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Maria M. Galano, Laura E. Miller & Sandra A. Graham-Bermann
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Avoidance Symptom Presentation of Preschoolers Exposed to Intimate Partner Violence in a Group Therapy Setting

Maria M. Galano, Laura E. Miller & Sandra A. Graham-Bermann

Post-traumatic stress disorder (PTSD) is a serious problem for children exposed to intimate partner violence (IPV). Recent changes to diagnostic criteria for PTSD include a reduction in avoidance symptom criteria from three to one and the separation of emotional numbing from avoidance symptoms, thus creating a need to better understand how avoidance symptoms of PTSD present themselves in young children. This study evaluated 56 children aged four to six as they participated in an intervention for mothers and children exposed to IPV. Therapists documented behaviours indicative of avoidance symptoms during group sessions. Data were analysed and coded into symptom categories and thematically emergent domains. Results demonstrated that avoidance symptoms fell into three separate categories: physical avoidance, emotional avoidance, and changing topics. Additionally, the data support the Diagnostic and Statistical Manual of Mental Disorders (5th edition) change to remove emotional numbing from the avoidance symptom category. These results give insight into how to develop more targeted treatments for PTSD as well as improve the assessment and diagnosis of PTSD symptoms in preschoolers.

Keywords: Intimate Partner Violence; Children; Post-traumatic Stress Disorder; Assessment; Avoidance

Introduction

Intimate partner violence (IPV) is a serious public health problem, affecting an estimated 15.5 million children annually (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Young children are at an especially high risk for being exposed to IPV (Fantuzzo & Fusco, 2007), making it critical to understand the effects
of exposure in this population. Children exposed to IPV are at greater risk for developing problems with substance use/abuse later in life (Smith, Elwyn, Ireland, & Thornberry, 2010) and have challenges with adjustment, including more internalising and externalising behaviour problems (e.g., Graham-Bermann, Castor, Miller, & Howell, 2012; Kitzmann, Gaylord, Holt, & Kenny, 2003). Notably, they may have elevated symptoms of traumatic stress (Graham-Bermann et al., 2012) and higher rates of post-traumatic stress disorder (PTSD) (Rossman, Hughes, & Rosenberg, 2000). Witnessing interpersonal violence has now been clearly identified as a potentially traumatic event in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013).

Although elevated rates of post-traumatic stress have been documented in preschoolers exposed to violence, the rates are quite variable. A review by Rossman et al. (2000) found that the rate of PTSD in youth varied from 13 to 56% depending on the population and measure used. For example, a study of three to six-year-old urban preschoolers exposed to a wide range of potentially traumatic events, including family violence such as child abuse or IPV and other types of violent exposures outside the home, indicated that 23% of these children had clinical-range post-traumatic stress symptoms (Crusto et al., 2010). However, in another study of only war-exposed youth aged one-and-a-half to five years old, a PTSD diagnosis was reported for 38% of the sample (Feldman & Vengrober, 2011). A third study of preschoolers exposed to IPV compared the rate of PTSD using two different criteria: DSM-IV-TR standards and a developmentally sensitive measure created by Scheeringa and Zeanah (1994). The rate of PTSD diagnosis was 17% using DSM-IV criteria, but an astounding 54% using the developmentally sensitive measure, reinforcing other research suggesting that the DSM-IV-TR criteria may not have accurately captured the extent of this disorder in young children (Graham-Bermann et al., 2012). It is hoped that changes to the DSM-5, which includes a new developmental trauma diagnosis of PTSD for children aged six and under, will help to enhance diagnostic validity and reliability for this age group; but the advent of new criteria also requires the need to more fully understand symptom presentation in this age group. Clear, qualitative investigations of diagnostic criteria will do much to assist in the accurate assessment and diagnosis of PTSD by clinicians and researchers.

