.

Although babies, pre-schoolers and children may present with similar symptoms, the way children process and respond to a traumatic event very much depends on their age and developmental stage. It is therefore very important for educators to understand how developmental differences may affect impact across age groups, as these will inform how best to help a child cope with a traumatic experience, such as natural disaster.

How do children react following trauma?

Children cope with trauma in different ways and there is no one 'standard' way that a child will react.

A child's response to a traumatic event will vary greatly depending on their developmental level, pre-trauma functioning, previous life experiences, level and type of exposure to the trauma, parental reactions and subsequent changes in living situation.

Whilst it is not always clear how children will react, research tells us that on average the majority of children are resilient and only experience minimal temporary distress. Some children will experience moderate to severe psychological distress immediately following the event but will gradually return to their previous functioning over time. A small minority of children will experience immediate traumatic stress reactions that persist or intensify over time. Finally, some children appear resilient at first, but develop trauma reactions later on.

Developmental considerations in children aged 0–24 months

Babies are especially dependent on their caregivers to nurture them and meet their needs for physical contact, comfort, food, sleep and attention. Developing a secure

Delivery partners:

Australian Government Australian Institute of Family Studies; Parenting Research Centre raising children well; Australian National University; RACGP

The National Workforce Centre for Child Mental Health is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program

February, 2019

attachment with a primary caregiver is a crucial task for this stage of development. However, after a trauma it can be challenging for a parent to meet all their child's needs. This can affect the child's sense of trust in their parent's ability to protect them.

Additionally, babies have minimal skills to communicate or cope with pain or strong emotions, making them highly dependent on their parents/caregivers to help them feel safe and secure and to regulate their emotions. This period is also when separation anxiety and fears of 'strangers' or unfamiliar people can develop. Babies may therefore be more aware of and frightened by separations from their caregivers and react fearfully around strangers. In the early stages following a trauma, it is therefore best to minimise separations from parents wherever possible.

Trauma responses to be aware of in children aged 0–24 months

- Heightened arousal (e.g. disturbed sleep, jumpy or easily startled, hard to settle or soothe).
- Changes in appetite (e.g. fussy eating, no appetite).
- Regression in previously acquired developmental skills (e.g. rolling over, sitting, crawling).
- Decrease in vocalisations.
- Behavioural changes (e.g. increased irritability, extreme temper tantrums, fussiness, attention-seeking, aggressive behaviour).
- Excessive clinginess to primary caregiver (e.g. crying upon separation, insisting on being picked up).
- Clinginess to anyone – even complete strangers.
- Decrease in responsiveness (e.g. lack of emotional reactions, numb appearance, lack of eye contact, little interest in environment/objects around them).
- Inconsolable crying.
- Alarmed by reminders of the event (e.g. sights, sounds, smells).

If left untreated or unresolved, trauma symptoms can cause significant, long-term negative impacts on children's social, emotional, behavioural and physical development. It is therefore important that children showing early symptoms of distress are referred for professional assessment and treatment to help alleviate symptoms, to ensure behaviours do not become engrained, and to help the child to continue to thrive and maximise their developmental trajectory.

Parenting and environment post-trauma

Following a natural disaster, parents may become preoccupied with coping with the event and providing life's necessities (e.g. repairing the home). Parents may also have difficulty coping with their own loss and grief. At this stage of development, children need positive reinforcement and encouragement to develop skills and independence. However, anxious parents may be reluctant to give the child autonomy or may inadvertently pass on their fear responses and difficulty coping to their child.

Parents suffering from depression may become more emotionally withdrawn, unresponsive and/or unavailable and may therefore have trouble helping their child to process and cope with distressing trauma symptoms.

The family plays a very important role in helping a child cope with a traumatic event. It is therefore important to be aware of how parents are coping with the trauma and whether they would also benefit from additional support.

