In this article, the author provides a theoretical framework and clinical guidelines for work with children and adolescents in the general population and in clinical populations in light of the terrorist attacks and bio-terrorist anthrax attacks in the United States. Recommendations for mental health providers, parents, and other caregivers are provided. Reactions are discussed from a developmental perspective and are organized by developmental stages of infants and toddlers, preschoolers, elementary school, middle school, and adolescence. Clinical perspectives are organized according to DSM-IV-TR classifications of anxiety disorders, mood disorders, and dissociative disorders. There is focus on symptom recognition and intervention strategies. [Brief Treatment and Crisis Intervention 2:135–151 (2002)]

KEY WORDS: adolescents, children, developmental perspective, depression, mental health professionals, PTSD, terrorism, trauma.

This article was prepared in response to the terrorist attack in the United States on September 11, 2001, and the subsequent bio-terrorist anthrax attack. This article is for mental health professionals who work with children and adolescents during time of acute traumatic crises. Intervention strategies for mental health professionals as well as strategies they can recommend to parents are covered. This article is also intended to be helpful to parents and caregivers.

Exposure to war and civil strife violence does not always lead to psychopathology in children and adolescents (Putnam, 1997), but children and adolescents in the general population can develop symptoms in reaction to these events, and children in clinical populations can reexperience or develop new symptoms in times of national crisis (Zubenko & Capozzoli, 2002). Terr (1990) has pointed out that the calm that children and adolescents have during a crisis can mask the reactions that linger after the traumatic event is resolved. The factors that influence intensity of symptoms and immediate or delayed onset of symptoms in children have not been carefully studied, but there are indications that the timing of symptom onset is associated with age, type of trauma exposure, intensity of...
trauma, duration of exposure, parental emotional well-being, parental reaction to the trauma, and quality and extent of peer relationships (Almqvist & Broberg, 1999; Laor et al., 1997).

Traumatic incidents of national scope have existed since the founding of the United States (Leys, 2000; van der Kolk, Weisaeth, & van der Hart, 1996). Traumatic reactions of children and adolescents to war have been studied since World War II (Gordon, Farberow, & Maida, 1999), and the key symptoms of nightmares, war-related fears, psychophysiological reactions, reactions to war-related stimuli, avoidance, and aggression have been refined and expanded (Saigh, Fairbank, & Yasik, 1998). During the last decade the intensity of traumatic events has escalated in the United States (Briere & Elliott, 2000; Varon, 1995), and traumatic events have been intensified by the increased media coverage over the last 50 years (Villani, 2001). Television has become a primary source of information, interpretation, and evaluation of events. Television itself has become a tertiary source of traumatization as people watch horrific events being broadcast repeatedly. While television is a source of information for people, it offers little assistance to parents who do not know how to address the concern and fears of their children. During the Gulf War one major network provided a Saturday morning show for children that was not very successful in addressing children’s concerns and reportedly may have led to more anxiety for viewers. During the current terrorist crisis, major network broadcasting aimed at addressing the concerns of children was limited. Numerous Internet sites are available, but parents have difficulty assessing the validity and reliability of information on these sites just as they have difficulty knowing if an expert appearing on television actually has experience working with traumatized children and adolescents. Internet sites are of limited value because some families do not have access to this technology. Internet sites can be helpful for mental health professionals seeking information to share with clients, but the information should be screened for relevancy and accuracy before being distributed to clients.

