

A Hidden Epidemic

Post Traumatic Stress Disorder and pediatric patients

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For 7-year-old Clare Lee*, the scent of cleaning solution, a photo in a book or words in a storybook can trigger a flashback to her time in a Chinese orphanage, causing her to re-live her nightmares almost everyday.

When Nancy Hemenway of Arlington, Va., adopted Lee from an orphanage in southern China, she noticed that Lee often has nights or episodes of dissociation Lee experiences on a regular basis.

After she was abandoned as an infant, Lee spent about 16 months in a Chinese orphanage, where she was surrounded by patients with mental illness and the elderly.

Uneducated caretakers, who are often former orphans themselves, staff many state-run orphanages. They often try to keep the children quiet, often by abusive means, including frightening stories, electric shocks and locking children in a "dying room."

Hemenway says, "It is likely [Lee] was considered a 'bad' baby because of the severity of her trauma." Lee has physical scarring on both ankles, "likely from being tied," Hemenway says. "She also has a fear of the dark."

When Hemenway visited the orphanage, she found the building "clean, but eerily silent," with no sound of children. Children are often left until silent. "Dying rooms" at these kinds of orphanages are more common. Lee may have been shut into a closet in order to keep her quiet.

At times, Lee, who suffers from complex post-traumatic stress disorder (PTSD) "appears dissociated, with increased anxiety centered around bedtime, night terrors, crying and screaming." Her symptoms are serious, continue and interfere with the daily functioning of children. For more information, visit the National Traumatic Stress Network (NTSN).

Because the smallest trigger – a smell, a sound or a picture in a book – can cause a flashback, Lee often has nightmares of the bathroom and will not bathe unless her mother is at eye level with her.

Misdiagnosis and Communication Challenges

According to Jane Koomar, PhD, OTR/L, FAOTA executive director of Occupational Therapy treating Lee, pediatric PTSD is often under-diagnosed, leading to increased frustration and a

When working with Lee, she started by providing organizing sensory input, in order to help her first through extending her foot to us, and then with eye contact and lastly through beginning to engage with us in the activity,” Koomar says.

Children with PTSD often exhibit more aggressive behaviors in an environment where they exhibit increased obsessive-compulsive behaviors. For example, she is acutely aware of her environment and all cabinets and doors so she can feel safe before she proceeds with an activity,” Hemenway

According to Koomar, who worked with Lee during a three-day intensive therapy session, “Lee continued to use the last line of a song we used during intervention as a way to signal to her therapists with her after she left the intensive [therapy session].”

Among pediatric patients with PTSD, sometimes a trigger can be isolated, such as a book or object identifiable. Once triggered, bouts of depression and crying may last for several days after the

It will take hard work and several intensive therapy sessions combined with regular OT; however, with her other team members on the use of sensation to help her with emotional regulation, she w

Defining Child Trauma

According to the NTSN, while some children "bounce back" after adversity, traumatic experiences during adolescent development and have profound long-term consequences.”

In particular, repeated exposure to traumatic events affects the brain and nervous system, “increasing engagement in high-risk behaviors and difficulties in peer and family relationships,” according

Because children with PTSD may exhibit behaviors at home that they keep under wraps at school, diagnostic codes to use before implementing a therapy regime.

Because not every child with PTSD experiences obvious abuse or neglect, PTSD is often misused as another “catch-all” diagnosis, Koomar says, “When an individual has PTSD they are often in a state of flight, fright or fight or move to overload and shutdown, which can ap

In addition, Koomar says children and adults with PTSD often have extreme sensory sensitivity and sensory defensiveness. “If a child lives in this state most all of the time, often coupled by flashbacks at night, they can also be seen as autistic,” Koomar says.

According to the NTSN, children and adolescents experience trauma under three different situations: physical injury or the death of someone else, facing imminent threats of serious injury or death to themselves or their physical integrity.

Twenty years of cumulative research found PTSD often results from the above experiences. “trauma, terror, horror or helplessness,” according to the NTSN. For example, acute causes of trauma include natural disasters, the community, terrorist attacks, natural disasters [earthquakes, floods or hurricanes], serious accidents, and physical or sexual assault.

In other cases, exposure to trauma can occur repeatedly over long periods of time, resulting in PTSD. These experiences result in a range of responses, including “intense feelings of fear, loss of trust, and shame.” This can include, for example, verbal abuse, unwanted or inappropriate touching, sexual violence, wars and other forms of political violence.

Signs and Symptoms: Living with Flashbacks

Child traumatic stress “occurs when children and adolescents are exposed to traumatic events that overwhelm their ability to cope with what they have experienced,” according to the NTSN.

