International Society for the Study of Trauma and Dissociation

Medical Professionals

Who is this Fact Sheet For?

This information sheet is for healthcare providers working with newborns, infants, children, and adolescent age young people who have experienced trauma, including prenatal trauma. Health care providers may include Medical Doctors and other Specialists, Physician's Assistants, Occupational Therapists, Physical Therapists, Speech and Language Pathologists, Nurses, Practical Nurses and Nurse Practitioners, Nutritionists, Osteopaths, Chiropractors, Naturopathic Medicine Doctors, Dentists and Dental Assistants and Technicians, and Respiratory Therapists, to name a few. Trauma and dissociation can impact all areas of a young person's development (e.g., cognitive, language, social, emotional), their mental health, and their physical health. Healthcare providers are in a unique position to recognize when trauma responses and symptoms may be interfering with a child or adolescent's health and wellbeing. They also have key roles in caring for the medical needs of these young people, as well as in referring them to relevant licensed health professionals who can provide specialized assessments and interventions (e.g. mental health providers, speech-language pathologists, educators).

The focus of these fact sheets are to support healthcare providers to more fully understand trauma and dissociation and to know when specialized referrals are needed. These sheets are designed to highlight the warning signs that complex trauma and dissociation might be at play, and healthcare providers without specialized training in complex trauma and dissociation should not feel a need to try to conduct a complete evaluation in this area. Instead, we encourage you to seek out providers in your communities who specialize in trauma and dissociation to both build your referral sources for further assessment and treatment, as well as to expand your network of colleagues for clinical consultation and guidance. Those wanting to learn more about this topic or expand their skill sets are encouraged to seek out additional training listed at the end of this document. It is important to also know that dissociation doesn't look any one way, and it involves the young person's inner subjective experience; observable and/or reported signs and symptoms of trauma responses can be important indications that further evaluation and assessment by a trained professional may be of crucial benefit. As such, the information below is intended to assist healthcare providers in identifying, understanding and helping young people who have experienced trauma and may be experiencing dissociation. As you read through this fact sheet and learn to support these young people, you are encouraged to take note of your own needs and practice self-care.

Could it be Trauma?

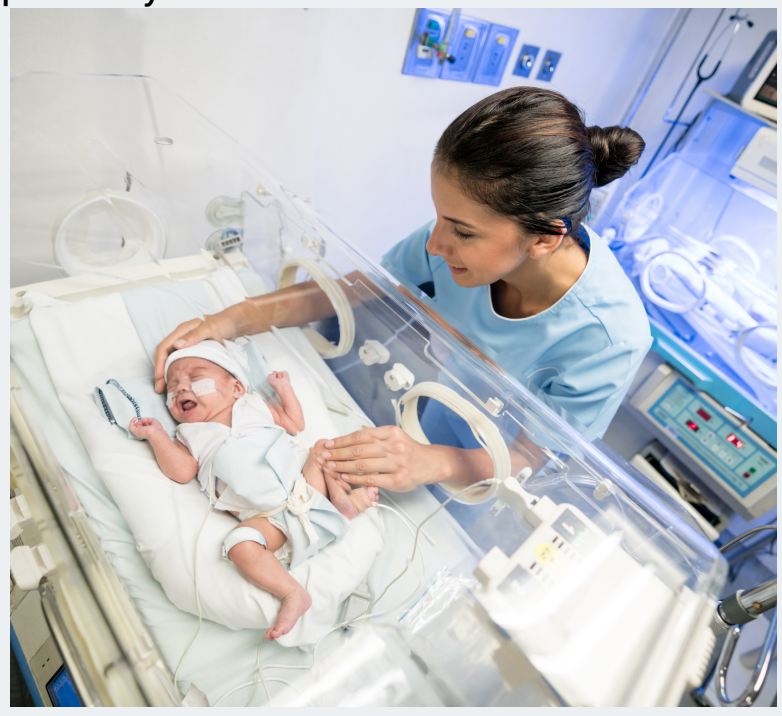
What is considered trauma?

"Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. "--SAMSHA, 2014, p.7

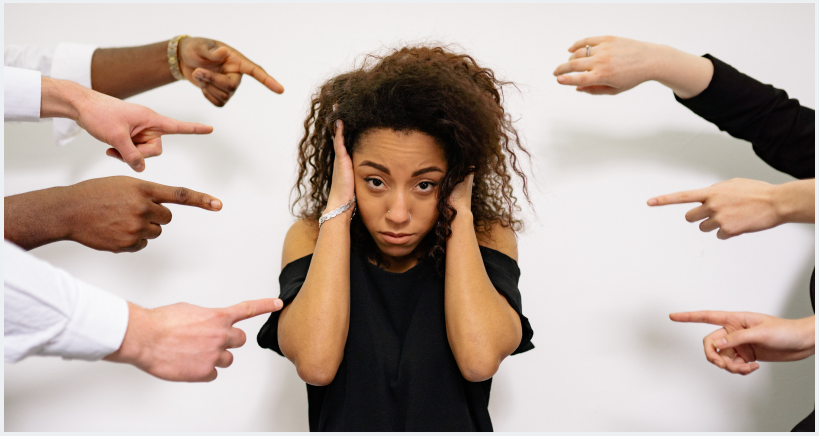
Trauma occurs when a child experiences an event that overwhelms them and exceeds their ability to cope, changing how they see and experience themselves, others, and the world around them. It may be an objectively stressful event (e.g. accident, abuse, severe illness) or a subjectively stressful event (e.g. separation from a caregiver, witnessing violence), and may lead to psychological and biologically-based survival responses that can continue long after the traumatic event has passed. A stressful event is not necessarily traumatic in and of itself, but may be traumatic in its effect on a particular individual. Thus, not every young person who experiences an extremely stressful event will actually be traumatized, but some will be. Some types of events are so extreme that they are likely to be traumatizing to most people. A traumatic event can be experienced directly by a person, witnessing someone else experience a traumatic event, or learned about a traumatic event having happened to a loved one or one's community. In psychological terms, "traumatic events" have traditionally been considered those that harm the psychological integrity of an individual.

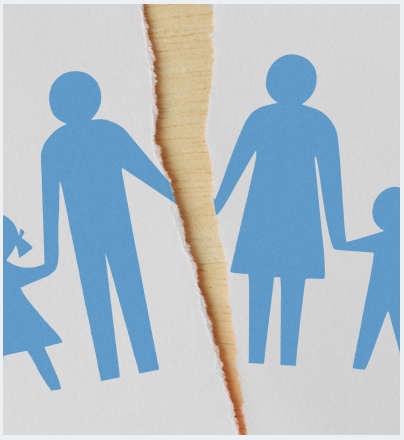
Potentially traumatic events can be single occurrences, chronic and repetitive over time, or complex in nature, meaning more than one type of potentially traumatic event has been experienced. Some examples may include:

- Difficult pregnancies
- Trauma, high levels of stress, significant illness, or domestic violence during pregnancy
- Pre-Birth trauma, affecting the mother and/or developing infant emotionally, medically, and/or physically
- Birthing complications
- Extended periods of time in the Neonatal Intensive Care Unit (NICU)
- The mother experiencing Postpartum Depression
- Painful, scary, and/or life-threatening medical conditions and procedures



- Diagnosed medical conditions at birth, early infancy, or in early childhood
- Medical treatments at birth, early infancy, and/or early childhood
- Adoption at any age
- Separation from caregivers, especially in young age
- Divorce or death of parent/caregiver
- Being cared for by chronically frightened and/or frightening parents
- Human-made disasters
- Physical abuse
- Sexual abuse
- Witnessing and/or experience of family violence (e.g., domestic violence, murder or suicide of a loved one)
- Incarceration of a loved one
- Bullying (including cyberbullying, cyberstalking, and online abuse)
- Witnessing or experiencing school and/or community violence
- The intergenerational impacts of historical traumas in communities of people (e.g., genocide, chattel slavery, and colonization)
- Emotional abuse (e.g., yelling, screaming, exploitation, and/or critical, demeaning statements being directed toward the child that leads to feeling unloved and/or thinking they are unwanted)
- Neglect of physical, emotional, medical, and educational needs
- Accidents that led, or could have led, to serious physical injury or death to self and/or others
- Unplanned/unwanted pregnancy
- Natural disasters, including the climate crisis and COVID-19
- Substandard living conditions such as poverty, homelessness and/or poor quality housing, food scarcity, poor air and water quality, parental/guardian unemployment
- Oppression, discrimination, and hate crimes related to social and/or cultural identity (e.g. racism, ageism, transphobia and trans-erasure, homophobia and heterosexism, xenophobia, sexism, classism)
- Trafficking (e.g., labor, sex)
- Grief and loss, including violent, repeated and/or extended separations from loved ones (including abduction/kidnapping of the child)
- Parental separation, abandonment, and/or alienation
- Mental illness and/or substance abuse in the home





What is Complex Trauma?