Theoretical Framework

The recommendations and strategies in this article are based on developmental theory (Bowlby, 1980; Bukatko & Daehler, 1998; Cassidy & Shaver, 1999; Sameroff, Lewis, & Miller, 2000), developmental traumatic stress theory (Herman, 1992; Pynoos, 1993; van der Kolk, 1987; van der Kolk et al., 1996) and general stress theory (Selye, 1974). The developmental approach in trauma work should be used by mental health professionals within a cultural context (Gordon et al., 1999). Developmental theory related to trauma exposure is in its early stages (Pfefferbaum, 1997), but it is well known that trauma can cause interruption of the developmental process and produce enduring lifelong impairment if not effectively treated (Brand, King, Olson, Ghaziiuddin, & Naylor, 1996; Ehrensaft, 1992; Giacominia et al., 1995; Herman, 1992; Hubbard, Realmuto, Northwood, & Masten, 1995; Kiser, Heston, Millsap, & Pruitt, 1991; Lauterbach & Southwick, 2000; Lipschitz, Rasmusson, Anyan, Cromwell, & Southwick, 2000; Lipschitz, Winegar, Hartnick, Foote, & Southwick, 1999; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Schiraldi, 2000; Solomon & Davidson, 1997; Terr, 1991). The developmental process can impact the clinical presentation of trauma (Cohen, 1998), but more often the developmental process is altered by the effect of the trauma (Lipschitz et al., 2000; Scheeringa, Zeanah, Drell, & Larrieu, 1995). Selye’s (1974) general stress theory holds that people under stress go through three stages. The first stage is alarm in which there is an acute physical and psychological reaction to stress. The second stage is resistance in which the individual attempts to cope with, adapt to, and
overcome the stress. The third and final stage is exhaustion that occurs as the stress persists and increases. General stressors are not usually traumatic. They constitute small, regularly occurring events that do not normally overwhelm and burden the person. General stress is made up of discreet stressful events that can usually be managed. When these discreet events increase rapidly, alarm, resistance, and exhaustion stages can overlap and occur within a short time period. When traumatic stress events are added to general stress, the symptom constellation becomes more acute and intense. The September 11, 2001, terrorist attacks should be placed in this context by mental health professionals. In our high-stress society many people live daily with general acute stress that was intensified by the September 11 traumatic events and the subsequent bio-terrorist anthrax attack. Closings of schools and daycare centers produced increased stress for working parents. Work stoppages and layoffs created new financial stresses for many families. Children being moved to different daycare centers and adjusting to parents’ new work patterns are just two examples of the additional cumulative stresses some children faced.

Pattern of Symptoms and Types of Trauma

Symptom level after trauma is usually related to three criteria: proximity, intensity, and duration. Proximity refers to how close the person is to the actual trauma event. Intensity refers to how extreme the traumatic incident is, and duration refers to how long the traumatic event lasts and is usually referred to as acute or chronic trauma (American Psychiatric Association, 2000).

Types of trauma are also corralled with level of reaction. The types of trauma are primary, secondary, and tertiary. Primary traumatization occurs to actual victims and witnesses to a horrific event, and secondary trauma occurs to people who care for those victims or friends and relatives of the victims. Tertiary trauma occurs to anyone who has indirect connection with the current event and may or may not have experienced a prior traumatic event. People who were in or near the World Trade Center when the attacks occurred are primary victims, and secondary traumatization occurred to family members, friends, school personnel, medical providers, emergency personnel, and mental health providers (Gordon et al., 1999). Tertiary victimization occurred to people who watched the attack on television and had no direct connection to victims. While these models are used to measure the expected level of symptoms, the reactions of individuals can be highly variable especially in the case of children and adolescents.

General Rules

Parents and caregivers can be most helpful to their children in times of national crisis by taking care of their own physical and psychological health (Saylor, Belter, & Stokes, 1997). Children are sensitive to mental and physical states of caregivers (Sack, Clarke, & Seeley, 1995). Caregivers should get adequate sleep, have a good diet, seek social support, and seek professional information about how to relate to children in times of crisis.

The caregivers should monitor their children and adolescents for any psychological or behavioral change. Key changes are sleeping less, sleeping more, change in eating patterns, resistance to or refusing to attend school, social withdrawal, loss of interest in normally enjoyed activities, excessive anxiety, and increased worry. Any changes lasting more than several days should result in seeking professional help. School counselors, clergy, physicians, and mental health professionals are key resources. Caregivers should seek additional help if the professional con-
tacted minimizes or justifies the symptoms and behaviors rather than acknowledging and addressing the child’s change in functioning.