For adults, DSM-5 divides PTSD into four specific symptom categories: re-experiencing, avoidance, negative cognitions and mood, and arousal (American Psychiatric Association, 2013). This is a modification from the previous edition, where avoidance symptom criteria included both attempts to avoid thoughts and reminders attached to the trauma as well as diminished interest and feelings of detachment (DSM-IV-TR; American Psychiatric Association, 2000). In the current edition, avoidance now only includes efforts to avoid memories and reminders of the traumatic event, while the separate symptom category of negative cognitions and mood includes an inability to remember parts of the trauma, diminished interest/participation in activities, and feelings of detachment from others (American Psychiatric Association, 2013). This interesting shift highlights the independent importance of both avoidance symptoms
and emotional numbing; the latter of which has been associated with delinquency and aggression (Allwood, Bell, & Horan, 2011). DSM-5 has also included more developmentally appropriate criteria for children; for example, a reduction in the avoidance symptom criteria from three to one for preschool children (American Psychiatric Association, 2013). This may have occurred for a several reasons, including evidence that requiring three avoidance symptoms in a diagnosis may have caused PTSD to be underdiagnosed in children (Scheeringa, Zeanah, & Cohen, 2011). Further, there was some concern that the highly internal/abstract nature of avoidance might make those symptoms inaccessible to children (Scheeringa et al., 2011). Given that this one symptom could be a determining factor in whether or not a child receives a diagnosis of PTSD, it is crucial that clinicians and researchers alike are able to accurately identify symptoms of avoidance in young children. Yet avoidance symptoms often go unnoticed, especially when compared with the more obvious symptoms associated with traumatic re-experiencing and aggressive behaviour.

In addition to changes in diagnostic criteria for young children, research suggests that PTSD is highly correlated with behavioural disorders in young children. Because children are frequently brought in for treatment due to behavioural difficulties, it is important that clinicians are able to recognise symptoms of PTSD to prevent diagnostic overshadowing of behavioural disorders. Earlier studies of PTSD comorbidities in children found that PTSD was significantly correlated with attention deficit/hyperactivity disorder (ADHD; Famularo, Fenton, Kinscherff, & Agustyn, 1996) as well as other behavioural disorders (Ford et al., 2000). More recent research has confirmed these findings; one study of PTSD in children post Hurricane Katrina found that approximately 33% experienced co-morbid PTSD and ADHD (Scheeringa & Zeanah, 2008). Further, they found that 60% of their sample experienced co-morbid PTSD and Oppositional Defiant Disorder (Scheeringa & Zeanah, 2008). Symptoms of PTSD in young children can include behavioural and emotional outbursts, such as temper tantrums, as well as more aggressive behaviour, both of which are symptoms of behavioural disorders. Given these similarities, as well as recent DSM-5 changes to diagnostic criteria for PTSD, there is an even greater need to differentiate between symptoms of these separate disorders.

Accurate assessment of avoidance symptoms is important for diagnosis, but also has implications for treatment of traumatised populations. There is some evidence that the presence of avoidance is a barrier to treatment success in adults with depression (Renaud, Russell, & Myhr, 2013); and in some cases early avoidant behaviour is predictive of a later diagnosis of PTSD in parents of children with cancer (Lindahl Norberg, Pöder, & Von Essen, 2011). Although these results have not been replicated in children, it is possible that the presence of high levels of avoidance may impede treatment efficacy.

