

[ptsd & trauma](#)

## Trauma Care for Children and Adolescents

**Has your child or teen experienced trauma? Learn from a clinical psychologist specializing in childhood trauma treatment what the symptoms look like and how different interventions can help.**



## What is childhood trauma?

When most people hear the word “trauma” they think of something that only happens to other people. According to the National Survey of Children’s Health, approximately 35 million U.S. children and adolescents have experienced a childhood trauma or adverse childhood experiences (ACEs). As this number seems large, you may be wondering what constitutes a childhood traumatic event. Childhood trauma can be defined as abuse (such as sexual or physical), witnessing domestic violence, neglect, accidents, chronic or sudden medical illness, a death in the family or parental illness, substance use, divorce, or incarceration. For children, ACEs or traumatic events can feel confusing and upsetting. Given this, you may want to reconsider if your child or a child you know has been through a traumatic event.

## Recognizing trauma-related symptoms in a child or adolescent

Often, children and adolescents who are affected by traumatic events do not recognize their symptoms. Firstly, most children are not aware they experience trauma because of the high frequency of adverse events, ultimately making the idea of, for example, [abuse or neglect](#) a “normal” experience. This is also true for caregivers who typically have challenges identifying symptoms of trauma.

Here are some signs and general symptoms that are typical for children and adolescents who have experienced traumatic events:

- **Hypervigilance/hyperarousal.** This is an abnormal state of increased responsiveness to stimuli accompanied by physiological and psychological symptoms (e.g., increased alertness, elevated heart rate and breathing). Most traumatized children dislike loud and abrupt noises and often feel “jumpy” or appear “wide-eyed” looking out for potential danger.
- **Avoidance.** Avoidance of thinking or talking about the traumatic event or places, activities, and people connected to the traumatic event.
- **Intrusive or unwanted thoughts.** Recurrent, distressing flashbacks, thoughts, or memories of the traumatic event. Often, a child may feel they are “reliving” the event or experience nightmares related to the event.

## What trauma looks like in children of different ages

Trauma symptoms often vary according to a child's age:

### Early childhood (ages 3-8)

**Unmanageable Behaviors.** If you have a child who is within the ages of 3-8, you may see an increase in aggressive, non-compliant, or oppositional behaviors. This means you may have more trouble managing your child's behavior because they struggle listening to directions or purposely defy your requests. This often happens because young children do not have the cognitive development to communicate their emotions effectively, so it is communicated in their actions and behaviors. This may also look like an increase in frequency of "temper tantrums" as children who have experienced traumatic events tend to try and control their environments and often their caregivers or parents. Their need to control is a way for them to manage their anxieties about the uncertainty or unpredictability of their world.

**Problems in social settings.** Often, these behaviors are not only difficult to manage at home, but in the school setting as well. Parents or caregivers may hear more concerns about their child's behavior with regard to listening to teachers and authority figures, increased conflict with peers, and trouble making or keeping friends.

**Heightened emotions.** Bouts of crying and emotionality are observed in young children who have experienced traumatic events. This may look like increased sensitivity or irritability resulting in more consoling over typically non-concerning stimuli, such as telling a child "no." Lastly, you may see an increase in hypervigilance or "being on the lookout for danger." Often times, children look wide-eyed and alert anticipating the next unpredictable event. It is common to see young children placing their hands on their ears in efforts to prevent hearing loud sounds.

### Middle childhood (ages 8-11)

**Regressed behaviors.** Middle childhood (ages 8-11) have similar presentation to children in early childhood. Despite these children being slightly older, their behavioral challenges still persist and often mimic behaviors that are much younger than their actual age. This means non-compliant, oppositional, and aggressive behaviors are still present and often times, more significant and unmanageable. Tantrums are still very much prevalent and begin to include increased verbal aggression (such as name calling, cursing, and hurtful

language to others).

**School challenges.** An increase in school challenges may arise both in academic performance and behavior. It may be difficult for your child to concentrate or listen to directions, causing grades to decline. Often, inattention can be misdiagnosed and confused with [Attention Deficit Hyperactivity Disorder](#) (ADHD). Similar to early childhood, trauma in middle childhood can cause behavioral problems with peers at school and in classroom settings, due to increased irritability and lower ability to tolerate frustration.

**Problems in social settings.** As children's social network typically begins expanding during these years, an increase in social or peer-to-peer challenges can occur. Because children who have experienced trauma have increased irritability, sensitivities, and hypervigilance, making friends or keeping friends tends to be difficult. Children may become controlling over their environments, including their peers, causing problems managing healthy friendships. These friendships often contain more conflict than normal caused by a child's behavioral challenges, in addition to their need to control.