**Clinical Guidelines**

The general rule to follow is that during the crisis, mental health professionals and caregivers should be prepared for increased reports of symptoms in children and adolescents. The professional should not rely exclusively on reports of teachers and parents regarding the child’s reaction because parents and teachers tend to underestimate child and adolescent distress (Pfefferbaum et al., 1999). Frequently the symptoms will not appear to have any direct relationship to the traumatic event. Loss of appetite and sleep disturbance are recognized by mental health professionals as associated with such events, but they are less likely to see anger outbursts at parents, caregivers, and peers as being associated with such events as a terrorist attack. Any atypical symptoms that develop in a child or adolescent during a national traumatic event should be evaluated in the context of the event. Parents who report new symptoms at such times frequently have not talked openly with the child about the trauma event. The recommended strategy for a mental health professional facing new and increased symptoms with onset during a national trauma should begin with the child and family by addressing how the parents have dealt with the child’s concerns associated with the trauma. If symptom onset is associated with the trauma, it should subside within a reasonable period after the traumatic event is over and intervention has been provided. Symptoms that persist should be viewed in the context of other sources or the emergence of a chronic condition associated with the traumatic event. Duration of symptoms can be highly variable depending on a number of factors, such as age, gender, caregiver support, caregiver availability, peer relationships, and sense of ongoing vulnerability. Vulnerability is mediated by development of a sense of safety. Symptoms usually persist as long as the child feels unsafe. The events of 9/11 and the subsequent events have the potential to produce an ongoing sense of being unsafe. This situation makes it difficult to make predictions of how long it would take for symptoms related to 9/11 events to remit. In the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; *DSM-IV-TR*) diagnostic system, acute stress disorder is present if symptoms persist for 2 days to 4 weeks and occur within 4 weeks of the traumatic event. Symptoms present for 1 month but less than 3 months are considered acute post-traumatic stress disorder (PTSD), and symptoms present for more than 3 months puts the disorder in the chronic category. In generalized anxiety disorder, symptoms must be present most days for at least 6 months, and in adjustment disorder, the symptoms must occur within 3 months of the stressor and can endure indefinitely.

With a finite stressor, symptoms usually remit within several weeks, but in the case of a recurring stressor or recurring reminders of the stressor, symptoms can persist for an unspecified period of time. The rule that is recommended is that any symptoms in a child or adolescent that persists more than 4 weeks should be evaluated by a mental health professional. Any serious, extreme symptoms such as suicidal thoughts or statements, refusal to eat, or substantial inability to sleep should be treated immediately.

Any trauma and stress-related intervention with children should be from a developmental perspective. Children at different ages have different cognitive and emotional responses and different capabilities for comprehending, interpreting, and integrating the event (Clark & Miller, 1998). The developmental perspective is used below to explore the broad categories of infants and toddlers, preschoolers, elementary school age children, middle school children, and ado-
adolescents’ reactions to a national trauma. This is a very broad categorization, but is made necessary by the brevity required in a journal article. It should be kept in mind that there can be broad overlap of the reactions developmentally, and the developmental categories used here are convenience groupings for the purpose of conveying information.

**Infants and Toddlers**

Research on infants and toddlers has shown that the perception of young children as blank screens with no awareness of events occurring around them has been proven false (Barnet & Barnet, 1998; Karr-Morse & Wiley, 1997). There is compelling evidence that even before birth a fetus has acute awareness of its surrounding and “life in the womb” can have lifelong effects (Nathanielsz, 2001). The “blank screen” position is illustrated by the earlier belief that when young children were the victims of sexual abuse, they did not need treatment because they were not aware of the abuse. Research has shown that very young children are acutely aware of the external environment and are responding to it constantly (Bloom, 2000; Bruer, 1999; Eliot, 1999; Golinkoff & Hirsh-Pasek, 1999; Gopnik, Meltzoff, & Kuhl, 1999; Siegel, 1999; Zeanah, 2000). While very young children will not comprehend the nature of traumatic events, they are sensitive to any changes in routine or changes in reactions of caregivers. For this reason, parents should make every effort to continue the normal patterns and routines that the child goes through. If routines are disrupted the parent should make extra efforts to hold the child more frequently than usual and talk to the child more. Talking to very young children who do not understand language can be very reassuring and comforting and soothing to them simply by hearing the voice of the primary caregiver (Bloom, 2000; Golinkoff & Hirsh-Pasek, 1999). Parents who must leave children in the care of strangers during these times should be alert to any changes in the child’s eating pattern, sleep pattern, activity level, and achievement of developmental milestones.

**Preschoolers**

Preschoolers have acquired language and have much more acute awareness of events taking place around them. Children engage in much imitative behavior in the earlier stages of this phase of development and are very inquisitive in the later phase. For these reasons the parent or caregiver should limit television viewing of the traumatic event, and the parent should be present whenever the child does watch television. The caregiver should use indirect methods of intervention to give the child release of any tension associated with the trauma. The child can be encouraged to do drawings, play games with the parent, and listen to music. Efforts to talk with the child at this age about the trauma directly should be brief, concise, and in the child’s language. The basic rule is to inquire, not to tell. Parents should avoid simply giving children lectures about the trauma, but instead should ask children what they feel or think. These comments should be presented in a nonsuggestive way. For example, a caregiver should not say, “Are you afraid because of what happened?” The more effective inquiry would be, “How do you feel about what happened?” Children at this age will need much reassurance that the caregivers will make them safe. Explanations of how the child will be made safe are important. Routines are also important for children in this age range and should be maintained as much as possible during crises.

