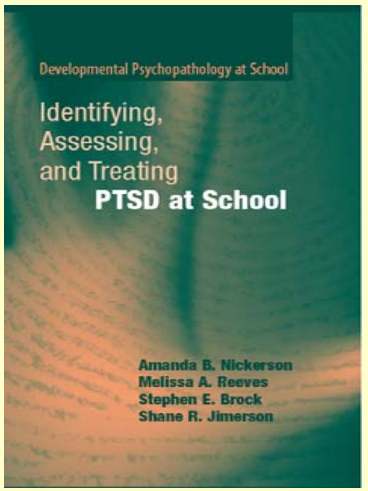
The Manifestations and Symptoms of, and Recommendations for, Students with PTSD

Renee Rodriguez,
School Psychology Graduate Student
&
Stephen E. Brock, Ph.D., NCSP
California State University, Sacramento

Preface

Nickerson, A. B., Reeves, M. A., Brock, S. E., & Jimerson, S. R. (2009). *Assessing, identifying, and treating posttraumatic stress disorder at school.* New York: Springer.



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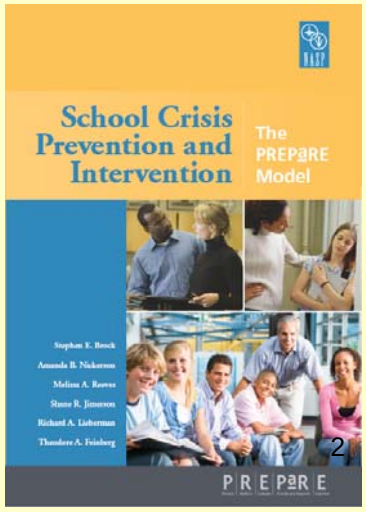

Preface

- PTSD involves exposure to a traumatic stressor.
- A traumatic stressor can generate initial stress reactions in just about anyone.
- However, not everyone exposed to these events develops PTSD.
- Among those who develop PTSD, significant impairments in daily functioning (including interpersonal and academic functioning) are observed.
- Developmentally younger individuals are more vulnerable to PTSD.

Preface

- Prevalence among school age youth
  - Trauma Exposure = 68%
    - 37% report two or more traumatic events
  - Lifetime prevalence of PTSD = 6 to 10%
    - 30% among some urban populations

APA (2000)

Presentation Outline

- Manifestations and Symptoms
  - DSM-IVTR Criteria
  - Developmental Variations
- Psycho-educational Interventions, Recommendations, and Treatment

Workshop Objectives

- From participation in this session participants will be better able to …
  - define and recognize PTSD in varying developmental levels
  - understand the school psychologist role and what services to provide to students.

PTSD Defined

- “a syndrome defined by the intrusive re-experiencing of a trauma, avoidance of traumatic reminders, and persistent physiological arousal.”

APA (2000); Perrin et al. (2000)

School Psychologists

- The role of the school-based mental health professional **is** to be …
  - able to recognize and screen for PTSD symptoms.
  - aware of the fact PTSD may generate significant school functioning challenges.
  - knowledgeable of effective treatments for PTSD and appropriate local referrals.
  - Aware of the limits of their training.
- It **is not** necessarily to …
  - diagnose PTSD.
  - treat PTSD.

Defining PTSD

DSM IV-TR

- An anxiety disorder that develops secondary to exposure (experiencing, witnessing, or learning about) to an “extreme traumatic stressor.”
  - An event that involves actual or threatened death or serious injury, or threat to ones physical integrity.
- “The person’s response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior).”

APA (2000)

Characteristics of PTSD

DSM IV-TR

- Core Symptoms
  1. Persistent re-experiencing of the trauma.
  2. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.
  3. Persistent symptoms of increased arousal.
- Duration of the disturbance is more than one month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

APA (2000)

Characteristics of PTSD

DSM IV-TR

- Re-experiencing Symptoms
  1. Recurrent/intrusive distressing recollections.
  2. Recurrent distressing dreams.
  3. Acting/feeling as if the event were recurring.
  4. Psychological distress at exposure to cues that symbolize/resemble the traumatic event.