Signs that a child needs further assistance

It is normal for children to show some changes in behaviour or difficulties managing emotions immediately following exposure to a traumatic event. However, some children will continue to experience problems that can have a significant impact on their social, emotional, cognitive and behavioural development. It is important to identify these children early on so that they can be provided with appropriate assessment and intervention. Further assessment or intervention may be required if:

- symptoms persist (> 1 month) or worsen over time
- symptoms represent a change from the child's normal behaviour
- symptoms are more intense or frequent when compared to other children of the same age
- symptoms prevent the child from engaging in age-appropriate tasks
- parents have concerns about the child's or family's functioning, request assistance, or are distressed by the situation.

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.have been revised and extended for use as part of the Emerging Minds: National Workforce Centre for Child Mental Health Community Trauma Toolkit.

Delivery partners:

Australian Government Australian Institute of Family Studies | Parenting Research Centre raising children well | Australian National University | RACGP

The National Workforce Centre for Child Mental Health is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program

February, 2019

Emerging Minds.

National Workforce Centre for Child Mental Health

How child care professionals can help children aged 0–24 months

After a natural disaster event, most babies and younger children who are well supported by nurturing and caring adults and predictable routines will overcome their distress and return to being themselves within a few weeks or months. Child care professionals working in early childhood facilities are uniquely placed to support babies and young children in their recovery post-disaster by providing them with a return to stable, predictable routines and opportunities to express emotions and feel understood. During this time, child care professionals may also identify children who continue to experience difficulties and may require further assistance.

Monitor symptoms over time

Babies and toddlers experience fear just like anyone else, but as their brains and bodies are still developing, they may not be able to make sense of what is happening. They can, however, communicate their experience and feelings through their behaviours (e.g. crying, clingy, withdrawn, angry, anxious) as well as verbal and/or non-verbal means (e.g. facial expressions, eye movements, play, drawings).

Children will have very different responses following a traumatic event. It is therefore important for educators to:

- be familiar with the types of reactions that children can have after exposure to a traumatic event
- remain vigilant and curious about changes in behaviour of any of the children in your classroom; and
- consider referral for further assistance if a child's emotional or behavioural difficulties are different from those pre-disaster, continue for longer than one month and/or get worse over time.

Maintain routines

Most children respond well to structured environments with clear goals, timelines and activities. Therefore, continuing with familiar day care routines is particularly important following a natural disaster. Routine helps to maintain consistency and predictability in one area of the child's life, reducing unnecessary stress and improving feelings of safety.

Limit exposure to media

Post-disaster, media images, radio talkback and general conversations about the event itself and/or disaster recovery efforts may arouse anxiety in babies and young children, creating greater fear, tension and confusion. Repeated images of the disaster event on television or web news (e.g. images of flooding or bushfire) may also cause the child to feel like the event is happening again, which can contribute to cumulative stress.

It is important to give babies and children enough information to feel secure and reassured but also be mindful of their level of exposure to the disaster and limit ongoing exposure to the media.

Delivery partners:

Australian Government Australian Institute of Family Studies · Parenting Research Centre raising children well · Australian National University · RACGP

The National Workforce Centre for Child Mental Health is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program

Visit our web hub today!

Emerging minds. com.au

emerging minds®

February, 2019

Listen with your eyes and ears

It is essential that all non-verbal and verbal communications with babies and young children are conducted with empathy and honesty. By being responsive and reassuring, you will demonstrate to the child that you understand and can share in their experiences and emotions. The child will then have faith that their feelings and concerns are normal, understood and acknowledged. In turn, this will help make them feel safe, secure and better able to manage their 'big' feelings. Be honest in answering questions, and (where possible) use the child's own words when discussing the event with them.

As babies and young children have a limited vocabulary to express their feelings verbally, it is essential to use active listening, reflective listening and observational skills to gather information about the level of distress the child may be experiencing.

- **Active listening skills:**
    - Try to really 'tune in' to the child by paying close attention to their words, expressions and body language.
    - Maintain eye contact and use your body language (e.g. nods, shrugs, facial expressions, gestures) to show you are listening.
    - Remain calm and controlled.
- **Reflective listening:**
    - Listen more than you talk.
    - Try to think and speak like a child (or as a younger child would if they could). By recognising and respecting the child's feelings, you will validate their experience.
    - Use short sentences to restate and clarify feelings and experiences.
    - Try and respond to personal content, rather than content that is impersonal or distant from the child. For example, you might say, 'You were really scared', or 'Sounds like you are feeling angry'. By paraphrasing and repeating back to the child what they are telling you, you will help them to develop language around their emotional experiences.