Bedtime is a crucial period for children. The parent should spend extra time with children after they go to bed. They should talk with them each night and reassure them of their safety and tell them pleasant, reassuring stories or read them soothing and comforting stories. The caregiver
should recount past fun times and talk about future planned fun events. Children who report bad dreams should be exposed to conscious dreaming at bedtime. This involves telling the child a story related to previous dream content that is reformulated with a positive theme and a good outcome. For example, a child who has dreams of the parents falling off a cliff can be told a story about parents who have small parachutes on their backs, that open up and let them glide peacefully to the ground when they are in high places. Dream catchers can be hung near the child’s bed and are effective in preventing bad dreams. Dream catchers can be purchased or the child can make them from various materials. The homemade dream catchers are preferred because that empowers the child in controlling the dreams. Children who have frequent and recurring nightmares (recurring frightening dreams with awakening from sleep) and night terrors (abrupt awakening from sleep with a scream or crying out) should be evaluated by a mental health professional. Nightmares occur in 10% to 50% of young children, and night terror disorder occurs in 1% to 6% of children (American Psychiatric Association, 2000). Bad dreams and nightmares from preexisting trauma can become intermingled with a new trauma. This is illustrated by the following case example:

Sammy is a 6-year-old who was physically abused by his father and the father’s companion. He was beaten with a belt and locked in a basement for punishment. He had soap put in his mouth for punishment. Sammy began showing aggression toward his sister and classmates at school. He had an extensive fantasy of seeing aliens.

Sammy was abandoned by his mother at 6 months of age. He was raised by the paternal grandmother and an aunt. The father took custody of Sammy when he moved in with the female companion in April 2001. When the abuse was discovered, Sammy was placed with the aunt. By September the symptoms had diminished significantly.

On September 11 Sammy became agitated after seeing the terrorist attacks on TV. The aunt had to take him to work with her for several days. He had a recurring dream of “bad people got mad at a woman and a plane came down to earth and cut her head off, and the bad people in the airplanes blew all the people up.” Sammy also had a parallel dream of his father’s companion in which “she was the devil. She was red and had horns and a tail.”

Any child evaluated by a mental health professional for trauma-related symptoms should be given a detailed sleep disturbance protocol analysis that includes review of dreams, nightmares, and night terrors. Distressing dreams of a traumatic event usually remit in several weeks and shift to generalized nightmares of rescuing others or of threats to self or others (American Psychiatric Association, 2000).

Sleep disturbance after a trauma usually takes the form of difficulty getting to sleep, awakening during the night, and awakening earlier than usual in the morning. For children with multiple sleep disturbances, research has shown that treatment for trouble getting to sleep should be addressed first, and in most cases the awakening during the night and early awakening will remit without intervention. In addition to the bedtime strategies mentioned above, extreme cases of difficulty initiating sleep can be treated with “graduated extinction,” which is gradually increasing the time that bedtime protests are ignored, and by using “bedtime fading,” which is deliberately keeping the child up later than usual with gradual resumption of the normal bedtime (Durand, 1998). Children who experience trauma-related sleep disturbance should be monitored during the day for sleepiness. Daytime sleeping could impair other developmental milestones.
especially in intellectual functioning of school age children.

**Elementary School Children**

Elementary school children will have in place cognitive and behavioral systems that allow them to develop sophisticated understanding of crisis events. There is a tendency of parents to overestimate the ability of children in this age range to understand adult conceptions and associations of concepts and events. Indirect play and activities can be used with this age group, but direct discussion can also be very effective and needed by children in this age group. The parent should follow the lead of the child in any discussion and should avoid suggestive questions. The parent should ask questions of the child on multiple levels. For example, helping parents to understand how the difference between cognitive and emotional processing can be helpful. This can be addressed through asking questions focused on what the child “thinks” about what has happened, and differentiating these questions from how the child “feels” about what has happened. The two conceptions can then be integrated through other questions, such as, “Do you think it is okay to feel that way about what has happened?”