The Current Study

While PTSD has been studied as an empirical outcome in intervention evaluation research, less is known about the specific therapeutic presentation of this disorder in
young children. Gaining a more complete understanding of preschoolers’ trauma symptom presentation in therapy is especially relevant at this time because of recent changes to the psychiatric diagnostic manual. As previously stated, this includes the separation of emotional numbing from avoidance symptom criteria as well as the reduction of avoidance symptom criteria from three to one in young children. Insight into symptom presentation in therapy can be useful to researchers and clinicians alike as they develop more targeted ways to identify and treat PTSD in children. The goal of this study is therefore to gain a basic understanding of how avoidance symptoms are presented in therapy through the use of qualitative data describing the behaviour of group therapy participants. Given the novelty of the current avoidance criteria, we did not constrain our analyses to specific hypotheses at the outset. However, the authors had the following questions in mind as we began to explore the data:

1. Are symptoms of avoidance recognisable in a group therapy setting?
2. How do avoidance symptoms present over the course of intervention?
3. How is avoidant behaviour distinct from symptoms of behavioural disorders?
4. Is the DSM-5 distinction between avoidant behaviour and emotional numbing observable and supported?

Methods

Participants

Data for this study were drawn from a larger randomised controlled trial intervention for mothers and children exposed to domestic violence within the past two years (Graham-Bermann, 2006). The sample consisted of 56 children ranging from four to six years old (mean = 5.00, standard deviation = 0.91). Twenty-seven (48.2%) of the participants were male and the sample was ethnically diverse (70% ethnic minority, primarily African-American and biracial).

Procedures

Approval of this study was provided by the university Institutional Review Board. Participants were recruited from the community and were eligible to participate if they had experienced physical violence with a partner within the previous two years and had a child between the ages of four and six. Interviews were conducted either in the families’ homes or in a neutral location in the community (e.g. a local shelter) before the intervention began, after intervention completion (about six weeks from the first interview), and six months post intervention. Mothers and children were compensated for their time. The intervention programme was conducted at a local community shelter. For a more detailed description of the intervention procedure, see Howell, Miller, Lilly, and Graham-Bermann (2013).

This main study was an efficacy trial of The Preschool Kids’ Club (described below). Given that there is little information about the ways in which trauma symptoms are expressed in very young children, questions were added to ascertain
basic information on this topic. Thus, this is a separate study that extended
information collected about the mothers and children in the main trial to that
collected by the group therapists. Each therapist was trained in identifying symptoms
of traumatic stress, and following each intervention session they documented any
interaction or behaviour of each child in their group that they believed indicated a
symptom of post-traumatic stress. This documentation included marking items on a
standard checklist of post-traumatic stress symptoms as well as providing qualitative,
behavioural descriptions of any endorsed item. Any other notable occurrences (not
necessarily indicative of post-traumatic stress) were also documented on the
same form.

**Intervention**
The Preschool Kids’ Club programme (Graham-Bermann, 2006) is an intervention
designed to reduce distress associated with witnessing violence by giving children
ways to discuss fears and worries, as well as responsibility for violence, and help
children learn safety planning in violent situations in a developmentally sensitive way.
It is adapted from the Kids’ Club programme (Graham-Bermann, 1992), which has
been empirically validated to reduce violence-associated distress in school-aged
children and to improve their coping. The intervention is carried out through a series
of 10 sessions, each with a specific focus, led by trained therapists. The programme
has been shown to reduce behaviour problems in children as well as to change
attitudes about the acceptability of violence when given in conjunction with a
programme for their mothers (Graham-Bermann, Lynch, Banyard, Devoe, & Halabu,
2007). The effect of this programme is stable up to eight months post intervention
(Graham-Bermann et al., 2007; Graham-Bermann, Howell, Lilly, & Devoe, 2011).

**Therapists**
The therapists were social workers, psychologists, and graduate-level students in
clinical psychology or social work assisted by advanced undergraduate students.
Before beginning the intervention, therapists received at least 10 hours of training and
completed reading assignments related to aspects of the intervention. Therapists were
also trained in the identification of trauma symptoms in young children. In order to
assure fidelity to the programme, therapists wrote process notes and participated in
weekly supervision by a licensed clinical psychologist throughout the course of the
intervention.