Avoid saying things like 'Don't be sad/angry/worried/upset' to reassure a child or baby. Being told not to feel a certain way may invalidate the child's feelings and leave them feeling shamed or misunderstood. Depending on individual circumstances, statements that reassure the child that they are safe now and assist them in thinking about their concern in a more positive or helpful way may be beneficial, e.g. 'Yes, the thunder was loud but it didn't hurt you, did it?', 'Yes, there was lots of rain and wind but you were safe in the evacuation centre, weren't you?'

Sometimes a child may convey incorrect information about the disaster, e.g. 'There was lots of loud noise and the sky was falling down'. This is the child's attempt to make sense of what they experienced. Consider whether giving them factual details will help reduce their stress and if so, use simple, concise language and check for understanding. 'I can see why you thought the sky was falling down because thunder is very loud. That made you scared. But the sky can't really fall down.'

Monitor your verbal expression

When talking with babies and young children it is important to consider your vocal tone, pitch, speed, loudness and inflection. Try and adopt a calm, soothing (i.e., deeper pitched) tone with a slower vocal pace. This will help the child to understand your words, even when they are distressed, providing a sense of security and reassurance.

If a child speaks in a sensory manner (i.e. what they heard, smelled, tasted, felt), support their statements: e.g. 'Yes, the thunder was very loud'. This will help children understand that it is ok for their personal experience to be similar or different to the experience of others.

Delivery partners:

Australian Government Australian Institute of Family Studies · Parenting Research Centre raising children well · Australian National University · RACGP

The National Workforce Centre for Child Mental Health is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program

February, 2019

Monitor non-verbal signals

Given the limited vocabulary of young children, most information about how a child is feeling will be gained by observing their facial expressions, body language, eye movements, vocal sounds and gestures.

Facial expressions such as the movement of eyes, mouth, cheeks, eyebrows and nose will reflect the child's moods and feelings. Paraphrase what you are observing. For example, you might say 'That noise is scary' or 'You look sad'.

Similarly, body language will also provide insight into the emotions the child is experiencing. For example:

Fear
Fear will typically manifest in both the face and limbs of the child. If the child's arms and legs seem stiff and tense, and/or if the child avoids eye contact or looks downwards, this may be a sign that they feel scared or nervous.

Anger
As with adults, tensed or clenched hands is a common way for children to express anger. Rigid head movements and a clenched jaw may also indicate that the child is angry.

Sadness
A hunched body posture, hung head, avoidance of eye contact, slowed speech and movement may all be indications that the child is sad.

When interacting with the child be mindful of your own body language, vocal tone and gestures. Communicate calmness and reassurance.

Set clear and firm limits/expectations of behaviour

During times of recovery, it is important for babies and toddlers to return to normal routines and functioning as soon as possible. Some children may 'act out' and misbehave in response to traumatic events, such as a natural disaster. It is important for educators to set and maintain clear expectations of behaviours and to communicate these to the child in an age-appropriate manner. Generally, children respond well to well-defined boundaries and routines that involve firm and clear limits for behaviour, and clearly stated (and implemented) consequences for misbehaviour.

Emphasise babies' and young children's strengths

Whether working through activities or playing, reinforce the child's strengths and abilities by naming them. For example, if a baby has grasped and held an object that she wanted, you could say 'You're so strong. Yes, you can get it'. For a slightly older child, actively provide opportunities for setting small goals, talk with them about how these can be achieved and celebrate their success: e.g. 'Where do you think the red square goes?' 'Yes, that's right. Great job working out that the square fits there'.

Be positive in your communications and actions

Babies and young children rely on the adults around them to help them manage and make sense of the world. Help them understand that the natural disaster was a temporary rather than permanent situation by being positive about the future and talking about progress being made with clean-up and rebuilding. Where possible, model positive coping skills like humour, positive statements, and problem-solving behaviours and encourage children to use these skills as well. Children look to adults to guide them in how to behave in unfamiliar situations, so your positive outlook, encouragement and reassurance are essential to supporting recovery after a natural disaster.