APA (2000)

Characteristics of PTSD

DSM IV-TR

- Avoidance & Numbing Symptoms
  1. Avoids thoughts, feelings, or conversations.
  2. Avoids activities, places, or people.
  3. Inability to recall important aspects of the trauma.
  4. Diminished interest/participation in significant activities.
  5. Feeling of detachment/estrangement.
  6. Restricted range of affect.
  7. Sense of a foreshortened future.

APA (2000)

Defining PTSD

DSM IV-TR

- Increased Arousal Symptoms
  1. Difficulty falling or staying asleep.
  2. Irritability or outbursts of anger.
  3. Difficulty concentrating.
  4. Hypervigilance.
  5. Exaggerated startle response.

APA (2000)

Defining PTSD

DSM IV-TR

- PTSD may be specified as
  - Acute
  - Chronic
  - Delayed onset

APA (2000)

Defining PTSD

DSM IV-TR

- Associated Features
  - Survivor guilt
  - Impaired social/interpersonal functioning
  - Auditory hallucinations & paranoid ideation
  - Impaired affect modulations
  - Self-destructive and impulsive behavior
  - Somatic complaints
  - Shame, despair, or hopelessness
  - Hostility
  - Social withdrawal

APA (2000)

Defining PTSD

DSM IV-TR

- Associated Mental Disorders
  - Major Depressive Disorder
  - Substance-Related Disorders
  - Panic Disorder
  - Agoraphobia
  - Obsessive-Compulsive Disorder
  - Generalized Anxiety Disorder
  - Social Phobia
  - Specific Phobia
  - Bipolar Disorder

APA (2000)

Developmental Variations

- Alternative Criteria for Diagnosing Infants and Young Children
  - Verbally stating trauma exposure is not required within the alternate criteria. Preverbal children cannot report on their experiences or reactions at the time of the traumatic event, and an adult may not have been present to observe this.

Yule (2001)

Expression of PTSD in Children vs. Adults

- Symptoms through play, drawings and/or stories, or may exhibit fears not directly related to the event (e.g. fears of monsters) and separation anxiety
- Children and adolescents often display disruptive behaviors (e.g.) impulsivity and inattentiveness, which frequently negatively affects their academic achievement.
- May isolate themselves from others and withdraw from their peers.
- Depression, anxiety and panic attacks are often associated as well.
- Regressive behaviors such as enuresis, encopresis and thumb-sucking.
- Children also experience a sense of foreshortened future as demonstrated through their diminished expectations of having a normal lifespan (e.g. marriage, children or a career), time skew (missequencing of events in recall).

Perrin et al. (2000)

Developmental Variations

- Preschoolers
  - Reactions not as clearly connected to the crisis event as observed among older students.
  - Reactions tend to be expressed nonverbally.
  - Given equal levels of distress and impairment, may not display as many PTSD symptoms as older children.
  - Temporary loss of recently achieved developmental milestones.
  - Trauma related play.

APA (2000), Cook-Cottone (2004), Dulmus (2003), Joshi & Lewin (2004), NIMH (2001), Yorbik et al. (2004)

Developmental Variations

- School-age children
  - Reactions tend to be more directly connected to crisis event.
  - Event specific fears may be displayed.
  - Reactions are often expressed behaviorally.
  - Feelings associated with the traumatic stress are often expressed via physical symptoms.
  - Trauma related play (becomes more complex and elaborate).
  - Repetitive verbal descriptions of the event.
  - Problems paying attention

APA (2000), Cook-Cottone (2004), Dulmus (2003), Joshi & Lewin (2004), NIMH (2001), Yorbik et al. (2004)

