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**Research Article**

# STATUS OF POST TRAUMATIC STRESS IN CHILDREN IN ARMED CONFLICT

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**A R T I C L E I N F O**

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**A B S T R A C T**

Armed conflicts represent a major situation on the state of post-traumatic stress, especially among this young population.
Children form a vulnerable population to the development of post-traumatic stress disorder. Its incidence among children survivors of disasters varies from 30 to 60%.
After a given event, the children exposed could have this type of disorder in the following months. They can have an evolution over the years, which can be prolonged until adulthood, become complicated, weigh heavily on the development and be responsible for a significant handicap.
The aim of the work is to illustrate the clinical features of this disorder through two cases of children seen in the context of the humanitarian medical mission on the Tunisian-Libyan border and in the camp of Syrian refugees in Jordan.



## INTRODUCTION

Armed conflicts represent a major situation of the occurrence of post-traumatic stress disorder, especially in children. During the last decades, there have been many armed conflicts, where the child has not been spared.

The existence of post-traumatic stress disorder (PTSD) in children has been officially recognized in the DSM-III-R, DSMIV and DSM-IV-R. However, the research has shown that DSM-IV-R's PTSD diagnostic criteria do not account for symptoms as they occur in infants and preschoolers and that these criteria underestimate the number of children suffering from distress and limitations due to trauma. Since then, an increasing number of studies have generated results justifying the inclusion of a PTSD subtype in the DSM-V for preschool children (10).

Post-traumatic stress disorder is the main psychopathological consequence of exposure to a major event that endangers and threatens the life or integrity of the subject or of others [1]. Its incidence among children survivors of disasters varies from 30 to 60% [2].

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After a given event, exposed children could have this type of disorder in the following months. They can have an evolution over years, which can be prolonged until adulthood, become complicated, weigh heavily on the development and be responsible for a significant handicap.
The post-traumatic stress disorder of international classifications is not the only type of observable disorder [3] in children or adolescents as a result of trauma, but it is the most characteristic form and more frequent of the psycho-traumatic attack.

**Diagnostic criteria**

**Posttraumatic stress disorder**

**NB**: The following criteria apply to adults, adolescents and children over 6 years of age. For children of 6 years old or younger, cf. the corresponding criteria below.
A. Exposure to actual death or threat of death, serious injury or sexual violence in one or more of the following ways:
1. Being directly exposed to one or more traumatic events.
2. Being a direct witness of one or more traumatic events that occurred to other people.
3. Hearing that one or more traumatic events have happened to a close family member or close friend. In cases of actual death or death threat of a family member or friend. The event(s) must have been violent or accidental.
4. Being repeatedly or extremely exposed to the aversive characteristics of the traumatic event(s) (e.g front-line workers collecting human remains, police repeatedly exposed to explicit child sexual abuse).
**NB**: Criterion A4 does not apply to exhibitions via electronic media, television, films or images,
except when they occur in the context of a professional activity.
B. Presence of one or more of the following invasive symptoms associated with one or more traumatic events that started after the occurrence of the traumatic event (s) at issue:

1. Repetitive, involuntary and invasive memories of traumatic event (s) causing distress.
**NB**: In children over 6 years of age, there is a repetitive play that expresses themes or aspects of the trauma.
2. Repetitive dreams causing feelings of distress in which the content and /or affect of the dream are related to the traumatic event(s).
**NB**: In children, there can be scary dreams without recognizable content.
3. Dissociative reactions (eg, flashbacks (retrospective scenes)) in which the subject feels or acts as if the traumatic event(s) were to recur. (Such reactions may occur on a continuum, the most extreme expression being a complete abolition of environmental consciousness.
**NB**: In children, specific reconstructions of trauma have been observed during play.
4- Intense or prolonged feelings of psychological distress when exposed to internal or external cues that evoke or resemble to an aspect of the traumatic event(s) in question.
must be present and begin after the event(s) or worsen after the traumatic event(s);
**Persistent avoidance of stimuli**
1. Avoidance or efforts to avoid activities, places or physical cues that awaken memories of traumatic events.
2. Avoidance or efforts to avoid people, conversations or interpersonal situations that awaken memories of the events or traumas.
**Negative alterations of cognitions**
3. Net increase in the frequency of negative emotional states (eg, fear, guilt, sadness, shame, confusion).
4. Net reduction of interest in important activities or reduction of participation in these activities, including play.
5- Behavior reflecting a social withdrawal.
6. Persistent reduction of the expression of positive emotions,
D. Significant changes in awareness and responsiveness associated with the traumatic event(s), beginning or worsening after the occurrence of the traumatic event(s), as evidenced by two or more of the following:
1. Irritable behavior or angry outbursts (with little or no provocation) typically expressed through verbal or physical aggression towards people or objects (including extreme outbursts of anger).
2. Hypervigilance.
3. Exaggerated startle reaction.
4. Difficulties of concentration.
5. Disruption of sleep (eg, difficulty falling asleep or interrupted or agitated sleep).
E. The disturbance lasts more than a month,
F. The disruption causes clinically significant suffering or an alteration of relationships with parents, siblings, peers, other caregivers or an alteration of school behavior.
G. The disturbance is not attributable to the physiological effects of a substance (eg drug, alcohol) or another medical disease

