

## Supporting Families Following a Traumatic Event

The iHV acknowledges that the baby or child's main caregiver may not be their biological parent but, for the purposes of this resource, the term 'parent' will be used throughout.

### What is a traumatic event?

**Traumatic events can be defined as direct or indirect experiences that put either a person or someone close to them at risk of serious harm or death.**

#### Examples of traumatic events are:

- Road accidents
- Experiencing or witnessing violence
- Abuse (this can include violence at school, experience of psychological, physical, or sexual abuse, or witnessing domestic violence)
- Serious illnesses or invasive medical procedures
- Dog bites
- Human accidents, such as fires

#### Rarer traumatic events for children in the UK include:

- Natural disasters such as earthquakes, tsunamis, serious floods or hurricanes
- A terrorist attack
- Conditions of war

The COVID-19 pandemic was also a traumatic event for many children. The pandemic caused uncertainty, fear, sudden loss, and disruption to routines and access to support services<sup>1</sup>.

More than two-thirds of children will experience at least one traumatic event by 16 years of age<sup>1</sup>. Please note that children aged 0-2 years are referred to as infants and toddlers in this document, whereas children aged 3-5 years are referred to as older children. We recognise that children develop at different rates; therefore, we recommend considering the child's developmental stage in addition to their chronological age.

### What happens when a child experiences a traumatic event?

Like adults, all children will react in different ways to a traumatic event and how they react may also depend slightly on their age and developmental stage. Children are likely to experience a range of responses in many different domains.

It is likely that children will experience a physical response, with symptoms such as:

- Increased heart rate
- Increased sweating
- Rapid breathing
- Changes in appetite
- Sudden onset of obsessive-compulsive or tic symptoms<sup>2</sup>

**More information on page 2**

**For additional resources see [www.ihv.org.uk](http://www.ihv.org.uk)**

The information in this resource was created on 16/11/2023.

Whilst we have taken every care to ensure the content of our resources is accurate and peer-reviewed at time of publication, evidence and advice may change over time. Therefore, please always exercise your own judgement. The iHV does not warrant or guarantee the accuracy or completeness of the information and cannot accept liability for use of our resources.

Should you doubt the accuracy of any of our content, please contact us: [info@ihv.org.uk](mailto:info@ihv.org.uk)

There may also be changes in children's behaviour – such as becoming jumpy, finding it hard to sleep, having meltdowns or being disobedient, or being overly clingy compared to usual. Behaviours like this are often caused by children struggling to manage their emotions (sometimes called emotional dysregulation) and being hyperalert to their environment<sup>3</sup>. This can make children more likely to seek proximity to their parents, look for comfort, and need more help to regulate their emotions. Parents are encouraged to respond to these behaviours and provide more physical contact, even when the child is objectively safe.

Regressive behaviours are also common, such as a resurgence of bedwetting or thumb-sucking. Children may become preoccupied with thoughts or images of the event or start experiencing nightmares. They may worry that the event will happen again. This may be observed by them being less able to concentrate or being easily distracted. A sudden onset of intense emotions is also to be expected – such as fearfulness, increased anxiety, anger or irritability. Directly after an event, it is also common for a child to experience shock, as they have not processed what has happened yet (sometimes called denial). Younger children may also experience dissociation (mentally blocking thoughts or feelings about the trauma) as a way to cope with what happened. This means that reactions do not always appear straight away but may start some days or weeks after the event. Adults may view dissociation as a sign that a child is coping with the trauma.

## Infants and Toddlers

Younger children may find it hard to recognise physical symptoms and instead report having a headache or stomach ache. Children who are pre-verbal and impacted by trauma will show behavioural changes. Infants and toddlers may also show:

- Changes in appetite
- Less playful behaviour
- Avoidance of eye contact
- Unusually high levels of distress when separated from their parent
- A regression in their physical movements, such as sitting or crawling becoming more clumsy<sup>4</sup>
- Dissociation as described above

It is important to note that some of these behaviours may be evident in children who have developmental differences or disabilities, so the behaviours listed above are not in themselves an indicator of trauma. All of these changes are normal reactions, and most children fully recover after a few weeks. However, a proportion of children (around 10%) develop Post-Traumatic Stress Disorder (PTSD – see below)<sup>1</sup>. This will depend on what kind of trauma they experienced and other risk factors, such as if they have ever experienced a traumatic event before. PTSD is a key concern following a traumatic event. However, PTSD often overlaps with other mental health difficulties, including depression and anxiety disorders<sup>5</sup>.