Depending on their age, children respond to traumatic stress differently. According to the NTSN, signs and symptoms include, “disturbed sleep, difficulty paying attention and concentrating, anger and irritability, and extreme distress when confronted by anything that reminds them of their traumatic experiences. These symptoms can lead to conditions, such as depression, anxiety and behavioral disorders.

For example, Lee will often cry at night in her sleep. During bouts of crying, she “sometimes has nightmares that may also accompany kicking before or after sleep. While children with PTSD may have bouts of anger, she will occasionally hit or kick in response to a trauma trigger.

Koomar says flashbacks are automatic responses to a trauma trigger and are not something you can control. “Flashbacks are very powerful and it is important to realize that with PTSD flashbacks, the person is not in control.”

Koomar says managing flashbacks requires time and careful therapy. “This cannot, and should not, be done overnight,” Koomar says. “It is not at all a situation where the individual can ‘overcome it’ or ‘pull themselves out of it.’ You cannot manage it. It is usually an incapacitating problem that needs a very careful and thoughtful therapist.”

Treatment: Combination Therapy and Consistency

According to the NTSN, traumatic stress can cause “increased use of health and mental health services, increased welfare and juvenile justice systems.” In addition, adult survivors of traumatic events may have difficulty forming relationships. However, when caught early enough, combination therapies can help people cope with PTSD.

Consistency is key for pediatric patients with PTSD. Flexibility within structure “and consistency with PTSD to feel safe,” Hemenway says. “Only when they feel safe are they able to build the neural pathways in higher cognitive areas to develop fully and to realize their full potential.”

She suggests that therapists work as a team with patient’s parents by providing materials to discuss trauma and how it affects every facet of a child’s life, from brushing their teeth to playground interactions.

Hemenway says one of the things that helped her work with Lee is the understanding of “what we need to structure our daughter's environment to make her feel safe and how we can promote processing of trauma.”

Hemenway strives to work closely with the therapist, which has helped them “develop trauma processing skills. The result of this is that she feels safe – and not in fear of her life.” This small change has made a big difference, she says it “helps her to allow us to be in control instead of feeling that her very survival depends on us.”

Koomar works with Lee during intensive therapy sessions using sensory integration interventions. Sensory interventions help her to feel more comfortable, which allows Koomar to progress with her. This therapy combination is helpful to “ground and organize the child and create excellent opportunities for learning.”

According to Eve A Wood, MD, clinical associate professor of medicine at the Tucson-based University of Arizona, *Take Charge of Your Emotional Life*, (Hayhouse, 2007), people with PTSD often have a very sensitive nervous system. “It’s a lot to get it really out of whack.” She says small things may unsettle them and “can very easily trigger a very highly developed activation system in patients with PTSD.”

“Consistency is really important,” says Wood. It is also important to refrain from revisiting the trauma, she says people need support that does not involve revisiting the trauma, for example, “activities that are fun, like watching a funny movie, playing a game or other things that enable you to connect, but are not about the trauma.”

Communicating with people experiencing PTSD is often challenging. Even with verbal patients, there may be sensory processing disorders or lack of eye contact. Lee, who communicates, when cued, uses play as a medium for processing trauma.

Since Lee began trauma/attachment and sensory therapies, she has clearly articulated a few vocalizations. These vocalizations are much more common when she is animated, feeling safe and secure in a moment.

Since her first initial therapy session with Koomar, she has continued to use the last line of her vocalizations to communicate that she wants her mother or to soothe herself. Hemenway says, “This holding therapy.” However, Lee has shown a significant increase in connection with her mother since her first session. She is soothed by her mother during transitions or at times of distress.

Practical Application

When working with a patient who exhibits PTSD symptoms, Koomar suggests therapists recommend that therapy professionals educate themselves about the psychology behind PTSD in order to help and speech therapists to have some training in the symptoms of PTSD so that they know to

PTSD and attachment disorder are often present in children who have a history of abuse and neglect. For more information, see *Building the Bonds of Attachment* (Aronson 2006), to learn about attachment issues and effective

Koomar says more research into pediatric PTSD is needed and collaborative treatment will be the way forward. She suggests therapists “explore the treatment combinations of OT and speech therapy to form research questions.”

While Koomar works to develop more evidence-based research, Hemenway is working to change the way society views trauma. She hopes society will begin to understand “how real trauma is and how it can destroy a child's life. A child who has experienced trauma should not give up hope.

“Given the right team, healing can take place,” Hemenway says. “As Dr. Perry said in his book (2007) ‘Once you know what to look for, you can see it everywhere in the lives of children.’ It’s a disaster sucking millions of dollars out of our society. It doesn’t have to be this way. Good research can help parents learn to therapeutically parent their traumatized child.”

*Subject’s name has been changed to protect her identity.

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