Screening Young Foster Children for Posttraumatic Stress Disorder and Responding to their Needs for Treatment

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Introduction

For over a generation, researchers have identified high rates of emotional problems in children entering foster care. In their pioneering study, Fanshel and Shinn (1978) described "emotional impairment" in nearly a third of their subjects. Depending on the age group sampled, as many as 80% of these at-risk children show evidence of developmental delays (Halfon, Mendonca, and Berkowitz, 1995; McIntyre and Kessler, 1986; Kendall, Dale and Plakitsis, 1995). In recent years, clinicians and researchers have attempted to pinpoint with greater precision the nature of the psychiatric distress experienced by foster children. Thus, though research findings on the overall level of psychiatric disorders remain unchanged, the diagnostic categories used to describe these at-risk children continue to evolve.

One of the recent advances in understanding foster children involves assessing them for Posttraumatic Stress Disorder (PTSD), which first achieved formal recognition in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the diagnostic handbook for mental health professionals, in 1980 (American Psychiatric Association, 1980). Two revisions later, the DSM IV (American Psychiatric Association, 1994) includes updated notes to account for the distinct responses of children who experience PTSD. At present, the criteria fail to differentiate adequately between PTSD in adults and children even though children, particularly young children, appear to respond much differently to traumatic stimuli than adults.

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As opposed to earlier diagnostic labels, Posttraumatic Stress Disorder seems to reflect more directly the experiential world of foster children. As Garbarino (1995) has noted, foster children are often exposed to numerous traumatic stressors in their "socially toxic environments," including physical and sexual abuse, homelessness, neglect, parental substance abuse and abandonment. While these stressors may tend to be chronic, they are also frequently acute and/or episodic in nature. PTSD symptoms overlap with the symptoms of other common psychiatric disorders such as depression and generalized anxiety disorder. In contrast to other diagnoses, however, PTSD captures the overall context of the child's symptoms by identifying these symptoms as a stress reaction to specific traumatic event/s.

Over the past decade an emerging body of research has documented the varying levels of children's exposure to trauma and the symptoms associated with that exposure. Symptoms may increase (Goenjian, Pynoos, and Steinberg, 1995) or decrease (Green, Grace, Vary, Kramer, Gleser, and Leonard, 1994) according to the nature of the trauma, developmental level of the child, and the existence of comorbid conditions. Individual therapy, including play therapy, is important so that children can share their anxieties at a pace consistent with their ability to integrate the experience of the trauma (Gillis, 1993). Group treatment and family therapy are also important modalities, using the insights of significant others as a source for information and coping strategies (Gillis, 1993). While some modalities, including cognitive-behavioral therapy, have produced encouraging results (Deblinger, McLeer, Henry, 1990), there is considerable research work to be done on comparing and treating differing trauma experiences across the spectrum of environments, ages, socioeconomic and cultural factors (Pfefferbaum, 1997).

Researchers are also gathering prevalence data on PTSD in inner-city youth. Burton (1991) found a positive correlation between exposure to community violence and PTSD. Also, Guevera (1991) in his study on gang violence found a positive correlation between the level of exposure to gang violence and PTSD. Inner-city foster children represent a highly vulnerable subset of at-risk children, and their rates of PTSD may be equal to if not higher than other vulnerable child populations.

In a recent study examining 87 children entering foster care aged six to eight, Dale, Kendall, Hessenauer and Humber (1997) found that 33% met criteria for a diagnosis of PTSD. Given the high prevalence rates found in these preliminary investigations, case workers who work with foster children should learn to identify the major signs and symptoms of PTSD. Likewise, clinicians who conduct psychotherapy with foster children should learn how to diagnose and treat this disorder. Early detection and treatment offers the best hope for steering these at-risk children, often victimized both by their families and systems purporting to serve their interest, toward productive, meaningful lives.

Identifying the Signs and Symptoms of PTSD

Posttraumatic Stress Disorder develops over time as the result of exposure to extreme stress. This reaction, which is accompanied by feelings of intense fear, helplessness and/or horror, tends to be chronic. Children with PTSD exhibit symptoms which fall into three general categories: 1) re-experiencing the traumatic events; 2) avoidance of stimuli associated with trauma and general numbing; and 3) heightened arousal.