**Heightened emotions.** As children begin to add more language to their world, expression of feelings may look like increased verbal tantrums and aggression. As stressors also increase (with more school and home responsibilities), children may become more irritable and exhibit the big feelings they are holding onto regarding their trauma.

## Adolescents (ages 12-18)

**Regressed behaviors and involvement.** As adolescents (ages 12-18) tend to individuate more at this age, we often see an increase in isolative behaviors, including avoidance of people and healthy coping styles. Adolescents who have experienced trauma tend to be significantly overly-expressive or under-expressive. Overly-expressed behaviors include both verbal and physical aggression to others. They can be long in duration and hard to manage. On the other hand, under-expressive behaviors might look like the exact opposite. Adolescents might isolate in their rooms, be verbally non-expressive and reserved, and non-reactive. Both of these coping styles tap into the symptom of avoidance as they avoid of the actual problem at hand.

**Mood alteration.** A decline in mood typically accompanies adolescents who have experienced trauma. Irritability increases and bouts of sadness and anger are more prevalent. Often times, these emotions are related to the traumatic events experienced. At home, [increase in conflict](#) typically occurs as parents are unaware of what is going on with the adolescent and attribute much of it to the moodiness of a growing teen. While some of

this may be true, it is important to keep in mind the symptoms related to trauma. Additionally, they're at higher risk of harming themselves due to increased feelings of sadness.

**School challenges.** Adolescents tend to have higher academic demands placed on them during this time, increasing their stressors and making it harder to manage their emotions. Adolescents tend to experience a decline in grades and overall lower performance in areas that they typically functioned well in before the trauma. Their ability to concentrate often declines as intrusive thoughts or unwanted imagery from the traumatic event replays in their mind. A decline in mood is often observed and influences their ability to perform. Skipping school and behavioral problems in the classroom may also increase.

**Problems with social relationships.** Peer-to-peer and romantic relationships tend to be most important at this stage regardless of trauma experiences. Adolescents who have experienced trauma typically isolate from friendships and tend to keep to themselves. Fear of friends not understanding, in addition to the lack of desire to have friendships, contribute to decreased social interactions. During this time, romantic relationships tend to form. Often, adolescents who have experienced trauma desire attachments to any person who exudes love or acceptance. It's advisable for parents to be mindful of the relationships that are formed during these times.

## Tips for parents

As the world often feels unpredictable, unstable, and chaotic for children and adolescents with trauma-related symptoms, creating an environment that promotes a child's socio-emotional well-being is imperative.

Here are some helpful parenting tips:

### **Tip 1: Provide stability and consistency**

Containing the space, also known as limiting your child's options for various activities, can help reduce a child's anxiety. This increases opportunities for children to feel safe because the world feels somewhat predictable as the rules stay consistent. Children with trauma often feel the world is ever-changing. With rules and boundaries, the child learns consistency in routine, that an authority figure is in charge, and they are safe. Rules create invisible parameters to promote healthy growth and well-being. Children are more aware than we know and respond well (as seen by their positive change in behaviors) to rule-

setting, helping them know what is and is not okay. They are even more likely to apply rule following in other settings such as with teachers in the classroom or other parents on play dates!

## **Tip 2: Add predictability**

Anxiety is typically referred to as the fear of the unknown. So, if we can address and dismantle a child's uncertainty, we give them control and knowledge. Setting expectations for events and activities beforehand adds predictability. As we cannot control all events in our children's lives, we can set them up for success by providing information about what to expect in certain situations. For example, if you are leaving the house to go to the store and your child is nervous about your whereabouts, informing them of the details of your trip, time frame, and how to contact you while you're gone will help to decrease anxiety. This allows your child to know what to expect.

## **Tip 3: Promote safety**

Environments that limit chaos and increase predictability provide children with a safer space to grow. For example, this does not mean having a relationship with your partner free of arguments, but rather taking those arguments to a private space to limit your child's exposure to conflict. Additionally, informing your child on who to contact and what to do in case of emergencies is setting your child up for success. Providing open spaces for your child to disclose their feelings and thoughts, without judgement, is helpful to promote safe spaces to grow. Children who have experienced trauma are often fearful of sharing information with caregivers due to a fear of punishment. Informing your child prior to traumatic events of your unconditional and supportive stance, may increase the likelihood your child will share their challenges and experiences with you.

## **Sources of support for your child**

**Peer network.** Your child's friends can support their recovery by lending an open ear and just being good listeners. Because trust is a challenge for a child who has experienced trauma, creating a space that feels safe and non-intrusive can be helpful. This might mean continuing to partake in usual and "normal" activities to create a space that feels normal for them as often they feel singled out given their trauma experiences. Having fun, "normal" conversations, and participating in regular events can be most helpful.