It is also important for educators to actively develop trusting, positive and open communications with children's parents, carers and families during this time. Parents and carers are in the best position to understand their child's medical, emotional and physical needs, so working together to develop a consistent and united approach to talking about the disaster is vital to children's recovery. Discuss communication options for staying in contact that allow for regular updates and sharing of success stories.

Delivery partners:

Australian Government Australian Institute of Family Studies | Parenting Research Centre raising children well | Australian National University | RACGP

The National Workforce Centre for Child Mental Health is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program

February, 2019

Provide choices – regain control

Traumatic events are usually beyond the control of the child, as are the consequences that follow. As such, during the traumatic event, children may feel a sense of powerlessness or loss of control. One strategy that might be useful for children is to provide them with choices or input into some activities. Involving children in decision-making can help restore their feeling of control.

Some examples of ways in which toddlers can be offered choices or be involved in decision-making include:

- being given a choice of activities (e.g. reading a book, drawing pictures, quiet toy time, singing)
- choosing ways in which they can help (e.g. water a plant, stack the cushions)
- choosing a particular song to sing or book to 'read along' to.

Relaxation

Babies and young children often respond well to relaxation techniques to assist them in emotional and behavioural regulation. These skills can be learned very early and used throughout their lives. Rest time routines provide a great opportunity to deploy conscious relaxation strategies such as holding, stroking and squeezing a stuffed toy while listening to meditation music and sounds. Where developmentally appropriate, children can also be taught to take long, deep, controlled breaths to slow the breath down and help them relax.

Safe 'relaxation' spaces

All facilities can benefit from having safe spaces that are specifically for children to use when they are experiencing difficulties in day care. This might be a quiet corner of the room, a tent or a 'cubby' where children's books, soft furnishings, squeeze toys or other quiet activities are placed. Educators may move with a child into this area to promote relaxation and encourage the use of different tools as relaxation aides (e.g. softly stroking the fur of a soft toy, squeezing a pillow, snuggling under a blanket, playing quiet relaxation music, softly humming a tune). As children become more mobile, toddlers can be encouraged to move to this space whenever they want to access 'quiet time'.

Summary

While childcare professionals may play an important role in identifying mental health concerns in babies and young children, their primary role is to continue to be a good child care professional. Child care professionals working in early childhood facilities are uniquely placed to support babies and young children by providing a return to stability, security and certainty for children who have been affected by natural disaster.

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.

Delivery partners:

Australian Government Australian Institute of Family Studies

Parenting Research Centre raising children well

Australian National University

RACGP

The National Workforce Centre for Child Mental Health is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program

Australian Child & Adolescent Trauma, Loss & Grief Network

The perinatal period: trauma and families

This tip sheet provides some information about trauma during the perinatal period . The perinatal period generally refers to the time during a woman's pregnancy, delivery and the first 12 months after the baby is born. This resource talks about the types of potentially traumatic events that are common at this time, their prevalence, and the impacts on the mother, her partner, her infant and other family members.

There is growing evidence about what can be done to help women and their families during this important life transition. The perinatal period provides an opportune time to provide help in order to disrupt the potential transmission of difficulties for the next generation.

Trauma and adversity

There is strong evidence that mothers who have experienced potentially traumatic events during their lifetime are at greater risk of a range of mental health problems during the perinatal period, including depression, anxiety and substance abuse disorders.

In order to understand more about how trauma impacts on individuals, it can be helpful to know how one traumatic experience can be different from another. Broadly speaking, trauma is separated in to two categories: single incident trauma and repeated or multiple traumas. Single incident traumas include single events such as car accidents, natural disasters, or one-off physical or sexual assault. Multiple or repeated traumas tend to be prolonged and interpersonal in nature, for example, child neglect; physical, emotional or sexual abuse. These multiple and repeated traumas tend to be more damaging to a child's social, physical and cognitive development and emotional regulation systems.