Children are subjected to a variety of interpretations of traumatic events in the school environment. Teachers make expressions to the entire class and to students individually. Students tell stories of what parents and friends have told them about the event. Principals frequently hold meetings with large groups of students to explain the events. Counselors talk with the students. In many schools, televisions are simply turned on and children are allowed to indiscriminately watch the traumatic events. It is important that the parent discuss with the child each day before school what the child anticipates about the day so that the parent can offer reassurance about any unrealistic concerns or worries the child has. When the children return from school the parent should inquire what the children learned at school or what they were told at school about the traumatic event as well as other activities the children participated in.

The parents should attempt to correct any inaccurate or frightening information the child has received. The mental health professional during therapeutic sessions should inquire of the child what exposure to traumatic information has occurred at school. The therapist should also explore what the child has seen on television and what it means to the child. The therapist should do a cognitive and emotional review of the event with the child. The therapist should also meet privately with the parents and establish how they are managing their own interventions with the child at home and how the adults are managing their own stresses. Parents should be encouraged to have contact with teachers to assess unusual behaviors at school such as sleepiness, changes in eating habits, or changes in peer relationships.

**The Middle School Child**

The middle school child is usually very active, self-interested, and involved in a number of social networks. All the strategies used with the elementary school child would apply during the middle school years, but the parent needs to monitor more closely what the child is learning from peers and close friends. Spending more time with the child is important at this stage, because unavailable caregivers can lead the child to use peers as a source of exclusive support. While peer support is important, it has limitations and should not be relied on solely. The middle school child is more likely to use distractions to cope with the anxieties and fears about the trauma. For example, children who are involved in sports may significantly increase their...
time spent in these activities to the detriment of academic work and time spent talking to parents. Children in this age group should not be allowed to watch television alone in their room. It is important that the parent monitor any television viewing at any childhood stage, but it is especially important during this stage.

**Adolescents**

There is a vast range of developmental issues in adolescents related to early adolescence, middle adolescence, and late adolescence. Generally, adolescence is a period of asserting independence. While parents should make efforts to talk with adolescents about crises, the parents should not be surprised if there is resistance to such discussion or that adolescents take the opposite position of the parent. In middle and late adolescence there is a tendency to have strong emotional responses to traumatic events, and these adolescents should be monitored closely for anxiety and depressive symptoms.

In adolescents depression frequently is manifested through anger, irritability, and sometimes aggression and rage (Herrenkohl et al., 2000). Some adolescents can become identified with perpetrators of violence, especially adolescents with preexisting mental disturbance. Other adolescents can have reaction formations in which they want to join the military or lifesaving professions. Adolescents should be encouraged to not make any significant decisions during the acute reactions to a traumatic event. Such decisions that have long-term consequences can cause problems for the adolescent later when an impulsive decision is regretted. Adolescents who have difficulty verbalizing fears should be encouraged to use drawing, poetry writing, and other expressive means to communicate internal states and reactions. Some adolescents resist such indirect interventions, but supportive efforts should be made to foster participation. Adolescents who offer individual resistance may be more responsive in a group situation because of the importance of peer acceptance.

**Reactions in the Clinical Population**

There is debate and limited literature about the role that trauma experiences play in the onset and course of psychiatric illness (Dohrenwend, 2000). There is evidence that the course of a mental disorder is correlated with and influenced by traumatic events (McFarlane, Brookless, & Air, 2001). Children and adults that mental health professionals treat have increased functional problems, and horrific trauma events directly and indirectly increase functional problems and symptoms for this population. The triggering effects of the 9/11 events, when there was a preexisting mental disorder, are illustrated by the following case vignette:

Tommy is a 9-year-old child from a stable family who was diagnosed 2 years ago with an anxiety disorder. He had several obsessive thoughts with excessive worry. He had ritual compulsions. He was treated with medication and psychotherapy, and the symptoms were in remission. After 9/11 Tommy refused to go out of the house on several occasions. Three weeks after the terrorist attacks, fighter jets flew over his school at low altitude and made a loud noise that caused the school to vibrate. The planes were diverting a small plane from a sensitive government facility that is protected as restricted air space. This event triggered fear in Tommy, and he developed physical symptoms in the form of headaches and stomachaches. He became very fearful of leaving the house and the earlier anxiety symptoms returned, but not at the same level as at the time of the initial onset of the disorder. Tommy reentered psychotherapy, and his med-
ications were increased. After a brief course of psychotherapy, the renewed symptoms remitted and Tommy was able to resume the previous level of functioning.