The aim of this work is to illustrate the clinical peculiarities of this disorder through two cases of children seen in the context of a humanitarian medical mission on the Tunisian-Libyan border.

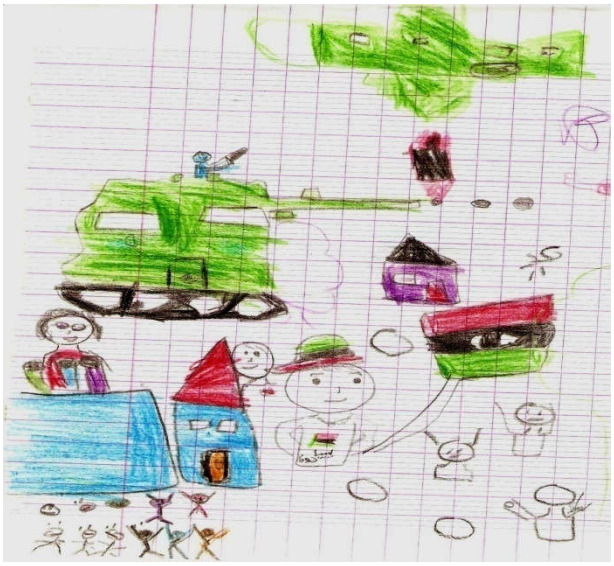
### *Clinical Case N ° 1*

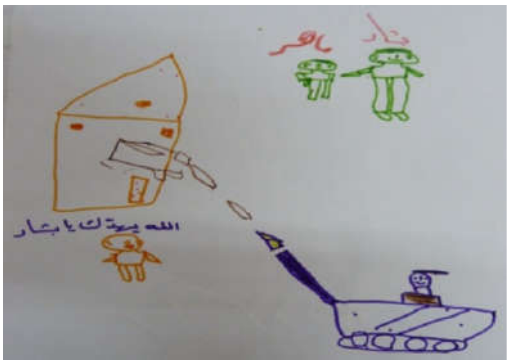
A. 12 years old boy, native and inhabitant Mesrata. He was brought by his parents in pediatric consultation for the management of somatic manifestations such as headache and asthenia. the pediatrician having noted his apathy and sent him to a child psychiatric consultation. The interview noted the presence of a gradual change in behavior in recent days, social withdrawal and a tendency to isolation, irritability, a lack of interest in usual activities with startle reactions, hypervigilance, as separation anxiety and sleep disrupted by night-time awakenings and nightmares. These demonstrations appeared a few days after a shootout in which he survived, and witnessed the death of a man.

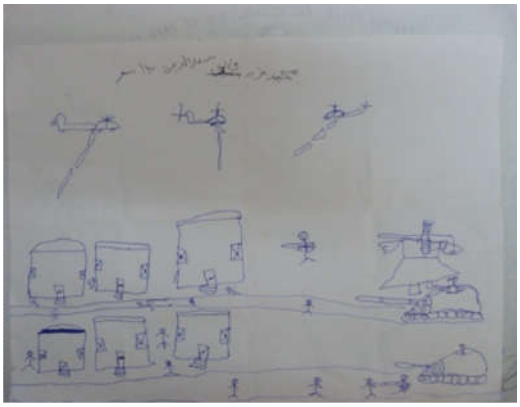
### *Clinical Case N ° 2*

K. is a 6 year old child from Deraa, attended the abduction and disappearance of his father by an armed group. He was brought to a psychiatric consultation by his mother after a month of this event, for sphincter disorders (secondary enuresis), sleep disorders made of night terrors, refusal to sleep alone, a tendency to regress with recovery of security objects and frequent tantrums.