**Measures**

**Demographics**
Demographic information was collected during the baseline interview with the
mother. She answered questions regarding her and her child’s age, race and ethnicity,
her relationship status, her family’s monthly income, and her employment status.
Intimate partner violence

The Conflict Tactics Scale—Revised (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) is a 78-item questionnaire designed to determine the level of intimate partner psychological and physical abuse as well as conflict management. Participants rate how many times a particular event has occurred in the past year on a seven-point scale (one time, two times, three to five times, six to 10 times, 11–20 times, greater than 20 times, and never). Higher scores indicated more frequent use of a particular tactic. The Conflict Tactics Scale—Revised has five subscales: Negotiation, Psychological Aggression, Physical Assault, Sexual Coercion, and Injury. The Conflict Tactics Scale—Revised was demonstrated to have reliability and validity across subscales (Stith et al., 2000; Straus & Douglas, 2004). For this study, only the victimisation questions were used (39 questions total). Reliability for the present study was $\alpha = 0.94$.

Post-traumatic stress symptoms

After each session, therapists assessed post-traumatic stress symptoms during therapy using a 22-question form based on the preschool PTSD scale, the Posttraumatic Stress Disorder Semi-Structured Interview and Observational Record for Infants and Young Children (Scheeringa & Zeneah, 1994). Following each of the 10 sessions, therapists indicated whether or not a behavioural expression of a trauma symptom occurred during the session. If a symptom was expressed, the therapists were asked to add a qualitative description of the behavioural expression of that symptom. (For a quantitative analysis of these descriptions on a subsample drawn from the same larger intervention study, see Modrowski, Miller, Howell, and Graham-Bermann, [2012]). Two therapists completed forms together and recorded any additional behavioural observations of the children in their group that they thought warranted further description. They responded to six questions on the form aimed at elucidating the presence of avoidance symptoms. These were that the child: tried to avoid hearing activities about violence by others or talking about it; tried to avoid activities related to violence; was not able to remember parts of the violence; did not play as much as other children in the group; seemed more withdrawn or less sociable than other children in the group; overall avoided or displayed less emotion than other children in the group.

Analytic Protocol

Latent thematic analysis was conducted following the steps identified by Braun and Clarke (2006). First, researchers familiarised themselves with the data, reading it over and noting initial ideas (Braun & Clarke, 2006). Then researchers created codes, assigning sections of data to specific codes (Braun & Clarke, 2006). The next step involved grouping codes into specific themes (Braun & Clarke, 2006); in this case, post-traumatic stress symptoms. The fourth and fifth steps involved checking over themes as well as refining them (Braun & Clarke, 2006), which the researchers did through continued discussion of themes until consensus was reached. The final step
involved the production of a report of the themes generated and mapped onto the data (Braun & Clarke, 2006).

All data were coded using NVivo 10 software. Coders consisted of four researchers; one professor of clinical psychology, two graduate students, and an advanced undergraduate student. The researchers followed the steps outlined above, generating and checking codes and themes to create a final map of post-traumatic stress symptoms in preschool children. The researchers achieved adequate reliability for NVivo analysis (κ = 0.84; Ishak & Abu-Bakar, 2012).

**Results**

**Intimate Partner Violence**

On average, mothers reported that they had experienced relatively chronic relationship violence. Including events of psychological abuse, verbal threats, physical and sexual violence, mothers had experienced, on average, 210 such acts of violence in the past year (standard deviation = 147.92).

**Total Avoidance Symptoms**

Following an analysis of themes as per Braun and Clarke (2006), researchers were able to group avoidance symptoms into three primary domains: physical avoidance, changes topic/refuses to speak, and emotional avoidance. Shy behaviours were coded separately from avoidance symptoms, given that researchers wanted to categorise behaviours that would be indicative of avoidance rather than temperament. Figure 1 summarises the codes under each domain. We were also interested in the overlap between avoidant behaviour and emotional/behavioural problems and emotional numbing, respectively.