Clinicians need to be alert to increased problems for children who have a history of mental health treatment or are currently in treatment. Symptoms of traumatic stress are frequently not obvious in diagnostic or treatment sessions (Scheeringa, Peebles, Cook, & Zeanah, 2001). Clinicians should do differential diagnosis of new referrals who may or may not have symptoms caused by the current crisis. There is a tendency for mental health professionals to not acknowledge and explore the reactions of their clients to national disaster events. The author did an informal survey of mental health practitioners after the Gulf War and after the current terrorist attacks. It was found that few mental health professionals routinely used any protocol to review reactions of their clients to September 11 events. This is illustrated by one practitioner who made no association between a 7-year-old client’s increased symptoms of anxiety and the fact that her aunt was temporarily unaccounted for after the Pentagon attack.

Children and adolescents with disorders uniquely related to the current crisis are at increased risk for triggering of new or heightened symptomology. The *DSM-IV-TR* disorders that are most often associated with trauma reactions are discussed in the following sections. Mood disorders, anxiety disorders, dissociative disorders, and adjustment disorders are discussed.

**Mood Disorders**

Children and adolescents who have been diagnosed with mood disorders are at high risk for increased symptoms, and should be monitored carefully during the crisis. This is especially the case if the parents have a history of depressive illness (Barondes, 1998; Stein et al., 2000; Wickramarantne, Greenwald, & Weissman, 2000), the child or adolescent has a history of recurring depression (Weissman, 2001) or symptoms of bipolar disorder (Geller et al., 2000; Paplos & Paplos, 1999). New or increased symptoms that should be monitored are sadness, tearfulness, social isolation, extreme sensitivity to rejection or failure, self-blame, difficulty in relationships, irritability, anger, hostility, somatic complaints, poor academic performance, weight change, daytime sleepiness, and memory problems (Mesman & Koot 2000a, 2000b; Weissman, 2001). If the war on terrorism continues for a protracted period as predicted, mental health professionals will have to be diagnostically more sensitive to dysthymic depression, which is a low threshold depression that can persist for years. It is characterized by eating and sleep disturbance, low energy or fatigue, poor concentration, difficulty making decisions, and a sense of hopelessness (Akiskal & Cassano, 1997; American Psychiatric Association, 2000). Children with dysthymic depression are at risk for recurring episodes of major depression (Kovacs, 1997), and children with this diagnosis should be monitored for the triggering effects from the current crisis.

Suicide is a risk factor in major depression, and a sense of hopelessness is highly correlated with suicide attempts. National crisis events can trigger suicidal thoughts. Thoughts or expressions of suicide, self-destructive behaviors, preoccupation with death and dying, taking care of unfinished business, and giving away cherished possessions should be considered key signals that a suicide attempt is a possibility (Bernet, 2001; Stewart, Manion, Davidson, & Cloutier, 2001; Walrath et al., 2001; Zalsman et al., 2000). The complex nature of depression, aggression, and suicidal ideation is illustrated by the following case example:

Nevin is a 15-year-old child who comes from a family with a significant history of conflict, domestic violence, and abuse. The parents are
now divorced. The father has spurned, ridiculed, and rejected Nevin for many years. The father was found to have mentally injured Nevin after a child welfare investigation. The father refused to see or talk to Nevin. Nevin has a history of depression, PTSD, violence and aggression toward adults and peers. He has assaulted his mother and siblings. He has destroyed property. In one incident he demolished the interior of the mother’s car after she made him stop playing video games to go to a therapy appointment. He was suspended from school for carrying a gun. Nevin has a history of psychiatric hospitalizations and appearance in juvenile court based on complaints from the father. Nevin was functioning better prior to 9/11. He was less aggressive and had developed more sadness to replace anger about the failed relationship with his father. On September 15, Nevin had to testify against his father in a criminal court case of physical assault of the mother by the father. During this time Nevin’s behavior got worse. He was more aggressive at home and at school. He was suspended from school for assault. He became depressed and had to be hospitalized. He stated to the therapist, “They should send me to Afghanistan and maybe I could do some good or else get killed.”

Anxiety Disorders

Children with other anxiety disorders that predated the terrorist attacks may be prone to increased anxiety and should be monitored for increased worry. Research has shown that children in the clinical population do not have worries that are different from children not in the clinical population, but their worries occur more frequently and with more intensity (Weems, Silverman, & LaGreca, 2000). Anxiety and worry are distinct, but related entities. Worry may be a more potent indicator of a child or adolescent’s functioning. Worry during a time of crisis can be reflected in increased routine worries such as worry about health, school performance, disasters, personal harm, future events, classmates, family, money, appearance, and friends. It is particularly important that the mental health professional review with clients who have anxiety disorders whether these clients worry about disasters and war since research shows that children in the clinical populations worry about these events at a higher level that the nonclinical population even during times of peace (Weems et al., 2000).

