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Trauma responses in children aged 2-4 years

Key Messages

- Children aged 2-4 years are vulnerable to the negative effects of trauma.
- There can be tremendous individual variability in trauma responses. Therefore, educators need to be aware of children who are exhibiting behaviour problems as well as children who are quieter and more withdrawn.
- Behavioural manifestations of trauma (e.g. tantrums, aggression, hyperactivity) may be misinterpreted as 'bad behaviour', ADHD or oppositional behaviour.
- Children aged 2–4 years are particularly at risk of adverse outcomes if they witnessed threat to their parent, were separated from their parent or if their parent reports significant psychological distress.
- Early intervention is recommended.

Natural disasters, such as floods, bushfires and storms, are often very traumatic for children as they can be faced with many frightening and overwhelming experiences. Preschool children are a high-risk group for poor outcomes following a traumatic event. However, due to the common misconception that children under the age of 5 are unaffected by trauma, this population is often neglected.

Pre-schoolers typically present with a similar pattern of traumatic stress reactions to those seen in older children and adolescents. However, there are several important unique developmental differences in the rate and manifestation of symptoms in preschool children.

How do young 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 of exposure to the trauma, parental reactions and subsequent changes in living situation.

Whilst it is not always clear how young children will react, research tells us that 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 pre-schoolers 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.

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Trauma responses to be aware of in children aged 2–4 years

- Heightened arousal (e.g. disturbed sleep, jumpy or easily startled by loud noises, difficulties concentrating, hard to settle or soothe).
- Changes in appetite (e.g. fussy eating, no appetite).
- Regression in previously acquired developmental skills (e.g. walking, crawling, toileting skills, talking like a baby, thumb-sucking).
- Loss of confidence.
- Sad and withdrawn appearance.
- Increased physical complaints (e.g. tummy aches, headaches).
- Behavioural changes (e.g. increased irritability, extreme temper tantrums, fussiness,
- attention-seeking, defiance, aggressive behaviour).
- Difficulty in concentrating and paying attention.
- Aggression and angry behaviours towards themselves or others (e.g. head banging, hitting, biting).
- Reliving of the trauma (e.g. traumatic play or drawing, nightmares, repeatedly talking about the event, asking questions repeatedly).
- Separation anxiety or excessive clinginess to primary caregiver or teachers (e.g. crying upon separation, insisting to be picked up, won't stay in room alone).
- Concern that something terrible will happen to primary carers.
- Clinginess to strangers.
- Development of new fears that are unrelated to the trauma (e.g. the dark, monsters, animals).
- Avoidance of reminders and/or visible distress at reminders of the event (e.g. sights, sounds, smells, tastes, physical reminders).
- Decrease in responsiveness (e.g. lack of emotional reactions, numb appearance, lack of eye contact, withdrawal from family, teachers and friends, less interest in play, restricted exploratory behaviour).
- Relationship difficulties with caregivers, siblings or peers.

Things to be aware of

There are important developmental issues to keep in mind when considering the impact of trauma on preschool children. These include:

Parent-child relationship
The impact of trauma must be considered within the context of the parent-child relationship. This is because, in comparison to any other age, young children are completely dependent on their caregivers to protect them physically and emotionally. Parents are also at risk of post-trauma reactions and this can impact on their ability to parent effectively following 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.

Developmental level
Preschool children are more likely to develop false assumptions or 'magical thinking' about the cause of the event (e.g. 'The flood happened because I was bad'). Young children are also more likely to overgeneralise or catastrophise from the facts they have available. Due to their limited communication skills, they may not be able to explain what is upsetting them or understand why their parents are distressed. Finally, they can have difficulties understanding that loss is permanent.

Misdiagnosis
It is very difficult to identify internalising symptoms in young children (e.g. avoidance of thoughts). Educators therefore need to be aware that there is a greater risk that children who exhibit high emotion and dysregulated behaviour (e.g. hyperactivity, temper tantrums, defiance, etc.) may receive inaccurate diagnoses including 'terrible twos', attention deficit/hyperactivity disorder (ADHD) or oppositional defiant disorder.

