HELLO!

- Children’s Psychological Medicine based at OUHFT
- 14 psychologists, 1 psychiatrist covering all medical specialties
- Inpatient and outpatient service
- Specialist team supporting children with Health Needs
  - e.g. chronic health conditions, acute health events, common childhood difficulties requiring specialist intervention as primary and secondary care has not been effective
- My role – general paediatrics and oncology
WHAT DO WE MEAN BY PT?
DIFFERENTIATING

- Normative adjustment / adaptation
- Post traumatic stress symptoms
- Post traumatic stress disorder
- “Traumatic events / experiences”
- Single vs cumulative events

Do all traumas lead to psychological trauma?
Psychological adaptation not predicted by severity of illness/impairment (O’Malley et al, 1980). What does?

Children and young people are incredibly resilient! TYAs with cancer – comparable levels of anxiety and distress to peers (Kazak et al, 1994).

Reciprocal links between physical and mental health are complex and multiple

But impact of mental health on physical health can be significant - Poor adjustment can be linked to 10-15% of teenagers not completing treatment (Yeh et al, 1999).

Can be delayed - 21% of adult survivors meet criteria for PTSD. Rates in parents much higher – why? Do we ask?
EXAMPLES

- Being told your child has a life limiting condition
- Seeing your child in PICU – almost died
- Falling off a horse – worried you will die!
- Undergoing cardiac surgery
- Experiencing sexual abuse
KEY ASPECTS OF PTSD

- Exposure to actual or threat of death, serious injury or sexual violence (including witnessing or exposure to details)
- Intrusive symptoms: Re-experiencing, dreams
- Arousal: irritability, angry outbursts, hypervigilance, startle response
- Avoidance: of internal (cognitive) or external reminders
- Alteration in mood or cognition: amnesia, persistent shame/guilt/sadness, detachment
- Duration longer than 1 month
- Clinically significant impairment
WHY IS TRAUMA IMPORTANT IN PAEDIATRICS?

- Trauma linked to other psychiatric co-morbidity in up to 80% of cases

In addition to general impact on QoL:

- Avoidance, hyperarousal, reliving
- Depression
- Anxiety
- Avoidance of health-seeking behaviours – appointments, procedures
- Reduced control over condition/recovery = long term impact
CHILDREN – OUR PATIENTS

- Around 2/3 of children will have experienced a “traumatic event” by age 16
- **Immediate impact:** Number of adolescents requiring surgical intervention following injury reporting PTSS – 47% (Zatzick et al)
- **Short term impact:** Number of children at risk of PTSD in short term following PICU admission in UK – 34% (Als et al)
- Early indicators of PTSD can present within days/weeks of admission following injury (Winston et al, 2002) with greater symptom-related distress an indicator (Ehlers et al, 2003)
- Length of PICU stay associated with number of PTSS (Als et al)
- Threat to life key in trauma presentations – procedure alone not sufficient (Walker et al, 1999)
40% of parents of children with injury had experienced 4 or more traumas pre child’s injury (Zatzick et al)

83% of children with cancer with PTSD had mothers with PTSD (Pelcovitz et al 1998)

Rates of PTS symptoms in parents can be as high as 95%

Re-traumatising through associated stimuli - Dex

Perception is important – subjective experience of threat to life

Parental distress important in child’s presentation
OUR ROLE IN PREVENTING PT
THINGS THAT HELP

- How bad news is disclosed can affect patient satisfaction with the care they receive and subsequent psychological adjustment to bad news.
  
  Roberts, et al., 1994; Ford, Fallowfield & Lewis, 1996

- How do we break news? Can we do it “better”? What factors get in the way of breaking bad news well?

- Consideration of environment – triggers and stimuli

- Management of procedures

- Supportive, empathic manner (NICE guidance)
WHAT TO LOOK OUT FOR?
TRAUMA VS EVERYTHING ELSE!