**Family.** Creating a safe space at home is crucial for children and adolescents who have experienced trauma. This might mean letting your child know that if they want to share anything, you or other family members will be ready to listen without any judgement or punishment. Often, children and adolescents do not share their trauma experiences, especially if they are related to sexual, physical, neglect, or [domestic violence](#). Verbalizing your place in keeping them safe will allow them to share more willingly. It is also important to not abandon your typical caregiving or parenting skills, and to also provide boundaries and set limits. Though it may be easy to feel deeply for your child because of their experiences, you also want to guide and help them live a healthy life that will help protect them in the future.

**Religious or spiritual groups.** If your family's religious faith provides support in times of need, reaching out to clergy or other congregants may be of assistance to you and your child. Because traumatic events can be devastating and emotionally taxing, it's easy to lose faith and hope. Turning to someone who can restore the one thing that might feel like the only resolution in the moment—your faith—can be significantly helpful.

## Types of professional treatment

When behavior or symptoms seem unmanageable or are interfering with your child's functioning (academic, social, or emotional), it's important to seek professional [mental health services](#) with a trauma-informed clinician.

The following mental health treatment interventions can be significantly helpful with alleviating your child's symptoms:

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** is an intervention used for children and adolescents (ages 3-18) and their parents who have experienced a traumatic event (or events). It resolves a variety of emotional and behavioral challenges resulting from the trauma through a cognitive-behavioral therapy model. Additionally, TF-CBT focuses on a gradual exposure component meaning the traumatic event is discussed over the course of treatment. Research has shown the more exposure is disseminated, the more mental health well-being is improved and trauma symptoms reduced. TF-CBT consists of an 8-step process that can be remembered by the following acronym:

- **P**sychoeducation of trauma symptoms
- **R**elaxation skills to use when distressed
- **A**ffect regulation - Learning about feelings

- **Cognitive coping** - Learning how our thoughts effect our feelings and behaviors
- **Trauma narrative** - A detailed story is told about the child or adolescents' traumatic event(s)
- **In-vivo exposure** - The clinician will expose the child to address any significant trauma triggers during intervention time
- **Conjoint sessions** - The narrative is shared with the caregiver or parent
- **Enhancing safety** - Teaching healthy skills for the future

**Parent-Child Interaction Therapy (PCIT)** is a parent-child dyadic play-based therapy aiding children (ages 3-7) who have trauma-related symptoms such as aggressive, non-compliant, and oppositional behaviors. PCIT promotes positive parent-child relationships and teaches parents effective behavioral management strategies. The two components of PCIT address enhancing the relationship between the parent and the child in a module called Child-Directed Interaction and strategies to gain compliance in a module called Parent-Directed Interaction. During these modules, parents are taught how to implement these skills (e.g., engaging and using positive play skills, giving effective and direct commands), ultimately reaching the following goals:

- Enhancing the relationship between parent and child
- Reducing negative behaviors
- Increasing positive behaviors
- Decreasing aggressive behaviors
- Decreasing non-compliant behaviors

**Dialectical Behavior Therapy (DBT)** is a cognitive, support-based, and collaborative intervention to help adolescents manage safety risks (e.g., self-injurious or suicidal ideations) and challenging irrational thoughts. Because management of safety and at-risk behaviors tend to be one of the main goals of this intervention, DBT requires individual treatment in conjunction with a DBT-based group intervention with same-aged peers. During this intervention, 4 modules are addressed including:

- Mindfulness and non-judgmental thoughts of themselves, the world, and others
- Interpersonal effectiveness of managing relationships and how to have healthy interactions with others
- Distress tolerance to learn how to tolerate distressful and painful events by accepting life in a momentary state. For example, radical acceptance is an aspect of distress tolerance that teaches the adolescent how to change thoughts towards accepting what is, and deciphering between willingness and willfulness.
- Emotion regulation skills are taught to help manage thoughts of suicide, anxiety,



sadness, irritability, anger, etc., and regulate emotions in a healthy way.

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## **Get more help**

[The National Survey of Children's Health](#) - Data on children's mental and physical health in the U.S. (Childhealthdata.org)

[Parent Child Interaction Therapy Training Center](#) - Learn more about PCIT. (UC Davis Health)

[An Overview of Dialectical Behavior Therapy](#) - How DBT works. (Psych Central)

[Trauma-Focused Cognitive Behavioral Therapy](#) - Learn about TF-CBT and search a directory

of therapists. (TF-CBT)