Family adversity, such as parental mental illneess, substance abuse, poverty, divorce and witnessing domestic violence have also be shown to impact on children's outcomes. However, it is also important to note that many children exposed to potentially traumatic events will be resilient, that is, they will maintain healthy levels of functioning despite the traumatic experience. Individual characteristics, such as personality characteristics and coping abilities, as well as positive aspects of the child's family and social environment have been shown to buffer against the effects of trauma and adversity.

Potentially traumatic events and vulnerability

Motherhood is generally considered to be a positive experience that is associated with feelings of joy, fulfilment and overwhelming love for one's baby. However, for some women, it can become a negative and re-traumatising experience. For instance, individuals who have experienced childhood trauma may have greater difficulties regulating their emotions, increasing their vulnerability to mental health problems during times of stress.

Once exposed to a traumatic event, the risk of experiencing further traumas is substantially higher . For example, women with childhood history of abuse can be more at risk of further abuse experiences such as intimate partner violence. These women show significantly higher rates of perinatal depression, anxiety and posttraumatic stress disorder (PTSD). For women who have PTSD related to childhood abuse, the process of preparing to become a parent can carry complex feelings and may worsen their anxiety or other posttraumatic stress symptoms.

Routine antenatal care or invasive procedures can trigger posttraumatic stress symptoms in women with a history of sexual abuse. Pregnancy also brings with it many potentially traumatic events (which may precipitate PTSD) including unexpected medical intervention, severe pain, or threat of death. If we consider the example of a painful, complicated and prolonged labour, we know that it is not whether the labour was prolonged or complicated, rather it is the mother's perception of the

The Australian Child & Adolescent Trauma, Loss & Grief Network/Trauma & Grief Network is funded by The Australian Government and supported by The Australian National University.

Australian National University

Australian Government
Department of Health

Australian Child & Adolescent Trauma, Loss & Grief Network

The perinatal period: trauma and families

experience which contributes to the development of trauma symptoms.

The mothers' social context can also plays an important role in her experience during pregnancy and after birth. Factors such as poor communication with delivery staff, low levels of emotional support and poor partner support are all risk factors for PTSD. Mothers may also experience traumatic loss due to miscarriage, stillbirth, abortion or early neonatal death.

Traumatic events can also occur after childbirth, such as when a vulnerable newborn needs admission to a neonatal intensive care unit.

In sum, research has revealed that childhood maltreatment, lifetime traumatic experiences, pregnancy stressors, re-traumatising labour experiences, postpartum events and poor social support can contribute to the development of significant mental health problems in mothers.

Posttraumatic stress disorder symptoms during pregnancy and postpartum

PTSD has been found to be more prevalent in the perinatal period than in general samples of women (6-8% vs. 4-5%; Seng et. al., 2010), highlighting this period as a time of greater vulnerability. Research has shown that PTSD as a consequence of childbirth occurs in 1.5% - 6% of deliveries (Ayers, 2007; Alder et. al. 2006). Considerably more women develop sub-clinical symptoms or severe anxiety, with an Australian study finding a prevalence rate of 10.5% in postnatal mothers (White et. al., 2006).

Research has suggested that PTSD symptoms during the perinatal period are likely to be due to an exacerbation of pre-existing PTSD. For example, Seng and colleagues (2009) found that mothers with a history of childhood maltreatment (eg severe neglect, phsyical, emotional or sexual abuse) have a 12-fold risk of developing PTSD in pregnancy. We also know that mental health conditions in pregnancy predict postpartum mental health; for example, antenatal depression is associated with postnatal depression and antenatal PTSD is associated with greater risk of postnatal PTSD. Once established, it can become a chronic condition with spontaneous remission of childbirth related PTSD uncommon in the first 6 - 12 postnatal months.

It is also common for people who experience PTSD to have other co-morbid difficulties such as depression, anxiety and substance abuse. This can also lead to further vulnerabilities for the individual as well as for their family and children. When a mother is experiencing multiple difficulties, there is a significant chance that these will impact on her whole family - her partner and her children.

Consequences

Posstraumatic stress symptoms during pregnancy can negatively impact on the child even prior to its birth. PTSD during pregnancy has been associated with lower birth weight, premature birth, and adverse neonatal and neurodevelopmental child outcomes. However, it is not clear whether this is directly due to PTSD symptoms or other factors that may be present such as, co-morbid depression or substance abuse.