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Signs that a child needs further assistance

It is normal for preschool 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 indicated 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
- behaviours disrupt others and the pre-school environment on a regular basis
- symptoms prevent the child from engaging in age-appropriate tasks
- there is evidence that the problems exist in multiple contexts (e.g. the problem occurs at preschool and at home)
- 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.

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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.

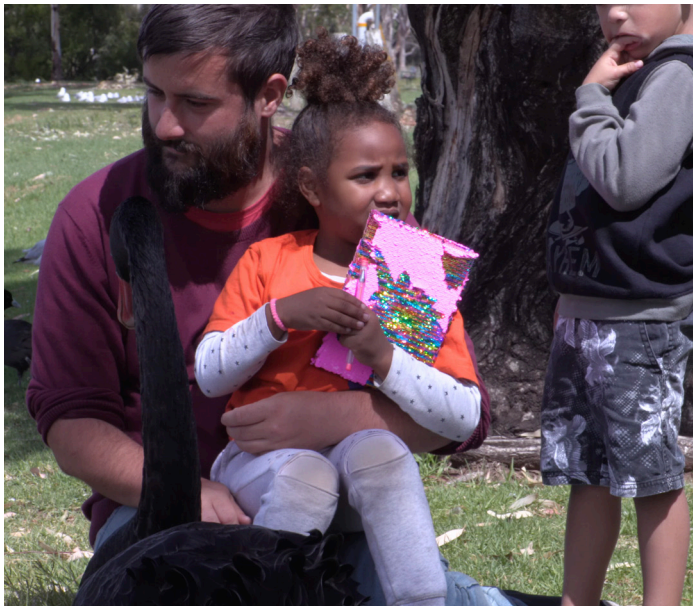
Negative alterations in thoughts and moods

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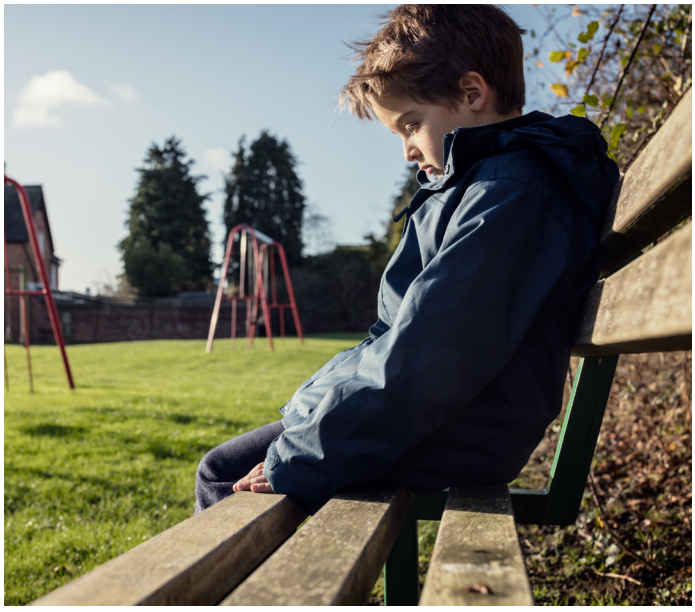
such feelings as non-specific anxiety about suddenly becoming ill, or fears of suddenly vomiting that are difficult to control.

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.

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Childhood trauma reactions: How and when to get help

Educators are often in the best position to notice when children need help managing their reactions to traumatic events, such as natural disasters. However, it can be quite difficult to work out what is happening for the child by simply observing their behaviour. Here are some hints for how you can work out when and what you might need to do to arrange help for your students.