These two children often drew scenes of war and violence







## DISCUSSION

Symptoms of post-traumatic stress were recognized in the mid-1800s. Doctors who treated men who had been in combat in the American Civil War identified "Dacosta syndrome" [4].
In 1952, symptomatology was recognized as a psychiatric syndrome, and was called a “gross stress reaction” in DSM-III. The current post-traumatic stress nomenclature was created by The American Psychiatric Association of its Diagnostic and Statistical Manual (DSM-III-R).

Some changes were added to the adult-based DSM criteria to attempt to resolve the presentation in children (for example, disorganized or agitated behaviour in criterion A; DSM-IV, 1994). However, the current DSM criterion fails to capture all the symptoms that occur in young people exposed to traumatic events, particularly those chronically exposed to traumatic events.

The DSM-5 made some changes, which tried to compensate for the difference in the presentation of symptoms in children and adolescents. These current criteria focus on reviviscence, avoidance, negative cognitions and hyperexcitation and the inclusion of a sub-type of PTSD for preschool children 10 (See box)

The state of stress traumatic comment in a general way Is established by the notion of exhibition previous to a potentially traumatic event (traumatic factor) with reaction of immediate distress, a syndrome of recollection or revival, a phobic syndrome (distress in the exhibition, the avoidances and the anxious anticipation), of a blunting of the general reactivity and the state of alert with neurovegetative hyperactivation [6]
The trauma is constantly looked back or "relived" In a stressful and intrusive way, as shown by the presence of intense memories, repetitive dreams, impressions or actions, "as if" The event was going to reproduce (illusions, even hallucinations, episodes dissociatifs or flashback).

The clinical demonstrations of PTSD at the child dress a particular aspect. The immediate reaction of the child during the traumatic event is translated by an intense fear, a feeling of powerlessness or horror, a disrupted or agitated behavior [7]. The phenomena of revival and avoidance can be present, but the behavior and the productions repetitive as the games and the drawings are more frequent than the memories and flashbacks, are frequently added to it painful somatization, phenomena of look dissociatives, difficulties increased in the separation and the regressive behavior. We can also note a linguistic and\or psychomotor delay, behavior of retreat or dumbness, as well as aggressive behavior [6].

A hypervigilance, the appearance of specific phobia, sleep disorders, concentration disorders are also possible at this age [7] as is the case of our first patient.

The neurovegetative hyperactivation covers a set of symptoms appeared after the trauma: difficulties of falling asleep and multiple awakenings, state of alert, hypervigilance and exaggerated reactions of burst, irritability and tantrum, disturbances of the attention and the concentration affecting schooling. Somatic complaints (headache and abdominal pain), very common in children, can be compared.

In children, regressive phenomena (enuresis, or thumb sucking) and manifestations of separation anxiety are common after psycho-traumatism. A school impact with a decline in performance may be in the foreground; this is the case of our 2nd patient. For these two children, the reason for consultation was for one of somatic nature, and for the other an enuresis, the active search for symptoms and traumatic event allowed the diagnosis and the establishment of a taking into account adapted load.

Economic pressure is more predictive of post-traumatic stress and psychological distress in youth [8]. Differences in religiosity and ideology would not take into account the stress response.

Regarding management, in a cross-sectional study, the researchers explored the hypothesis that multiple forms of child abuse and neglect would be associated with lower social support for women and increased stress in adulthood. Which, in turn, amplify their vulnerability to symptoms of depression and post-traumatic stress disorder [9], hence the need for long-term follow-up.

## CONCLUSION

Post-traumatic stress disorder in children in armed conflict is a common clinical situation. It requires active screening, and sensitization of the various actors in the field to allow early management on which the prognosis and development of the child depend.

The complexity of cases is, in most cases, a matter of specialized care; its quality as well as that of the reception of young victims and their families being a major prognostic factor in contrast with the risk of iatrogenic over-evaluation.

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