The symptoms of PTSD can be so debilitating that it can adversely impact the mother's relationship with her infant, partner and other family members. For example, the symptoms of PTSD (recurrent nightmares, flashbacks, intrusive recollections, hyperarousal and emotional numbing) can understandably interfere with the mothers' attunement and bond with her infant. The mother may feel fearful of the baby, fear harm to the baby, or find it difficult to soothe or settle her child due to her own symptoms.

Avoidance is a key posttraumatic stress symptom and this may extend to avoidance of the baby, of sexual activity,

The Australian Child & Adolescent Trauma, Loss & Grief Network/Trauma & Grief Network is funded by The Australian Government and supported by The Australian National University.

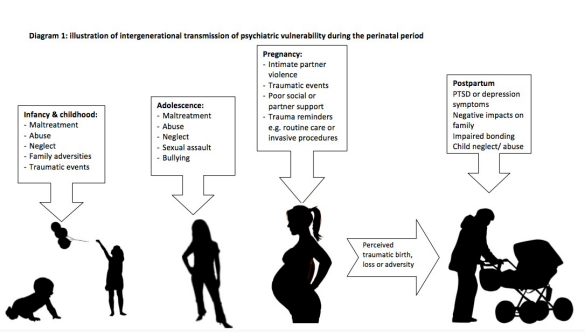
Australian National University

Australian Government
Department of Health

Australian Child & Adolescent Trauma, Loss & Grief Network

The perinatal period: trauma and families

even postponing or avoiding future childbearing. Parent's past or current trauma experiences can affect their ability to protect and nurture their child, further raising the child's lifetime risk of psychiatric vulnerability (see Diagram 1).



Other evidence highlighting the intergnerational impacts of trauma stems from research into the damaging consequences of forcible separation of Indigenous children. For expample, the offspring of Indigenous mothers who were forcibly separated from their natural family were over twice as likely to be at high risk of clinically significant emotional or behavioural difficulties when compared with those from intact families.

What we know about the impact of trauma in the perinatal period highlights the imperative need for prevention strategies and early identification of at risk families. Early recognition of trauma signs and symptoms, ideally in pregnancy, can lead to effective treatment for the mother and potentially interrupt the pattern of intergenerational transmission of maltreatment and psychiatric vulnerability for the infant.

For more information:

» earlytraumagrief.anu.edu.au

Written by:
Rebecca Reay and Amanda Harris.

Rebecca Reay is a researcher with the Australian National University academic unit of Psyhiatry and Addiction Medicine and ACT Health. Rebecca has extensive experience in researching and working with women experiencing mental health difficulties during the perinatal period.

Amanda Harris is a Psychologist and the Director of the Australian Child & Adolescent Trauma, Loss & Grief Network.

References:

Alder J, Stadlmayer W, Tschudin S, Bitzer J (2006). *Post-traumatic symptoms after childbirth. What should we offer?* Journal of Psychosomatic Obstetrics and Gynecology. 27 (2), 107 - 112.

Ayers, S (2007) *Thoughts and emotions during traumatic birth: A qualitative study.* Birth, 34(3), 253 - 263.

Seng J, Kane Low LM, Sperlich MI, Ronis DL, Liverzon I (2009). *Trauma history and risk for PTSD among nulliparous women in maternity care.* Obstetrics & Gynaecology. 114: 839 - 847.

Seng JS, Rauch SA, Resnick H, Reed CD, King A, Low LK, McPherson M, Muzik M, Abelson J, Liberzon I. (2010). *Exploring posttraumatic stress disorder symptom profile among pregnant women.* Journal of Psychosomatic Obstetrics & Gynecology, 31(3): 176 - 187.

White T, Matthey S, Boyd K, Barnett B, (2006). Postnatal depression and posttraumatic stress after childbirth. Prevalence, course and co-occurence. Journal of reproductive and infant psychology. 24(2): 107 - 120.

The Australian Child & Adolescent Trauma, Loss & Grief Network/Trauma & Grief Network is funded by The Australian Government and supported by The Australian National University.

Australian National University

Australian Government
Department of Health