Developmental Variations

- Preadolescents and adolescents
  - More adult like reactions
  - Sense of foreshortened future
  - Oppositional/aggressive behaviors to regain a sense of control
  - School avoidance
  - Self-injurious behavior and thinking
  - Revenge fantasies
  - Substance abuse
  - Learning problems

APA (2000), Cook-Cottone (2004), Dulmus (2003), Joshi & Lewin (2004), NIMH (2001), Yorbik et al. (2004)

Manifestations at School

Manifestations at School

- Lower GPA
- Lower academic achievement test scores
- Classroom adjustment difficulties
  - Difficulty concentrating
  - Inattention
  - Irritability
  - Aggression
  - Withdrawal

Saltzman et al. (2001)

Warning Signs

Preschoolers

- Decreased verbalization
- Increased anxious behaviors
- Bed wetting
- Fears (e.g. darkness, animals, etc)
- Loss of increase in appetite
- Fear of being abandoned or separated from caretaker
- Reenactment of trauma in play Cognitive confusion
- Regression in skills (e.g. loss of bladder/bowel control; language skills, etc..)
- Thumb sucking
- Clinging to parents/primary caretakers
- Screaming, night terrors
- Increased anxiety

Pfohl et al. (2002)

Warning Signs

School Aged Children

- Irritability
- Whining
- Clinging
- Obsessive retell
- Night terrors, nightmares, fear of darkness; sleep disturbances
- Withdrawal
- Disruptive behaviors
- Regressive behaviors
- Depressive symptoms
- Emotional numbing
- Psychosomatic complaints
- Overt competition of adult attention
- School avoidance
- Increased anxiety
- Loss of interest and poor concentration in school
- Decrease in academic performance
- Feelings of guilt

Increase in aggressive or inhibited behaviors

Pfohl et al. (2002)

Warning Signs

Adolescents

- Emotional numbing
- Flashbacks
- Sleep disturbances
- Appetite disturbance
- Rebellion
- Refusal
- Agitation or decrease in energy level (apathy)
- Avoidance of reminders of the event
- Depression
- Antisocial behaviors
- Revenge fantasies — Increase in aggressive or inhibited behaviors
- Difficulty with social interactions
- Psychosomatic complaints
- School difficulties (fighting, attendance, attention-seeking behaviors)
- Increased anxiety
- Loss of interest and poor concentration in school
- Decrease in academic performance
- Feelings of guilt

Pfohl et al. (2002)

Assessment/Evaluation of PTSD

- Screening Methods
- Diagnostic Interviews
- Self-Reports
- Differential Diagnosis
- Psycho-educational Evaluation

Brock (2006), Brock et al. (2009), Nickerson et al (2009)

Identification/Assessment

Psychological Trauma Risk Checklist

Low risk	Moderate risk	High risk
Physical proximity ☐ Out of vicinity of crisis site	*Physical proximity* ☐ Present on crisis site	*Physical proximity* ☐ Crisis victim or eye witness
Emotional proximity ☐ Did not know victim(s)	*Emotional proximity* ☐ Friend of victim(s) ☐ Acquaintance of victim(s)	*Emotional proximity* ☐ Relative of victim(s) ☐ Best friend of victim(s)
Internal vulnerabilities ☐ Active coping style ☐ Mentally healthy ☐ Good self regulation of emotion ☐ High developmental level ☐ No trauma history	*Internal vulnerabilities* ☐ No clear coping style ☐ Questions exist about pre-crisis mental health ☐ Some difficulties with self regulation of emotion ☐ At times appears immature ☐ Trauma history	*Internal vulnerabilities* ☐ Avoidance coping style ☐ Preexisting mental illness ☐ Poor self regulation of emotion ☐ Low developmental level ☐ Significant trauma history
External vulnerabilities ☐ Living with intact nuclear family members ☐ Good parent/child relationship ☐ Good family functioning ☐ No parental traumatic stress ☐ Adequate financial resources ☐ Good social resources	*External vulnerabilities* ☐ Living with some nuclear family members ☐ Parent/child relationship at times stressed ☐ Family functioning at times challenged ☐ Some parental traumatic stress ☐ Financial resources at times challenged ☐ Social resources/relations at times challenged	*External vulnerabilities* ☐ Not living with any nuclear family members ☐ Poor parent/child relationship ☐ Poor family functioning ☐ Significant parental traumatic stress ☐ Inadequate financial resources ☐ Poor or absent social resources
Crisis reactions and coping behaviors ☐ Only a few common crisis reactions displayed ☐ Coping is adaptive (i.e., it allows facilitates daily functioning at pre-crisis levels)	*Crisis reactions and coping behaviors* ☐ Many common crisis reactions displayed ☐ Coping is tentative (e.g., the individual is unsure about how to cope with the crisis)	*Crisis reactions and coping behaviors* ☐ Mental health referral indicators displayed (e.g., acute dissociation, hyperarousal, and re-experiencing of the crisis; depression; psychosis) ☐ Coping is absent or maladaptive (e.g., suicidal/homicidal ideation, extreme rumination, excessive avoidance/precautions, substance abuse)
Total:	Total:	Total:

Brock & Davis (2008)

School Based Treatment

- Prevention (Key):
  - Strengthen Resiliency
    - Internal Resiliency
    - Foster External Resiliency
    - Ensure Psychological Safety
    - Minimize Trauma Exposure
    - Shape Traumatic Threat Perceptions

Yule (2001)

School Based Treatment

- Psychological Triage
  - Crisis Exposure
  - Threat Perceptions
  - Personal Vulnerabilities
  - Crisis Reactions
  - Durability of crisis reactions

Brock (2006), Brock et al. (2009), Nickerson et al (2009)

School Based Treatment

- Immediate Crisis Intervention
  - General Issues
    1. Cultural differences
    2. Body language
    3. Small groups
    4. Genders
    5. Appropriate tools
    6. Frequent breaks
    7. Develop narrative

School Based Treatment

School-Based Interventions

- Psychological First Aid
  - Clarify trauma facts
  - Normalize reactions
  - Encouraging expression of feelings
  - Provide education to the child about experience
  - Encourage exploration and correction of inaccurate attributions regarding the trauma
  - Stress management strategies

Brock (2006), Brock et al. (2009), Nickerson et al. (2009)

School Based Treatment

- Education and Goal Setting
  - identification of specific, measurable targets is essential skills when anxious).
- Psychological Education
  - Parents and Teachers
  - Students

Perrin et al. (2000)

School Based Treatment

- Academic Interventions
  - Promote Initiation/Focus
    1. Increase structure
    2. Consistent and predictable daily routines
    3. Short breaks and activities
    4. External prompting (cues, oral directions)
    5. Allow time for self-engagement instead of expecting immediate compliance

Brock (2006), Brock et al. (2009), Nickerson et al. (2009)

Treatment

- Coping Skill Development
  - Train the child to recognize “triggers” for anxiety to increase their sense of mastery and to reduce avoidance.
  - There are a variety of coping skills can be taught to the child (i.e., relaxation, positive self-talk} imagery, and problem-solving).
  - Thought-stopping techniques may occasionally be encouraged to control overwhelming thoughts that occur in school or at night.

Perrin et al. (2000)

Treatment

- Termination and Relapse Prevention
  - When the active treatment phase is near completion, have the child identify what has been learned & describe how they will cope in the future with recall of the trauma and any long-term effects.
  - Refocusing the child on school, their enjoyment of pleasant activities, and wishes for the future are helpful.
  - Relapse prevention should be discussed and the child encouraged to identify potentially stressful situations that may be on the horizon.

Perrin et al. (2000)

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School Psychology Graduate Student
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Stephen E. Brock, Ph.D., NCSP
California State University, Sacramento
brock@csus.edu
www.csus.edu/indiv/b/brocks/