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LETTERS TO EDITOR

RECOGNITION & CLINICAL ASSESSMENT OF CHILDHOOD PTSD

Sir,

Compared to the literature on adult PTSD that on PTSD in children is sparse, and one cannot generalize the adult findings to children. Parents, teachers and even the mental health professionals' under-recognize prevalence of PTSD in children. Possibly, by the use of psychological mechanisms like denial, rationalization that children are too young to remember the trauma and the need to reassure themselves that the children are not 'damaged' (American Academy of Child and Adolescent Psychiatry [AACAP] , 1998).

The mainfestation of PTSD in children is different from that in adults in several ways. Re-experiencing can mainfest as repetitive play in which the trauma is enacted, dreams which may or may not have any specific trauma related contents and actual reenactment of the trauma. Numbing and avoidance may take the form of restlessness, hyperalertness, poor concentration and behavioral problems. Children may have periods during which they have only re-experiencing or only avoidance and numbing which alternate between each other, rather than exhibiting both groups of symptoms simultaneously. One of the varied manifestations is a dissociative symptom, which may take the form of hallucinations or disorganized thinking and behavior. Pre-school children can present with features of separation anxiety, stranger anxiety, fear of monsters or animals, avoidance of situations that may or many not have connection to the event. They may be preoccupied with certain words or symbols that may or may not have connnection with the event (AACAP, 1998). There can be compulsively repetitive play, which represents part of the trauma but fails to relieve anxiety (Post traumatic play) or play which represents part of the the trauma but which is less repetitive and more like normal play (play re-enactment), both of which can be representative of re-experiencing. In the place of avoidance/ numbing, only constriction of play, social withdrawal, restricted range of affect or loss of acquired developmental skills can be present. Another interesting manifestation may be "omen formation" (Terr, 1983). Children start believing that there are certain signs, which predict a traumatic event and if they are alert, they can detect these signs (omens).

Clinical Assessment

Children present unique challenge to the clinician assessing the PTSD symptoms. They may not report their psychological reactions to the trauma unless they are specifically asked about aspects of trauma. Hence, experts believe that directly asking the child about PTSD symptoms as they relate to the stressor is always required (AACAP, 1998). Cognitive immaturity of the children may also be disadvantageous, as the child may not be given the opportunities to talk about the event (Hoare, 1993). Since DSM IV requires verbal descriptions from patients of their experiences and internal states, their limited cognitive and expressive language skills make inferring their thoughts and feelings difficult. Eliciting symptoms of avoidance and linking them with trauma is very difficult in children, and hence the stress on these symptoms in the diagnostic systems is less applicable to the children. To add to the problems, parents and teachers have been shown to be poor reporters of PTSD symptoms in children. Formal and objective assessment of play can also aid in diagnosing PTSD in children. (AACAP, 1998).

Many symptoms of PTSD overlap with other childhood disorders namely, ADHD, depression, conduct disorder, oppositional defiant disorder and substance use (AACAP, 1998). Moreover, PTSD is highly comorbid with these conditons. Children

try to cognitively suppress by conscious attempts to distract themselves via motor restlessness or impulsive behavior. This combined with the hyperarousal symptoms [criterion D of DSM IV] makes differentiation from attention-deficit disorder difficult. Possibly, when pre-existing ADHD is a vulnerability factor to develop PTSD. Similar mechanisms hold good for other comorbid disorders also. In post- disaster situation, other factors like complicated grief reactions, survivor guilt and trauma-induced demoralization may occur. Differentiation of PTSD from other comorbid conditions is therefore difficult, but is very important to accomplish, as the treatment can vary. From the above, it is clear that clinicians should spend a considerable amount of time with children to elicit symptoms of PTSD, which may include play or projective psychological tests. One may like to use either semistructured interview schedules or self/parent report instruments. Though several of them are available for use in different age groups, none of them is deemed optimal (AACAP, 1998). Development of an instrument to tap PTSD in children of all age groups especially in the Indian setting is therefore very much a felt need.

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