Throughout the course of the intervention, 38 children (67.9%) exhibited at least one avoidance symptom. The number of avoidance symptoms per child over the course of the intervention ranged from zero to 19 (mean = 3.32, standard deviation =

![Figure 1](Coding Schema for Avoidance Symptoms in Group Therapy.)
The total number of symptoms did not vary by child gender or age. An analysis of avoidance symptoms over sessions revealed a peak in avoidance symptom presentation at session three, with a continual decline in the number of avoidance symptoms exhibited in each session after that. For a graphical representation of this trend, see Figure 2. The two sessions with the greatest occurrences of avoidance symptoms were sessions three and four.

Physical avoidance

Forty-eight per cent of avoidance in group therapy involved children physically distancing themselves from what was occurring in the group, or refusing to participate (see Figure 1). This distancing was the result of reminders of family violence that occurred as part of the treatment content. In one example, a child "Went into a corner by herself when the issue of safety and fighting in the family came up”. Sometimes, children went a step further by hiding after removing themselves from the group. For example, it was reported that another child “Ran under the table when group leaders talked about things kids might feel when there’s fighting in the family”. Removing oneself from the group also overlapped with refusal to participate in group activities: “[Child] did not feel like participating in the majority of the session—kept walking around the group to avoid the activities”.

For those children exhibiting symptoms of physical avoidance, behavioural symptoms were also present in approximately 10% of cases. For example, in one case: “… when asked at first (before he actually answered), asked about fighting in the family, [child] threw markers and ran across room”. Here we see a behavioural outburst and emotion dysregulation combined with removing oneself from the group. Emotional/behavioural problems also overlapped with refusal to participate (see...
Figure 1). For example: “when making posters of what boys and girls can be when they grow up, he refused to put a father on the poster and crumpled it up. He became upset and didn’t want to participate anymore”. These emotional/behavioural problems came up more frequently when children refused to participate than when they removed themselves from the group.

Changes topic/refuses to speak
Therapists described children’s discomfort with the session content by noting that some tried to change the topic from session content. In some cases, this was done deliberately. For example: “When discussing conflict resolution (such as what could a child do instead of hitting someone), she gave a couple of responses and then bluntly said she didn’t want to talk about it anymore”. In another case: “When talking about families in the future, one of the boys brought up an incident when his dad punched him and his mom. [Child] asked the group leaders if we could stop talking about this.” In other cases, a child would simply move to change the topic without directly asking a therapist to do so. In one instance during a discussion of violence, “… this child began to complain of not feeling well—initially saying she had a ‘sore tooth’, which became a ‘sore throat’. Requested a glass of water, then wanted to see her mother.” Six per cent of the examples were represented by this category.

Emotional avoidance
Finally, avoidance during therapy had emotional indicators; such that children became more emotionally distant and avoided social interaction in uncomfortable situations. Emotional avoidance represented 38% of total avoidance symptoms. For example, one child “Became withdrawn when leaders were talking about how it’s never the kids’ fault when parents fight”. Social withdrawal was also marked by body language (“Made little eye contact and said few words throughout the session”) and solo play (“Spent the last five minutes of this session playing alone with puppets”). Additionally, social withdrawal overlapped with other domains of avoidance. In one case, a child withdrew and removed herself from the group:

For about five minutes at the end of the session when we read, she sat in a corner and told the leaders to “go away” and “stop” (this was right after safety planning and running away from a discussion of fighting in the family).

This also happened in several other cases. For example: “[The child] was distant from the group. Would not sit in the group circle or play games. Would not talk to other children.” In another case:

During an activity when we had the kids look at ambiguous pictures, some of which indicated conflict, she would not say anything about the pictures and wanted to color instead. At one point, she began coloring and moved away from the group.