Acute stress disorder (ASD) and PTSD are likely to increase in the clinical and nonclinical populations of children and adolescents in response to the terrorist attacks, but the potential incidence of PTSD may be less than expected given the high symptom threshold required to diagnose PTSD. To diagnose PTSD requires six or more symptoms related to reexperience of the trauma, avoidance/numbing of stimuli associated with the trauma, and symptoms of arousal. Research from the Oklahoma City bombing found that arousal symptoms, which occur with intrusion or avoidance were the most distressing PTSD responses (Pfefferbaum et al., 1999).

While no United States national prevalence statistics are available, studies have shown that approximately 13% of children who have experienced trauma meet the diagnostic criteria for PTSD, but 50% of children resettled in the United States who were exposed to political violence meet the diagnostic criteria for PTSD (McCloskey & Walker, 2000). Therapists need to be aware of these findings and not overlook the possibility of other disorders that coexist with PTSD symptoms, such as major depressive disorder, panic disorder, agoraphobia, OCD, generalized anxiety disorder, social phobia, and specific phobia (American Psychiatric Association, 2000). Mental health professionals should also take into account that PTSD symptoms are gender-related in adolescents, and females are six times more likely than males to develop PTSD.
after a trauma (Giaconia et al., 1995). Children and adolescents who have bereavement associated with the trauma are significantly more symptomatic for PTSD symptoms (Stoppelbein & Greening, 2000). Children who were separated from parents or caregivers after the disaster are at more risk of developing PTSD symptoms (Pfefferbaum, 1997). Children and adolescents who are in destabilized homes or are in foster care are at high risk for subtle reactions to the terrorist attacks. Children who have visitation may become concerned about the welfare of the noncustodial parent during his or her absence. The anthrax attack has led some parents to make preparations if they have to leave their homes. This can be very upsetting for children who have a history of out-of-home placements or a history of frequent moves.

Infants and toddlers can develop attachment-related disorders (Solomon & George, 1999; Zeanah & Boris, 2000) and PTSD. These disorders are difficult to diagnose because very young children are constantly undergoing developmental changes, and they lack verbal abilities to communicate subjective experiences (Zeanah & Boris, 2000). While very young children can develop PTSD, very few meet the full criteria for the disorder as defined by the DSM-IV-TR. Scheeringa et al. (Scheeringa & Gaensbauer, 2000; Scheeringa & Zeanah, 2001; Scheeringa et al., 1995; Scheeringa et al., 2001) have developed alternate criteria for PTSD diagnosis in infants and very young children.

Dissociative Disorder

Dissociative symptoms can be associated with PTSD or can develop independently of PTSD. Dissociation is a common reaction to trauma. Steinberg and Schnall (2000) have identified the core symptoms of dissociation as amnesia (inability to remember past events), depersonalization (feelings of detachment from the self), derealization (feeling of detachment from one’s environment or other people), identity confusion (confusion about sense of self), and identity alteration (a change of role or personal identity). Dissociative symptoms in children are difficult to recognize and diagnose because of rapid changes associated with the stages and evolution of identity development during childhood and adolescence. In early childhood it is difficult to distinguish depersonalization and identity alteration from fantasy play. In adolescence “tuning out” of adults is difficult to differentiate from derealization. Children and adolescents in the clinical population should be monitored for dissociative symptoms. It is important for the clinician to recognize the difference between “normal” (dissociation not associated with maladaptive responses) and “pathological” (diagnosable disorders associated with maladaptation) dissociation (Putnam, 1997). Dissociation in times of stress can be normal for children and adolescents, and can function as a defense mechanism. Dissociation becomes problematic when it is maladaptive and interferes with activities of daily living. It can be difficult to assess when dissociative reactions have crossed over from normal to dysfunctional (Putnam, 1994).

Children in the clinical population should be monitored for dissociative symptoms if they have prior diagnoses of PTSD, ASD, eating disorder, attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, conduct disorder, mood disorder, substance-related disorders (Putnam, 1997; Silberg, 1996) or sexual abuse, physical abuse, and neglect. Key dissociative symptoms related to age-appropriate assessment are frequent forgetting, excessive lying, confusion about dates and time sequences, poor concentration, staring into space (trance states), fingering toys without playing with them, radical change in style of dress, magical thinking, flat affect, and hearing voices. Diagnosis of dissociation in children is more likely to occur in children with preexisting mental disorders, and diagnostic assessment should include
standardized testing because of the complex nature of dissociative disorders (Silberg, 1996).