Children who experienced trauma during the COVID-19 pandemic are more likely to experience depression<sup>6</sup>. Children who experienced traumatic events when they were very young or babies may appear to be unaffected by what has happened. However, they may develop a vulnerability to structural changes in their brain caused by the trauma. This can have impacts on their emotional, behavioural, cognitive, and social functioning later in life<sup>7</sup>.

**More information on page 3**

## What is PTSD?

The American Psychiatric Association<sup>8</sup> describes PTSD in their latest Diagnostic and Statistical Manual (DSM-5-TR) as having the following groups of symptoms lasting for one month or more and causing significant changes to daily functioning:

- Intrusion symptoms such as recurrent, involuntary flashback memories, or traumatic nightmares of the event. Some children may re-enact the events through play or drawings.
- Consistent avoidance of trauma thoughts, feelings or triggers. This could include avoiding the area where the traumatic event took place or people that they associate with the event. In contrast, they become dissociated from the event, block out all thoughts and feelings about it, and seem to withdraw socially.
- Changes to thoughts and mood, such as negative beliefs and expectations, excessive self-blame, negative trauma-related emotions such as fear, anger, guilt or shame. In younger children, this may manifest through constricted play. Toddlers and mobile infants may also seem hyperalert to possible threats and seek safety or comfort in situations where they are objectively safe.
- Changes in arousal and reactivity, including irritability, reckless behaviour, an exaggerated startle response, difficulties with concentration, and sleep disturbance. This may also include serious emotional dysregulation, with episodes of dissociation common in younger children.

DSM-5-TR includes a new subtype of PTSD for children younger than six-years-old due to having only abstract cognitive capacities and emerging verbal expression, so the symptom criteria are necessarily more behaviourally based<sup>9,10</sup>.

PTSD in children often co-exists with other mental health disorders, such as anxiety and depressive disorders<sup>11</sup>.

## Children who might be at risk of developing PTSD

Children are at increased risk of developing PTSD symptoms following a traumatic event when:

- they felt or thought their life was threatened;
- they have previously been exposed to other traumatic events;

- they already have an anxiety disorder;
- the event involved interpersonal violence or abuse;
- when their families are facing adversity, such as poverty, unemployment, housing issues<sup>12</sup>.

## Why is detecting PTSD so important?

PTSD symptoms are unlikely to remit on their own<sup>13</sup>. Disruption to these normal processes can have adverse long-term effects on child development and adjustment.

## Treating PTSD

The 2018 NICE guidance<sup>3</sup> recommends a range of treatments for children of different ages (see below). It is also suggested that any treatment should take place at least one month after the traumatic event (as this is when a PTSD diagnosis can be made). The guidance also stressed that children should not be given any form of psychologically-focused debriefing about their experiences as this may be re-traumatising for children.

- Children aged 0-2 years-old: It can be very difficult to recognise trauma in children this age, and so there are currently no recommended treatments<sup>14</sup>. See the Good Practice Points below for advice on how to support parents and families.
- Children aged 3-4 years-old: There are currently no treatments recommended by the NICE guidance. However, there is some evidence that Child-Parent Psychotherapy can effectively support young children who have experienced trauma<sup>15</sup>.
- Children aged 5-6 years-old with a diagnosis of PTSD or clinically significant symptoms: It is recommended that individual Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) be considered for children this age<sup>3</sup>.
- Children aged 7-17 years-old with a diagnosis of PTSD or clinically significant symptoms: Individual TF-CBT is recommended, however, Eye Movement Desensitisation and Reprocessing (EMDR) can also be considered if children do not respond to or engage with TF-CBT<sup>3</sup>.

Drug treatments should not be offered as a treatment for PTSD in children or young people aged under 18 years<sup>3</sup>.

**More information on page 4**

## Good Practice Points

### ■ Share your knowledge of children's normative responses to trauma.

If parents are worried about their children's mental health, reassure them that many changes are to be expected and are completely normal.

- » **For parents with infants or toddlers**, it is important to help their children feel as safe as possible as this will help children to regulate their emotions and reduce dissociation. Maintaining children's routines, creating a calm environment, and avoiding unnecessary separations may help with this.
- » **For parents with older children**, let them know that for most children these changes are usually just short-term, and if they are still present after one month, then it is an opportunity to seek further psychological assessment and support. Explain that it is helpful to tell their children about the reactions they might expect following the trauma – and it is normal for them to have a wide range of emotional, physical or behavioural reactions – giving examples. As above, encourage parents to promote feelings of safety for children to reduce dissociation and improve emotion regulation.