Numbing
Emotional numbing was also present in this sample; it represented 8% of the total examples. This was differentiated from emotional avoidance in that there was a noticeable loss of emotional insight, rather than discomfort with the situation. For
example, one child “Said ‘nothing’ was a feeling and this is how she felt when there was fighting in the family”. In other cases, children’s behaviour would indicate a lack of emotion: “… she was very matter of fact about the whole ordeal when discussing the violence”. Another striking example of this lack of emotion is the following: “He talked in a robotic voice and stared blankly, and would not give eye contact when leader needed to address his behaviors”. Numbing was also reported as inappropriate emotion in response to conversations about violence: “[Child] laughed when violence was spoken about”.

There was very little overlap between emotional numbing and other avoidance categories. In fact, there were only two instances where overlap occurred. One was an overlap between numbing and social withdrawal:

The child did little overlap between emotional numbing and other avoidance categories. In fact, there were only two instances where overlap occurred. One was an overlap between numbing and social but without the expression of emotion.

The second instance was overlap between numbing and refusal to speak. In this case the child: “Refused to fully discuss feelings associated with family violence. Visually, [the child] appeared upset. She claimed she felt ‘nothing’ as an emotion in response to fighting in the family.”

**Shy behaviour**

Researchers also coded a category called “slow to warm up”, which looked at shy behaviours displayed by children during the group sessions. This type of behaviour was present in 21% of the sample. Examples for this category include: “Seemed shy and reserved compared to others. Had to be invited more than once to participate, though he was clearly paying attention”, and “Slow to warm up in group, quiet and reserved, waited to be called on. But more engaged by end of group—shared with other kids independently.” The majority of this type of behaviour was seen during the first three sessions, although there were some codes for this behaviour as late as session seven.

**Discussion**

The goal of this study was to describe how young children present avoidance symptoms in a group therapy setting. Our analysis revealed several different ways in which avoidance symptoms manifest. Physical avoidance was largely categorised as some action in which a child avoids reminders of violence by removing himself or herself from group activities. Changing the topic involved a shift in the narrative by the child that took the conversation away from the topic of violence in the family. This was done through both direct and indirect statements. Refusing to speak was another way in which children tried to move themselves away from the topic of violence, although this was less common. Emotional avoidance encompassed social withdrawal behaviours, and was distinct from shy behaviour. Finally, there was evidence that emotional numbing was distinct from these other examples of
avoidance behaviour. This supports changes in the DSM-5, which stipulates emotional numbing as a separate symptom category for PTSD. Additionally, this qualitative analysis demonstrates that the avoidance symptom category is quite large and heterogeneous, making it an important focus for researchers and clinicians when conducting a careful and evidence-based assessment of symptoms.

Avoidance symptoms followed a mostly downward trend over time; with a sharp peak at session three (see Figure 2). The content of session three addresses emotions in general and, more importantly, emotions related to violence in the family. Much of the session time is spent working with children to identify emotions such as, happy, sad, mad, worried, and so forth. The way in which this can be accomplished varies, from making lists to creating paper puppets that demonstrate different emotions. Therapists then work with children to identify situations where different emotions could be present. This is done through displacement (e.g. “How would kids feel if there was fighting in the family?”), rather than addressing children directly. In addition to identifying emotions, therapists and children brainstorm ways in which children can deal with negative or uncomfortable emotions. This session marks the first time that children and therapists begin to directly address the topic of family violence, which might explain why we see such a dramatic peak in avoidance behaviours in this session. It is reasonable to expect that if this is the first time that traumatised children are coming into contact with the very topic they are trying to avoid, then they may demonstrate more avoidance symptoms.

Session four, which also has a relatively high number of avoidance symptom reports, deals with assessing responsibility for violence, and introduces the idea that “it’s never the kids’ fault when parents fight”. It is only after session four that we see any marked decrease in avoidance symptoms. Sessions five and beyond focus on enhancing coping strategies as well as managing emotions through factors such as safety planning and conflict resolution activities. While there is a slight peak at session seven (which addresses gender and plans for the future), it is not nearly as high as in earlier sessions. Overall, we see that avoidance takes time to emerge and may linger for a few sessions before decreasing. This trajectory suggests that a period of adjustment may be needed before children are truly able to participate in group therapy.