Complex trauma describes exposure to multiple types of traumatic events that are repetitive and have wide-ranging and long-term impacts on a person. Adverse experiences that can result in complex trauma are usually severe, chronic and ongoing, pervasive, and interpersonal in nature. Complex trauma typically begins early in life and can disrupt many areas of child development including the ability to form safe, secure attachments with others.

Red Flags and What to Look For

Healthcare providers can rely on the following acronym to identify the most common signs of trauma exposure (FRAYED, Forkey et al., 2021):

- F: frets (anxiety and worry) and fears
- R: regulation difficulties (of behavior or emotion, hyperactivity, impulsivity, aggressive, inattentive)
- A: attachment challenges (insecure attachment relationships with caregivers), poor peer relationships
- Y: yawning (sleep problems) and yelling (aggression, impulsivity)
- E: educational and developmental delays (especially cognitive, social-emotional, language, and communication)
- D: defeated (hopeless), depressed, or dissociated

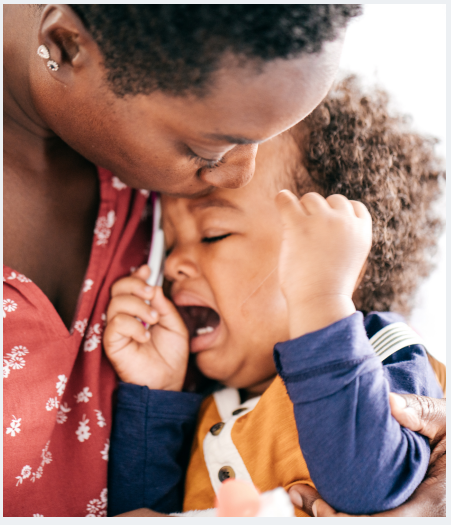
Traumatic stress in children may be expressed through the following additional symptoms, which may be determined through further screening, assessment, and observation. As healthcare providers, asking specific questions about the following symptoms can support decision making around further screening, assessment, and observation.

Behaviors

Reports of significant changes in a child's activity level and increased disruptive behaviors, or reduced activity observed as shutting down, zoning out, over-compliance, or flat affect; reported developmental regressions or delays in meeting social-emotional milestones such as language and communication, regulation, attention and play; oppositional and defiant behaviors; reports that the child is easily startled; self-destructive and/or self-injurious behaviors; avoidance of certain activities, people, places, and things; use of substances, disordered eating, and other unhealthy ways to cope.

Mood

Reports of increased irritability; rapid mood swings; passivity; 'spacing out;' flat affect; depression or withdrawal; temper tantrums; emotional overhwelm of sadness, anxiety, worry, anger, fear, hopelessness, physical aggression; shutting down; thoughts of suicide or wanting to die.



Social

Reports that the young person is clingy or withdrawn and isolated; difficulties with social and/or physical boundaries; trouble forming and sustaining relationships; anticipating and perceiving rejection and abandonment.

Cognitive
Reported difficulties with memory, processing new information, making inferences, concentration, receptive and expressive language and communication, attention and focus, remembering tasks and expectations, distractibility, learning new things, inconsistencies or varying skills levels ; 'spacing out'; expressing a foreshortened sense of their future; having negative thoughts and expectations about themselves, others and the future; and low self-esteem and self-confidence.

Social Body/Physical
Reports of unexplained headaches, stomachaches, vague aches and pains; sensitivity/insensitivity to pain; feeling detached from their body; difficulty recognizing what their body needs (e.g., hunger, temperature); disruptions in sleep cycles, eating patterns, and elimination patterns (medically unexplained struggles with bladder and bowel control, and/or diarrhea/constipation); and events of seizure like motions, which are non-epileptic in nature.

What is Dissociation?

Dissociation can be considered a biological and psychological response that may occur during or after traumatic events as a means of coping with it. Dissociation is when the brain disconnects awareness from experience, feeling, sensation, and/or the self. Children, even more than adults, may dissociate when they are overwhelmed by fear or pain and cannot escape. When there is no escape from the widespread and repetitive nature of complex trauma, children may use dissociation to disconnect from and block out what is happening to them, what they are feeling, what they are thinking, who is causing the harm or pain, and what they are sensing in order to cope and survive. The ability to dissociate is rooted in protection and the innate ability to survive the unimaginable.