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Many children entering out-of-home placements are exposed to life-threatening traumatic events. After all, the purpose of out-of-home placements is to protect children seen as "at-risk" for physical or psychological injury. When asked about exposure to traumatic events, a sample of 152 children between the ages of six and eight entering out-of-home placements in Baltimore City report the following stressors:

Traumatic Event	% Endorsement
Fear of being shot or stabbed	72.6%
Hearing gunshots around home or school	66.7%
Fear that something bad might happen	58.1%
Physical abuse/fear of physical abuse	46.2%
Witnessed car accident, fire or injury	46.2%
Know gunshot or stabbing victim	45.3%
Car accident, fire or other injury	27.2%
Verbal threats of physical harm	17.1%
Sexual abuse	3.4%

These 152 children were administered the PTSD Symptom Inventory for Children (PTSD-SIC)(Eisen, 1996). This instrument was part of a screening protocol for children entering the foster care system, through a health clinic specifically designed for emergency out-of-home placement. The PTSD-SIC is a measure which asks questions that directly parallel the criteria outlined in the DSM IV, though there is expansion of the criteria to account for those experiences that are germane to children who live in traumatic communities as well as dysfunctional familial environments. For example, the chronicity of hearing repeated gunshots night after night in one's neighborhood could qualify as a traumatic "re-experience," when coupled with the additional problem of environmental instability resulting from out-of-home placement. These types of reoccurrence (and their impact on children) are not accounted for as "recurring" or "reliving" experiences as defined in DSM IV.

Of the 152 children assessed in the Baltimore study, 33% were found to meet criteria for PTSD, a rate significantly higher than seen in the population at large. In addition, many other children who did not meet criteria for PTSD also reported high levels of distress. Children with PTSD were more likely to report the following: distressing recollections of traumatic events, nightmares, avoidance of thoughts associated with traumatic events, purposeful avoidance of situations which evoke traumatic recollections, difficulty recalling important aspects of trauma, feelings of sadness, worries about premature death, sleep disturbance, poor concentration, hyper vigilance, and exaggerated startle response. Not surprisingly, children with PTSD also tended to exhibit more depressive symptomatology than children without PTSD, highlighting the comorbidity of these two disorders. Symptoms such as sleep disturbance, difficulties with memory and concentration, and feelings of sadness are characteristic of both depression and PTSD.

In light of this evidence, professionals should be aware of the possibility of PTSD in children who exhibit some or all of the following symptoms:

- nightmares and/or difficulty sleeping
- persistent sadness
- poor concentration or forgetfulness
- fears about dying before adulthood
- jumpiness or nervousness
- flashbacks of traumatic event
- play which seems to reenact traumatic event
- refusal to discuss/denial of traumatic event
- avoiding people, places, or things which may remind child of traumatic event
- forgetting important facts about traumatic event
- constant watchfulness and guardedness

Professionals working with at-risk children must also realize that childhood trauma manifests itself in a number of ways besides such overt violence as physical or sexual abuse. Of the 152 foster children in our sample, 44% with PTSD had a history of physical abuse and 11% with PTSD had a history of sexual abuse. Often overlooked by both the research and clinical communities, neglect also has a deleterious impact on children. In the Baltimore City population, an overwhelming majority (71%) of children with PTSD had a history of severe neglect. Although a subset of children had multiple reasons for entering care, many entered care solely due to neglect.

Although childhood PTSD is gaining recognition as a common sequella of neglectful or abusive environments, the standardized measurement of PTSD in children is still in its infancy. Only a handful of instruments have been developed (e.g., Briere, 1996; Eisen, 1996; Saigh, 1989; Pynoos & Eth, 1987)[1]. At present, case workers and others who work on behalf of children must familiarize themselves with the behavioral manifestations of PTSD in order to identify children who may be in need of specialized services.

Treating PTSD: Some General Guidelines

As the literature demonstrates, most children placed in foster care are exposed to multiple traumatic events

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and manifest a variety of behavioral and emotional symptoms (Dubowitz, Zuravin, Starr, Feigelman, and Harrington, 1993; Hochstadt, Jaudes, Zimo, and Schachter, 1987; Kendall et al., 1995; McIntyre and Kessler, 1986). As a result of lack of adequate developmental and educational experiences, these children also typically show evidence of cognitive delays and deficits (Hochstadt et al , 1987; Kendall et al., 1995). Tragically, few foster children are referred for the appropriate mental health treatment to address these concerns (Dubowitz et al., 1993; Frank, 1980; Gruber, 1978). Those children who do receive services are generally served in traditional outpatient settings.