### ■ Talk to parents privately.

Wherever possible talk to parents, whether it is about themselves or their child, in a private place away from children. Explain that you want to provide a safe space for them to express their distress and worries openly, however, this can be extremely distressing and disturbing for children to observe or over-hear. Re-iterate that it is important for their children not to over-hear them talking about the event and how it has impacted on them as much as possible.

### ■ Guide parents to look after themselves.

Parents may also be affected by the event. It is important that parents think about their own response to the event and seek professional advice when needed. It is possible that parents will have very different reactions to the event, and also different ideas about how to support their children. Invite them to present to their children as a united front, as children can very easily pick up on these differences and it can further complicate their processing or sense-making of the event.

### ■ Encourage parents to support their children in the short-term.

Share the iHV Parent Tips, Supporting Children and Young People After a Traumatic Event. This will help parents support their child through this challenging time.

- » **For parents with infants or toddlers**, it is important that parents understand the importance of how they respond to their children's subjective need for physical and psychological proximity. This will help the child regulate their emotions. It is also important to be aware of the child's developmental stage, how trauma may be experienced, and how children may express their reactions to this.
- » **For parents with older children**, encourage parents to explain to their children that the event is now over and to dissuade them from looking at news coverage, as reliving the event could be upsetting and confusing. Not all children will want to talk about the event at all but, for those that do, support parents to share the facts of the event with their children which may help clarify any misunderstandings. Encourage parents to try and keep normal routines as much as possible, as this will help promote security and familiarity.

### ■ Be vigilant to developmentally sensitive signs of PTSD and barriers to talking openly.

A large proportion of PTSD in children goes undiagnosed as picking up the symptoms, particularly in younger children, is challenging. Another challenge is that PTSD can often be mistaken for depression – as there are many overlapping symptoms. Symptoms to look out for that distinguish PTSD from depression in children are jumpiness, regressive behaviours, nightmares, re-experiencing the event through play, or drawing or reporting uncontrollable intrusive thoughts or images. Be aware that it may be hard for many children to talk about the traumatic event, they may have made sense of it by blaming themselves – so guilt, self-blame and shame can be a barrier to discussion. It can be helpful to explore how they understood what happened and why, so you can allay any misconceptions. Additionally, they may avoid talking about it at all as it triggers distressing memories.

**More information on page 5**

## Good Practice Points continued

### ■ Do not offer formal trauma debriefing.

As mentioned above, the evidence for counselling and/or debriefing immediately following trauma with the aim of preventing the onset of trauma symptoms is inconsistent, and in some cases, formal critical incident debriefing has been found to be unhelpful and is therefore not recommended by the NICE guidance (2018)<sup>3</sup>. This means that formal, structured debriefing services should not be offered by health visitors, school nurses, midwives or other professionals. However, children and their parents will value the space to discuss their experiences, so offering a space which will allow them to talk at their own instigation without prompts may be of benefit.

### ■ Be aware of risk factors for PTSD for children.

There is evidence that children who have experienced previous traumas, have a pre-existing anxiety disorder, and live in a family facing adversity are more vulnerable to developing PTSD in the face of a recurrent trauma. Health visitors are well-placed to strengthen early relationships between babies and their parents. They can identify risk early and ensure close monitoring for a potential referral to a specialist parent-infant or mental health team.

### ■ Signpost families for specialist trauma assessment and treatment.

For many areas of the country, this referral may be to local child and adolescent mental health services. TF-CBT and EMDR are the recommended treatments if PTSD is suspected.

### ■ Protect time for personal reflection and supervision.

Research has shown that professionals working with families who have experienced a traumatic event can be vicariously traumatised themselves<sup>16</sup>. Clinical supervision has been highlighted as a way to effectively reduce the risk of staff burnout<sup>17</sup>. Speak to your manager about how they can best support you.