Physical avoidance was the only area where we saw overlap between behavioural/emotional problems and avoidance. From previous work, we know that there is symptom overlap between PTSD and other behavioural disorders, such as ADHD (Ford et al., 2000). Therefore, it is important to be able to distinguish between avoidance symptoms and other behavioural symptoms. In this study, behavioural outbursts such as crying and temper tantrums occurred; however, they were unified in that they all took place as reactions to reminders of/discussions about traumatic events/experiences and were connected with other avoidance symptoms. This evidence indicates to the authors that behaviour problems in response to traumatic content are likely to be symptoms of PTSD, especially when they are coupled with other types of avoidance symptoms.
Emotional avoidance was the most common type of avoidance symptom displayed by the children in our study. This supports other work that has shown social withdrawal to be a common PTSD symptom in young children (Feldman & Vengrober, 2011). Additionally, social withdrawal had a significant amount of overlap with the other domains of avoidance. One possible explanation for this is that PTSD over time, and in particular the expression of avoidance symptoms, may lead to feelings of social isolation from others. This social isolation, in turn, may become a mechanism for avoiding uncomfortable situations, which then could perpetuate a vicious cycle of avoidance.

Changing the topic/refusing to speak was the least noted form of avoidance in group therapy (6% of all cases). However, it is important to note that what could be labelled as obstinate or distracted behaviour actually may be a child attempting to avoid traumatic topics. Again, this becomes significant as we try to separate symptoms of post-traumatic stress from behavioural symptoms of diagnoses such as ADHD. Similar to physical avoidance, this type of avoidance is presented as a reaction to discussions about trauma and violence in the family, making it possible to distinguish post-traumatic response from behavioural problems.

One common thread that brings together these diverse categories of avoidance is that they all took the children away from what was happening in the therapy session. This is significant, given that the content of each session varied and may not necessarily have been covered in depth again. In this study, the sessions with the most avoidance were in sessions that dealt with responsibility for violence as well as fears concerning violence in the family. This presents a challenge for therapists trying to help children with post-traumatic stress, because those high in avoidance may be missing key aspects of their treatment. These findings also suggest a need for interventions for traumatised children to first focus on reducing avoidance symptoms in order to remove a possible barrier to treatment. For example, a brief Trauma Focused-Cognitive Behavior Therapy (TF-CBT) for children exposed to trauma was able to reduce avoidance and hyperarousal symptoms, but did not affect re-experiencing symptoms (Cohen, Mannarino, & Iyengar, 2011). In the present study, avoidance symptoms gradually declined over the course of 10 sessions. From the data presented by Cohen et al. (2011) it is not clear when reductions in avoidance symptoms occurred, but it is possible that an early focus on avoidance symptom treatment may allow for greater reductions in other symptom categories over the course of intervention. Further investigations are necessary to determine the relationship between the presence of persistent avoidance symptoms and other treatment outcomes.

Although emotional numbing was not a frequently reported behaviour, it is still noteworthy. In particular, we found almost no overlap between emotional numbing and other avoidance symptoms. Some degree of overlap would be expected, given that they are features of the same diagnosis; however, the overlap within the other avoidance codes was much greater than the overlap between emotional numbing and those same codes. The authors believe that this finding lends support to the separation of avoidance and emotional numbing in recent revisions to the DSM.
Apart from this, also significant is that emotional numbing is present in this very young population, given its potential to have detrimental effects. In one study of middle school children, early emotional numbing was found related to later delinquent behaviour and aggression and adolescence (Allwood et al., 2011). Evidence such as this suggests that reducing emotional numbing in young children may reduce adjustment problems later in their life.