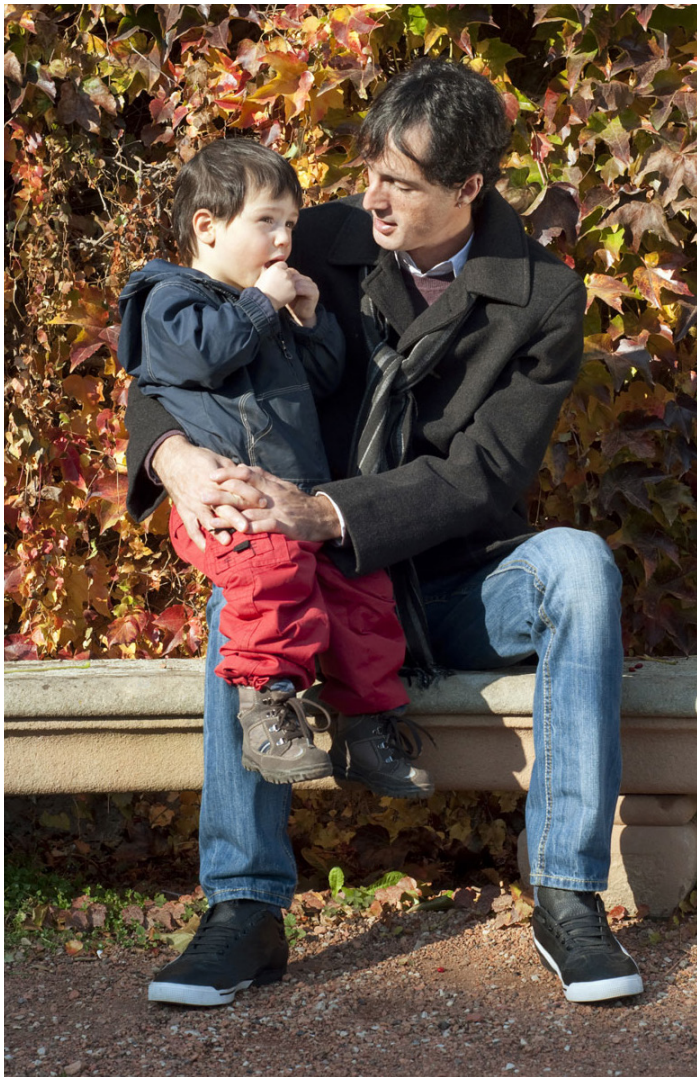
Talk to the child

One of the best ways to work out if the child needs help is to talk to them. There are a few things you can do to make this a bit easier:

- Let your student know that you are concerned and want to help. Having someone who will listen is often exactly what children are after.
- Consult the school counsellor or guidance officer if you think you need help or the child prefers not to talk.
- Get background information. Talk about your concerns with the child's parents/caregiver.

Dealing with disclosures

Sometimes when talking to children, they may disclose sensitive information, either about the traumatic event you are discussing, or about other events that you were not aware of. It is important for teachers to be aware of their duties and responsibility to both the child and others, and to consult with school administrators where appropriate.



How to determine whether the problem is serious?

It is normal for children to show some changes in behaviour or difficulties managing emotions immediately following a traumatic event. Fortunately, the majority of children are resilient and will return to their normal functioning over time. However, some children will experience more intense and interfering reactions or reactions that persist over time, which most often benefit from further assessment and intervention.

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Further assessment or intervention may be required if the child shows:

- symptoms which persist for longer than a month or worsen over time
- a significant decline in concentration, academic performance or classroom participation that interferes with their daily functioning or causes significant distress
- ongoing or worsening difficulties regulating emotions (e.g. difficulty controlling emotions such as crying, anger)
- significant and lasting changes in social functioning (e.g. withdrawing from friends, fighting, interpersonal difficulties, physical and verbal aggression) that causes problems for the child or others
- behaviours that disrupt others and the classroom environment on a regular basis
- behaviours or difficulties that prevent the child from engaging in age-appropriate tasks or developing appropriately (e.g. advancing academically, advancing socially, maturing appropriately, interruptions to developmental milestones such as speech, and language)
- behaviours typical of a younger child (e.g. difficulties toileting, using 'baby talk')
- evidence that the problems exist outside of school as well (i.e. the problem occurs in multiple settings such as at home, with friends, at school); or
- the presence of ongoing stressors outside of school which may exacerbate difficulties (e.g. financial difficulties, housing issues, parental separation, death of a family member).