## Additional Reading:

### To support children:

- MindEd: [www.minded.org.uk/](http://www.minded.org.uk/)
- Royal College of Psychiatry - Mental health and growing up factsheet: traumatic stress in children: information for parents, carers and anyone who works with young people: [bit.ly/2ZCGZq4](https://bit.ly/2ZCGZq4)
- National Institute for Health and Care Excellence guidance [NG116] Post-traumatic stress disorder: <https://www.nice.org.uk/guidance/ng116>

### To support parents:

- Mental Health Foundation:
  - » How to look after your mental health: [bit.ly/2UcCGRs](https://bit.ly/2UcCGRs)
  - » How to sleep better: [bit.ly/2Zw2m0h](https://bit.ly/2Zw2m0h)
  - » The impact of traumatic events on mental health: [bit.ly/2NBYzIB](https://bit.ly/2NBYzIB)

More information on page 6

## References

1. Lewis SJ, Arseneault L, Caspi A, Fisher H, Matthews T, Moffitt T, et al. The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people. *Lancet Psychiatry*. 2018 Dec.
2. Lafleur, D. L., Petty, C., Mancuso, E., McCarthy, K., Biederman, J., Faro, A., ... & Geller, D. A. (2011). Traumatic events and obsessive compulsive disorder in children and adolescents: is there a link?. *Journal of anxiety disorders*, 25(4), 513-519
3. National Institute for Health and Care Excellence. Post-traumatic stress disorder. 2018 [accessed 13 Sep 2023]. Available from: <https://www.nice.org.uk/guidance/ng116/chapter/Recommendations>
4. Department of Health, Victoria State Government. 2022 Apr [accessed 18 Sep 2023]. Available from: <https://www.betterhealth.vic.gov.au/health/healthyliving/trauma-and-children-newborns-to-two-years>
5. Møller L, Augsburger M, Elklit A, Sogaard U, Simonsen E. Traumatic experiences, ICD-11 PTSD, ICD-11 complex PTSD, and the overlap with ICD-10 diagnoses. *Acta Psychiatrica Scandinavica*. 2020 May;141(5):421-31.
6. Barendse ME, Flannery J, Cavanagh C, Aristizabal M, Becker SP, Berger E, et al. Longitudinal change in adolescent depression and anxiety symptoms from before to during the COVID-19 Pandemic. *J Res Adolesc*. 2023 Mar;33(1):74-91.
7. Parent Infant Foundation. Understanding early trauma and the importance of early relationships. 2022 [accessed 18 Sep 2023]. Available from: <https://parentinfantfoundation.org.uk/wp-content/uploads/2022/06/Understanding-Early-Trauma-Report-final.pdf>
8. American Psychiatric Association. Posttraumatic Stress Disorder. 2022 [accessed 13 Sep 2023]. Available from: [https://www.psychiatry.org/file%20library/psychiatrists/practice/dsm/apa\\_dsm-5-ptsd.pdf](https://www.psychiatry.org/file%20library/psychiatrists/practice/dsm/apa_dsm-5-ptsd.pdf)
9. Scheeringa MS, Zeanah CH, Drell MJ, Larrieu JA. Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. *J Am Acad Child Adolesc Psychiatry*. 1995 Feb;34(2):191-200.
10. Scheeringa MS, Myers L, Putnam FW, Zeanah CH. Diagnosing PTSD in early childhood: an empirical assessment of four approaches. *J Trauma Stress*. 2012 Aug;25(4):359-67.
11. Cohen JA, Scheeringa MS. Post-traumatic stress disorder diagnosis in children: challenges and promises. *Dialogues Clin Neurosci*. 2022 Apr.
12. Trickey D, Siddaway AP, Meiser-Stedman R, Serpell L, Field AP. A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clin Psychol Rev*. 2012 Mar;32(2):122-38.
13. Yule W, Bolton D, Udwin O, Boyle S, O’Ryan D, Nurrish J. The long-term psychological effects of a disaster experienced in adolescence: I: The incidence and course of PTSD. *J Child Psychol Psychiatry*. 2000 May;41(4):503-11.
14. Blank M. Posttraumatic stress disorder in infants, toddlers, and preschoolers. *B C Med J*. 2007 Apr;49(3):133.
15. Early Intervention Foundation. Child-Parent Psychotherapy. 2016 [accessed 18 Sep 2023]. Available from: <https://bit.ly/46fP9a8>
16. Isobel S, Thomas M. Vicarious trauma and nursing: an integrative review. *Int J Ment Health Nurs*. 2022 Apr;31(2):247-59.
17. Martin P, Lizarondo L, Kumar S, Snowdon D. Impact of clinical supervision on healthcare organisational outcomes: a mixed methods systematic review. *PLoS one*. 2021 Nov;16(11):e0260156.

### Author:

**Dr Camilla Rosan** Programme Lead for Families and Chartered Clinical Psychologist, Mental Health Foundation

### Updated by:

**Hannah Hopson** Research Assistant, Anna Freud

**Abi Miranda** Head of Early Years and Prevention, Anna Freud