A child may dissociate during and after any of the traumatic events listed above, or when reminded about any of the events listed above, even long after the event(s) are over. Reminders are called "triggers," and triggers are not always obvious and/or overt. It is important to remember that if the child receives support and feels safe soon after a frightening event, any dissociation may be temporary and therefore not problematic. Besides dissociating during and after a traumatic event, for some people dissociation can become a longer term coping strategy to get through stressful (even if potentially not traumatic) situations in everyday life. The symptoms below are examples of how dissociation may show up in healthcare settings.

What Symptoms May I See in a Healthcare Setting?

Dissociation can show up in unique ways for kids and youth, leaving adults confused at what may be happening. These symptoms are unique to each child, and may occur rarely (e.g., A few times a year) or perhaps more frequently (e.g., A few times a day or week). Symptom presentations may vary depending on the healthcare setting, type of care being provided, and expectations of the youth's engagement in that service. Some of the common symptoms of dissociation that may warrant further investigation include reports of:

- Physical or bodily changes or concerns that a doctor may not be able to find a medical problem or cause for (and which may be a result of the tension or anxiety from trauma that is being 'held' unconsciously in the body).
- Wetting or soiling themselves without feeling it, smelling it, or even knowing it is happening.
- Getting hurt (e.g., getting a cut, breaking a bone, or harming themselves) and not feeling the pain or being aware that they have been hurt.
- Feeling their body parts change and get smaller or bigger, or feeling like parts of their body have disappeared or are not real or over which they have no control.
- Feeling like they are seeing everything around them through a fog or like a dream as if the world around them isn't real or feels very far away.

,

- Complaints of stomach aches, headaches, seizure-like motions, or other physical problems (for example, difficulty breathing, trouble walking, genital pain, loss of Sudden and abrupt changes in mood, behavior, feelings, or attitudes that a child may not be able to explain or remember.
- Having certain skills or being able to do certain activities easily and well (handwriting, sports, math, reading, assignments), but then, perhaps even the next day, having trouble with them or no longer knowing how to do or complete them.
- 'Spacing out' or 'zoning out,' and not knowing what is going on around them. Time may pass and they don't know what happened during that time. They may have difficulty remembering information.
- Behaving aggressively, or being mean at one point, and then becoming passive, loving or caretaking at another time.
- Sudden emotional shifts from one extreme feeling to a completely different or opposite feeling without showing any of the in-between emotions. The reason for this change in emotion may not be clear or make sense to you and/or others.
- Seeming calm one moment, and then in the next moment becoming explosive, aggressive, frightened, tearful or panicky.
- Expression of emotions that do not fit what is happening, such as laughing during a sad and upsetting situation or becoming sad or angry in a joyful situation.
- Not showing emotions, denying having feelings, or appearing to not be aware of any feelings at all.
- Behaving very grown up one moment and then behaving like a much younger child (even a baby) at another moment.
- Using different names to refer to themselves, or referring to themselves as "we."
- Using different voices or mannerisms at different times.
- Dramatic and sudden changes in facial expression, such as going from smiling to angry without any apparent reason

- Eyes that appear to be in a dead stare when you are talking to them, like they are miles away, or with a glazed look, particularly when aggressive, enraged or scared.
- Sudden and dramatic changes in preferences and interests.
- Finding themselves in a place and not knowing or remembering how they got there. For example, they may be sent to the principal's office for misbehaving and not remember leaving the classroom, walking to the office, or even why they are even there.
- Thinking and feeling that a completely safe situation is extremely unsafe and presenting as very fearful, or alternatively, interpreting unsafe situations as safe.
- Having no recollection of important events, such as birthdays, holidays, family vacations or camping trips.
- Having no memory of having done something even when there is proof of it (e.g., when someone saw them do it).
- 'Hearing' voices inside their head (note that children seldom talk about this unless directly asked).
- Reporting that there are people inside them that say mean things and boss them around, or that provide comfort. These are different from the pretend or imaginary friends that young children commonly have and outgrow.
- Thinking badly about themselves, perhaps even wanting to die, and seeing the world as a frightening and threatening place. Then suddenly appearing to feel good about themselves and the world, and to be hopeful about the future.
- Flashbacks, or reliving a traumatic event, where they are unaware of their present surroundings.