Finally, shy behaviour was a fairly common behaviour in our sample, although it was distinct from social withdrawal. Despite this being readily observed in our sample, it is not a behaviour indicative of PTSD, but rather a temperamental trait. Therefore, when assessing PTSD, clinicians and researchers alike may be careful not to confuse avoidant behaviour and child temperament. This might involve using contextual factors such as novelty (i.e. it is the first session of therapy) and time (i.e. children who seemed withdrawn at the beginning of the hour are readily participating 20 minutes later). Our results support this idea given that the majority of avoidance symptoms coded were in later sessions rather than earlier sessions. Our data also suggest that observable avoidance symptoms are reactionary rather than spontaneous. For example, many observed instances of avoidance were during times when therapists were trying to address the issue of violence or activities directly related to the violence. These are markers that may help to identify avoidance symptoms in a clinical setting.

**Limitations**

These data are limited in that all of the participants in the study were from the Midwest and were primarily either Caucasian, African American, or Biracial. This also was primarily a low-income sample. Having a more diverse sample in terms of geography, income and racial/ethnic background could be beneficial to our understanding of avoidance symptoms in more diverse groups of children.

Additionally, our data are a secondary source of information because they come from clinicians’ reports of children’s behaviour in therapy. Therapists’ notes were not necessarily complete accounts of what occurred in each session, and in some cases did not provide enough detail to be coded. Video footage of children’s behaviour in therapy might have allowed us to more clearly see children’s behaviour without any previous interpretation by the therapists. In addition, we may be better able to see the antecedents and consequences of different symptoms. In this way, video footage could provide a more reliable and better contextualised understanding of avoidance symptoms.

**Future Directions**

Future studies might also examine children’s trauma symptom presentations in individual therapy, at home or in school. The current study only examined these behaviours in the context of group therapy, where behaviours such as removing oneself from the group were easily observed, given that they occurred in the presence
of multiple children. Physical avoidance symptoms such as this might therefore be less observable or observed in different ways in individual therapy. An examination of individual therapy notes might allow us to identify the equivalent of this behaviour in the individual context, refining our assessment of avoidance symptoms. Additionally, these behaviours should be coded through direct observation as well as through therapists’ detailed and child-specific notes. Using a secondary source such as notes gives a less objective view of occurrences in therapy, which could change the symptoms we were able to identify. Furthermore, the use of notes sometimes decontextualises behaviour, making it more difficult or, at times, not possible to code symptoms. Future studies would do well to empirically analyse the relationship between avoidance symptoms and treatment outcomes in young children. Given that avoidance symptoms represent a potential barrier to treatment and thus may affect outcomes, research on this relationship may give us ways to address this issue in interventions. Finally, the developmental course and presentation of avoidance symptoms needs to be studied in order to enhance identification, because symptom presentation may vary with the age of the child.

**Clinical Implications**

This study provides several points of useful information for clinicians. First, it identifies unique domains of avoidant behaviour in preschoolers with clear examples of how their behaviour appears. Further, these data suggest that treatments should account for the fact that children need a period of acclimatisation before they are fully able to engage in therapy. Clinicians can use this information in their own work when trying to diagnose and treat children exposed to traumatic events. This research also helps to distinguish avoidant behaviour and emotional numbing, which are now two separate symptom categories for PTSD. Knowledge of this differentiation can help ease the process of assessment for clinicians. Finally, this research examines some of the potential overlap between PTSD and behaviour disorder symptoms. Given that this is one of the concerns for the differential diagnosis of PTSD, it is important that clinicians gain a better understanding of what separates symptoms of PTSD from symptoms of other disorders. This could occur through continuous assessment of symptoms with IPV-exposed children rather than only pre-treatment and post-treatment symptom evaluations to help separate persistent avoidance symptoms from what might be symptoms of a behavioural disorder. Taken together, these findings allow for avoidance symptoms to be more readily identified in the course of treating young children, ultimately allowing for more accurate diagnosis and intervention, and thus reducing harm.

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References