How to get help

There are many different ways in which you can help the child and their family. It is important to know when you can help, when to utilise school-based resources and when you might need to make a referral to an external agency. Below are some guidelines/suggestions for what you can do when you think a child needs further help:

- Familiarise yourself with your school's guidelines and policies for such issues.
- Get to know the support resources available within your school such as guidance officers, school nurses, school psychologists, support workers and principals.
- Think about what you as an educator can do to help the child or the whole class following traumatic events.
- Refer the child on for further assistance.

How to refer for further help

Sometimes, no matter how supportive the classroom or home environment is, a child may still require professional assistance following a traumatic event. It may be helpful to discuss referral options with parents and/or the child. Early intervention is considered important.

Referral options include:

Community services and help lines

There are some services that parents and children (and educators) can access at any time, without having to see someone in person. Many of these can be found on the internet, and a few key services are listed below. Your guidance officer or school counsellor might be able to help you find more services available in your area.

- Kids Helpline – 1800 551 800
- Lifeline – 13 11 14
- Parentline – 1300 30 1300
- Australian Centre for Grief and Bereavement – 1800 642 066
- beyondblue – www.beyondblue.org.au
- Carers Australia – 1800 242 636

General practitioners

GPs are a great place to start for information, support and referral if required.

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Private allied health professionals

Children and parents can also seek private individual assistance from various allied health professionals – in particular, clinical psychologists who are trained in assessment, diagnosis and treatment of various emotional and behavioural difficulties in childhood and adolescence.

Community-based mental health professionals

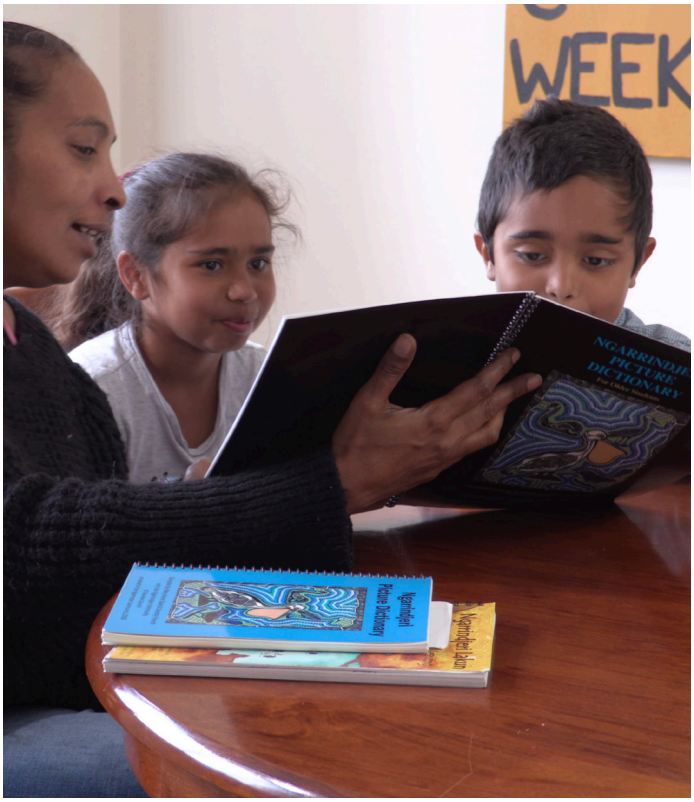
Families may be eligible to receive assistance through their local Child and Adolescent/Youth Mental Health Service (CAMHS or CYMHS). In most instances, families are able to self-refer for this service by calling their local centre.

Infant and baby mental health services

Each state and territory of Australia will have a dedicated perinatal and infant mental health service operated by the government. Families should visit their GP to gain further information.

Private mental health professionals

Families are also able to arrange for assistance through private psychologists. Availability of psychologists will vary according to location, and it is recommended that families first contact their GP to obtain a referral and to assess their eligibility for rebates through Medicare. In addition, families may also be eligible for rebates through private health funds and should contact their health provider to enquire about rebates. Parents may also independently seek private practitioners through the Australian Psychological Society (APS) at www.psychology.org.au/Find-a-Psychologist



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