Reaching Out for Help or Further Investigation

When a child or adolescent is showing symptoms of trauma or dissociation, start by consulting with other relevant healthcare providers, including mental health professionals, who are skilled in the assessment and treatment of trauma and dissociation. This may include counselors or therapists, doctors (e.g., pediatrician, psychiatrist, specialist), child-development professionals (e.g., speech-language pathologists, occupational therapists), and school staff (e.g., school counselor, other educators) working with the child. It is important to look into the regulations and healthcare professions in your region in order to determine and identify who would be the appropriate mental health providers to seek out. This is because countries and regions regulate mental health services differently based on licensing authorities, access to resources, the subsequent practice and referral systems.

That said, as a healthcare provider you are encouraged to describe what you are seeing and why you are concerned, and to make a referral for an assessment from a trauma-specific lens. This assessment would evaluate the child's symptoms, strengths and challenges, as well as identify the supports that would be most beneficial for the particular child. See ISSTD Adult Fact Sheet V: Getting Treatment for Complex Trauma and Dissociation for information about finding the right mental health professional. Symptoms of trauma and dissociation respond well to specialized treatment, particularly with early diagnosis and treatment.

Creating Hope- Treatment for Complex Trauma and Dissociation in Kids and Youth

Complex trauma and dissociation may present very differently in different aspects of a child's life. For example, a child may have separation anxiety issues, low self-worth, sleep problems (e.g., you may hear that a child is struggling with falling asleep or staying asleep), self-harm and thoughts of dying, dissociative behaviors (as mentioned above), or unexplained medical complaints, among other challenges. All of these can make it confusing to search for and provide appropriate help. It is important to realize that due to growing insights into complex trauma and dissociation, the role of resilience, and effective treatment possibilities, treatment for trauma and dissociation is possible and available. Depending on the child's specific strengths and challenges, treatment may sometimes be lengthy; however, the therapeutic process can help bring about profound change. Healthcare providers have an important role in identifying the signs and symptoms of complex trauma and dissociation as a means of supporting the child's healing.

Steps You Can Take in the Assessment and Treatment Process

When trauma and dissociation is suspected, appropriate referrals can be made to trauma-specific services, supports, and therapies that are tailored to the child's unique strengths, challenges, and history, and which will in turn support positive outcomes in healing:

- Learn about how trauma symptoms in children may show up in your specific workspace, including the effects of trauma on physical health and clinical presentation. Learn how to ask about traumatic experiences and symptoms, so you can more effectively assess and understand the child's experience.
- Learn about dissociation and how to recognize its manifestations in children.
- Take medical symptoms seriously and rule out organic causes before assuming that somatic symptoms are psychological.
- Take a holistic approach to understanding the child's symptoms and healthcare needs. This would include assessing the impact of social determinants of health and potential traumatic experiences on the child's presenting symptoms.
- Depathologize and destigmatize symptoms of trauma and dissociation by providing the child and caregivers with information about how children may respond after traumatic experiences.
- Take into account that disability and developmental delays increase risk for victimization and trauma.
- Identify individuals, agencies, organizations or departments that can provide additional specialized services through a trauma-specific lens. These individuals and agencies can be your go-to referral sources for assessment and treatment across different healthcare disciplines, including mental health.
- Collaborate with the child's caregivers and any other mental health and medical professionals involved in the child's care. A collaborative approach ensures consistency and appropriate wrap-around support across all areas of the child's life.

Trauma Informed Trainings

For information on additional trauma-informed training, please email info@isst-d.org

References and Helpful Resources

Forkey, H., Griffin, J., & Szilagyi, M. (2021). Childhood Trauma and Resilience: A Practical Guide. Itasca, IL: American Academy of Pediatrics.

Gerber, M. R. (Ed.). (2019). Trauma-informed healthcare approaches: a guide for primary care. Springer.

Silberg, J. (2022) 2nd Edition. The child survivor. New York: Routledge

Waters, F. S. (2016). Healing the Fractured Child: Diagnosis and Treatment of Youth with Dissociation. New York: Springer Publishing Company.

Yehuda, N. (2016) Communicating Trauma: Clinical presentations and interventions with traumatized children, Routledge, New York.

https://www.aap.org/en/patient-care/trauma-informed-care/