Perhaps because no specific symptom profile has emerged for maltreated children in general, no specific treatment protocol has been developed to treat post-traumatic symptoms in foster children. However, because of the ongoing process of emotional and environmental adjustments that result from initial and multiple placements in foster care, these children may re-experience the stressor of continued instability in their lives. Young foster children may therefore exhibit a wide range of problems, depending on the stressors to which they have been exposed. In our opinion, any treatment model for these traumatized children must be both integrated and comprehensive, combining individual, family and community-based interventions. The uniqueness of often chronic environmental instability, fear of abandonment, lack of positive parental bonding, abuse, and neglect should lead to "strategically planned therapy" for the life of the child while in foster care. That is, the therapist should gauge the effects of recovery and additional trauma based on how well the child is making personal adjustments while in placement. Furthermore, because the basic health needs of foster children have often gone unmet (Hochstadt et al., 1987; Chernoff, Combs-Orme, Risley-Curtis and Heisler, 1994) mental health treatment is contingent on addressing any outstanding medical problems.

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Individually-tailored treatment thus encompasses the child's physical, developmental and psychological needs. The abused foster child may need extra supports and opportunities to succeed at age appropriate tasks at school, home and with peers. Success and mastery experiences are crucial to remedying feelings of low self-esteem and helplessness. Such experiences can be achieved through school placement, tutoring, and involvement in structured peer group activities such as sports, scouts and church groups.

Individual therapy should be conducted by a mental health professional familiar with the long-term effects of child maltreatment. Trauma-focused treatment should address both re-experiencing and avoidance symptoms by encouraging the child to work through traumatic events in a safe setting. Dealing with past trauma helps the child gain some feelings of mastery over the event and his[2] feelings related to it.

Individual interventions should also address the distorted belief systems that often develop in response to traumatic stress. The abused child needs to "unlearn" that he was responsible for the precipitating traumas. Abuse also teaches children to expect that close relationships are always fraught with physical, emotional or sexual violation. Likewise, the child needs to change his concept of self and others, giving up the dual role of both protector of parents and helpless victim of abuse. Gone unchallenged, these belief systems may lead the child to reenact his traumatic history in subsequent relationships and environments.

Several coping strategies can address the symptoms related to hyper arousal, such as jumpiness, being on edge, extreme caution and emotional hyper reactivity. Self-comforting strategies such as deep breathing, progressive relaxation and "thought-stopping" may prove useful. A critical component of therapy involves encouraging the child to grieve his deep losses. As a result of abuse and neglect, most foster children have experienced multiple losses including loss of home and neighborhood, loss of family and loss of personal safety. The feelings related to the loss of a parent, even an abusive one, are complex. Therapy should help the child process these painful emotions in order to develop healthy new attachments.

Therapists should attempt to include all available sources of support — within both the family and community — in treatments tailored to the individual child's needs. Without these supports, individual therapy may be severely limited, perhaps even contraindicated. It may be detrimental to begin trauma-focused treatment with a child who does not have an adequate level of safety and stability in his home or community environment. Therapists should thus attempt to enlist the support of the child's immediate and extended family, foster parents, and social workers along with personnel from his school. In practice, rarely are all these individuals available, so therapists must work with whomever is willing and able.

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[1] The Child Behavior Checklist (CBCL) by T. M. Achenbach has recently added a section covering posttraumatic stress disorder

[2] We use the reflexive pronoun "his" to refer to both boys and girls

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Mental health professionals need to educate other professionals involved with a child's care on the profound sequellae of abuse and neglect. Unfortunately, many significant others may not understand the connection between trauma and problematic behaviors, leading to additional blame and rejection for traumatized children. In family therapy, current care givers and biological parents can learn behavioral management strategies for problematic behaviors. Family therapy may also provide a context within which parents can begin to understand how their own childhood experiences, which often included maltreatment, have affected their relationships with their children. Family members may be able to supply essential background information on the child's history and behaviors. Finally, therapists should encourage care givers to reach out to parenting groups such as Parents Anonymous. Foster parents and others entrusted with the care of traumatized children also need support both to develop the skills required to attend to the specialized needs of these children and to replenish their own resources.

Conclusion

An overwhelming number of children entering the child welfare system have been exposed to life-threatening traumas. In our sample of 152 children aged six to eight entering foster care in Baltimore, one-third met DSM IV criteria for a diagnosis of Posttraumatic Stress Disorder (PTSD). These traumatized children urgently require timely clinical interventions. Traumas such as abuse and neglect tend to produce a multitude of confusing and unsettling feelings. Young children, who are still developing a sense of self, do not have the emotional defenses to process these intense feelings on their own.

Case workers and other professionals on the "front lines" must learn both to identify children with PTSD and to arrange for appropriate referrals in the community. We advocate a community treatment model whereby the child's therapist builds bridges with other significant figures in his life such as his foster parents, biological parents, teachers and pediatrician. Ultimately, the healing process involves reconnecting the child both to his own traumatic history and to his community. As a society, we can ill afford to ignore the needs of our traumatized children because they embody our future.

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