**Adjustment Disorder**

In the *DSM-IV-TR* diagnostic system, adjustment disorder is a result of a single identifiable stressor or multiple identifiable stressors that can be recurring. The person does not meet the criteria for another disorder such as a mood or anxiety disorder. An adjustment disorder can be quite broad in the range of symptoms such as depressed mood, anxiety, disturbed conduct, or combinations of these symptoms. Adjustment disorder differs from PTSD in that PTSD requires a horrific stressor and a specific symptom complex. Adjustment disorder can be considered acute (symptoms present for less than 3 months) and chronic (symptoms persist for more than 6 months). Bereavement would be a more likely diagnosis if the child had a friend or family member who died as a result of the terrorist attacks (American Psychiatric Association, 2000; Munson, 2001).

It is possible that many children may have this disorder as a result of the 9/11 attacks, and may never come in contact with a mental health professional. When symptoms persist or reach a level beyond expectations for the level of the stressor, children may enter the mental health system. Clinicians should do a thorough differential diagnosis before diagnosing this disorder to ensure that a serious mood or anxiety disorder does not go undetected.

**Television**

The role of television as an influence on emotional states and behavior in children has been debated since television was first introduced to the public. Longitudinal study of television viewing has demonstrated broad-range positive and negative effects on children’s behavior, attitudes, and emotions. Viewing of violent television programming has been found to negatively influence school grades, participation in creative activities, leadership abilities, aggression, and participation in extracurricular activities (Anderson, Huston, Schmitt, Linebarger, & Wright, 2001). Television is an integral source of information regarding traumatic events, but at the same time can give rise to feelings of fear, can trigger symptoms, and in some cases have long-term effects on behavior and emotions. Various broadcast organizations have established guidelines for coverage of traumatic events, but these guidelines are often ignored and do little to decrease anxiety and fear. For example, much television coverage is geared to high ratings based on providing the most gruesome and close-up images, creating logos that are eye-catching, and playing haunting background music during programming. For example, during the Columbine school shootings, several networks used a logo that looked as if the viewer were peering through a rifle sight and put faces of children within the sights. This logo had the effect of triggering for some people memories of the horror of the actual shootings. Television can be a powerful trauma trigger. For example, emergency personnel who have assisted in traumatic events in their own community report being triggered for trauma memories of these events when they watch on television current traumatic events taking place in another community. Some emergency workers have been so moved by the television reporting that they volunteer to go to the site of the current incident based on the memory of a past horrific incident in which they provided assistance. The same is true of children who have witnessed a traumatic event in public and later viewed the same event or subsequent events on television. Any child who has been a primary or a secondary victim of trauma should be monitored for tertiary trauma...
when subsequent traumatic events occur. One way mental health professionals and caregivers can assist children is to monitor closely any television viewing related to traumatic events through limiting the amount of television watching time and screen out programming that is provocative or highly likely to trigger memories. Parents should also contact schools and inquire about what television programming children will see at school, and how the school will monitor television programming to which the child is exposed.

**Limitations**

The terrorist attacks on the United States are unprecedented and the resulting war is unique. There is no existing trauma literature focused on such an incident that could guide recommendations for intervention. The author relied on literature and clinical experiences from related forms of trauma, and research on disorders associated with conditions similar to the terrorist attacks, but the symptoms and reactions may be different in this case. Also, the war against terrorism continues to unfold, making it difficult to assess the full impact of the war. The reader should keep these limitations in mind when applying the content of this article to clinical and personal situations.

If the war on terrorism continues for an extended period as has been predicted, we will need to develop more sophisticated and relevant measures of childhood psychological distress associated with political tension life events and social upheaval (Netland, 2001; Sloan, Adiri, & Arian, 1998). We also will have to better train mental health professionals in the specifics of assessment and treatment of sociopolitical stress on children in civilian and military families (Jensen, Martin, & Watanabe, 1996; Kelley et al., 2001; Stewart, Lord, & Mercer, 2001), and our society will need to provide sustained supportive services for families and children (Apfel & Simon, 1996).

**References**


In H. S. Akiskal & G. B. Cassano (Eds.), *Dysthymia and the spectrum of chronic depressions* (pp. 208–219). New York: Guilford.