Attachment  Behaviour  Anxiety  Normative development
IN YOUNGER CHILDREN

- Often sleep related – nightmares
- Wetting / soiling
- Behaviour – aggression
- Clingy / attachment seeking behaviours
- Generalises to other things / people
MIDDLE CHILDHOOD

- Regression to younger stages
- Somatisation
- Magical thinking
- Blaming self
- Multiple and repetitive questions
TEENAGERS / PARENTS

- More akin to adult trauma
- Detached / flat when talking about it
- Reports of sleep issues
- Intrusive memories – hard to shake
- Physiological signs when describing an event – tearful, redness, sweating
- Not making eye contact/going into their own world when describing an event
- Not wanting to talk about events in front of the child
- Heightened general baseline anxiety levels that don’t reduce over time
- Heightened startle response during consultations

Symptoms should dissipate within a few weeks of the event – if not, consider ?PTS
PTS AND PAEDIATRICS

• James is a 17 year old boy on long term follow up from his treatment of ALL, successfully completing treatment last year. James doesn’t want to come in for his follow up appointments, “kicking off” at his mother before every appointment.

• Jenny is a 9 year old girl who underwent surgery for a cardiac condition aged 5. She presents having nightmare and struggling with sleep.

• Lara is a 14 year old girl who repeatedly presents to her GP with abdominal pain and is referred to gastroenterology and diagnosed with IBS.

Where is the possibility of trauma?
WHAT SHOULD I DO?
IDENTIFICATION

- Observations:
  - Signs of physiological arousal e.g. flushed cheeks, sweating, avoidance
  - Cancel or DNA appointments
- Questions:
  - Question child directly – do not rely solely on parental report
- Thorough history?
  - Consider whether parent needs support too
- Was this the first really scary thing to have happened to you, or have there been others?
- How does your body feel when you think about that blood test/coming into hospital?
- Does your mind play back what happened, a bit like in a film?
TREATMENT

• Many sub clinical forms of PTS can be treated through psychological techniques such as graded exposure

• Watchful waiting for mild symptoms within 4 weeks of trauma – follow up at 1 month

• Intervention should only be offered within first month if symptoms are severe

• Less evidence for treatments in children – trauma focused CBT strongest

• Narrative exposure therapy
NICE recommends referral to a specialist where PTSD is suspected

NICE recommends referral if significant deterioration in wellbeing or functioning following a trauma

Diagnosis and treatment should be made by a specialist

Trauma-focused CBT for older children; play and systemic therapy if appropriate (less evidence base)

CAMHS or other specialist service for general trauma

CPM for medically related trauma
LET’S TALK ABOUT US...
PT IN STAFF

- 42% of physicians evaluated experienced stress lasting from several hours to more than three days following 'bad news' consultations. Ptacek & Ellison, 2001
- Many of the things you witness meet criteria!
- Doctors, nurses, play specialists, ward clerks...
- High rates of exhaustion, compassion fatigue and risk of burnout in children’s hospital staff – linked to repeated exposure to trauma

In what ways are our coping strategies as staff similar to the trauma response?
THE FLIP SIDE OF TRAUMA
GROWTH AND THRIVING

- Increased psychological maturity than peers
- Greater emotional openness
- Greater compassion and empathy for others
- Better relationships
- Greater self-resilience and new strengths
- Changes in coping skills
- Greater sense of the preciousness of life
- Increased recognition of vulnerability and struggle (and a deeper appreciation for life)
- Changes in life outlook
- New values and priorities
- Sense of meaning
- Wisdom
- Spiritual development
CONCLUSIONS

- Psychological trauma takes many forms in Paediatrics
- Untreated traumatic stress can have long term health and psychological impact
- Traumatic symptoms common in immediate and short term
- Symptoms may be easily confused with common childhood presentations
- Symptoms of trauma in staff common and may mirror helpful strategies for managing trauma
- Specialist assessment and treatment may be necessary
THANK YOU