SAVE
Support and treatment of traumatized children After ViolencE
DIDACTIC MATERIALS
ADHD us PTSD

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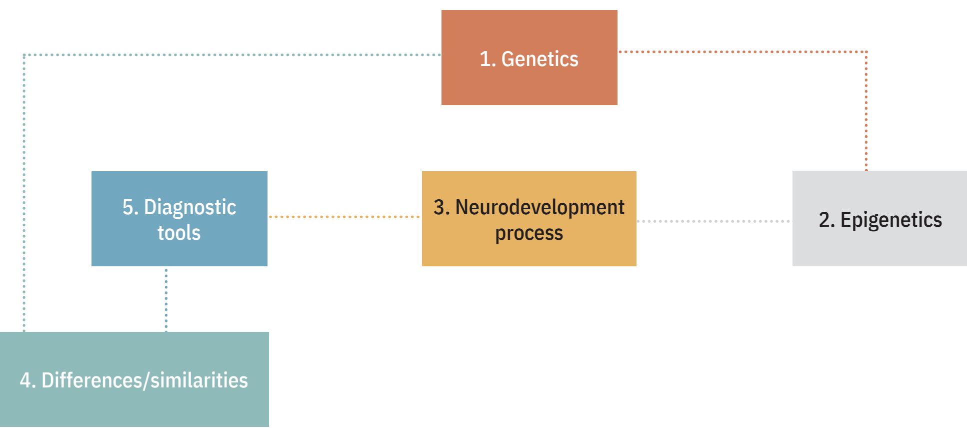
DIDACTIC MATERIALS
ADHD us PTSD

Traumatized children could meet the typical criteria for ADHD, even though symptoms were not present in their early development. This is because PTSD rewires and affects the development of a growing brain, stunting the growth of areas dealing with emotional regulation, impulse control, and self-awareness.

ADHD cannot cause PTSD, although people with ADHD are more prone to high-risk behavior, relational problems, leaving them vulnerable to traumatic events. Additionally, children with ADHD can be difficult to manage, raising their risk of maltreatment from a caregiver. These examples are indirect social effects of the disorder, not the direct, physical impact of trauma on brain functioning.

In a good clinical practice, the specialist can use different tools (standardized tests) as well as refer to the aspects that intersect, contribute to composing the development framework. (1-2)



Differences and overlap of these two conditions lead to confusion, but we know that they could simultaneously occur. When it happens, each worsens the effect of the other. ADHD children are usually less resilient and more prone to impairment than their non-ADHD peers. When they face the trauma, they may be more vulnerable to its worst effects.

Effects of chronic or repeated exposure to stress (or a single exposure to severe stress) at different stages of life depend on the areas of the brain that are developing or declining at the time of exposure. Stress in the prenatal period influences the development of many brain regions involved in regulating the hypothalamus-hypophyse-surrene axis (HPA) - i.e. the hippocampus, frontal cortex and amygdala.

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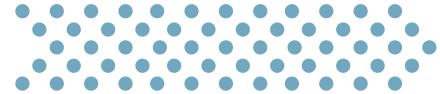
Postnatal stress has different effects: exposure to maternal separation in childhood leads to increased secretion of glucocorticoids, while exposure to severe abuse is associated with reduced levels of glucocorticoids.

Life-events



Adverse Childhood Experiences (ACEs): more or less chronic negative pathway incidents experienced in childhood that compromise the attachment processes and psychophysical development of the child. (3).

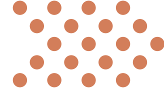
ADVERSE CHILDHOOD EXPERIENCES (ACES)

Direct

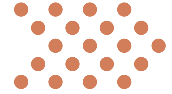
- Sexual abuse Witnessed violence
- Recurrent psychological maltreatment
- Recurrent physical maltreatment
- Physical neglect
- Emotional neglect

Indirect

- Witnessed violence
- Alcoholism
- Drug addiction
- Psychiatric diseases (severe depression, mental disorder, suicidal acts)
- Single parent / no parent
- Family member charged with a crime
- Loss of a relative (death or abandonment, divorce)
- Economic disadvantages and job instability
- Parent's previous abuse



Different-Similarities ADHD us PTSD



As highlighted by the National Child Traumatic Stress Network (2016), below we show the overlapping and different symptoms (4):

TRAUMA

- Feelings of fear, helplessness, uncertainty, vulnerability
- Increased aurousal edginess and agitation
- Avoidance of reminders of trauma
- Irritability, quick to anger
- Feelings of guilt or shame
- Dissociation, feelings of unreality or being "outside of one's body"
- Continually feeling on alert for threat or danger
- Unusually reckless, aggressive or self-destructive behavior

OVERLAP

- Difficulty concentrating and learning in school
- Easily distracted
- Often doesn't seem to listen
- Disorganization
- Hyperactive
- Restless
- Difficulty sleeping

ADHD

- Difficulty sustaining attention
- Struggling to follow instructions
- Difficulty with organization
- Fidgeting or squirming
- Difficulty waiting or taking turns
- Talking excessively
- Losing things necessary for tasks or activities
- Interrupting or intruding upon others

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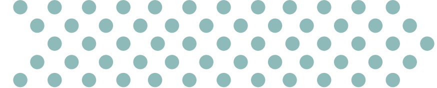
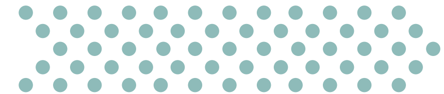


Material



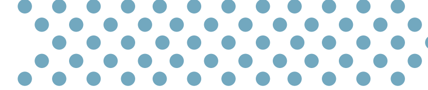
The specialist can make use of standardized tools which are useful but not decisive to guide the diagnosis.

Diagnostic tools for PSYCHOPATHOLOGICAL evaluation

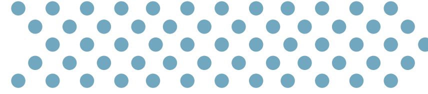
- K-SADS PL (Kaufmann 2016)
- MASC ** Multidimensional Anxiety Scale for Children (March, 1999)
- CDI ** Child Depression Inventory (Camuffo et al., 1992),
- CDRS –R** Children Depression Rating Scale (Pozwansky et al) (yrs 6-12)
- CBCL* Child Behavior Checklist (Achenbach, Rescorla 2005) (yrs 1.5-5)
- CBCL* Child Behavior Checklist (Achenbach, Rescorla 2001) (yrs 6- 18)
- CBCL- YSR** Child Behavior Checklist Self Report (Achenbach, Rescorla 2001) (yrs 11-18)
- CONNERS* Conners Parent Rating Scales long version (Conners, 2007)
- FAD Family Assessment Device (Epstein 1983)

Diagnostic tools for POST TRAUMATIC and stress response assessment

- TSCYC* Trauma Simptom Checklist for Young Children (J.Briere, 2005) (yrs 3-12)
- TSCC** Trauma Symptom Checklist for Children (J. Briere,1996) (yrs 8-16)
- CSBI* Child Sexual Behavior Inventory (Friedrich,1998) (yrs 2-12)
- IES-R** Impact of Event Scale –Revised (Weis, Mamer, 1996) (adolescent)
- PSI* Parent Stress Index (Abidin 1995) (yrs 3-19)
- CLES* Coddington Life Events Scales (R. Dean Coddington, 2009) yers 5-16
- ACE (ADVERSE CHILDHOOD EXPERIENCES) QUESTIONNARIE



Questions



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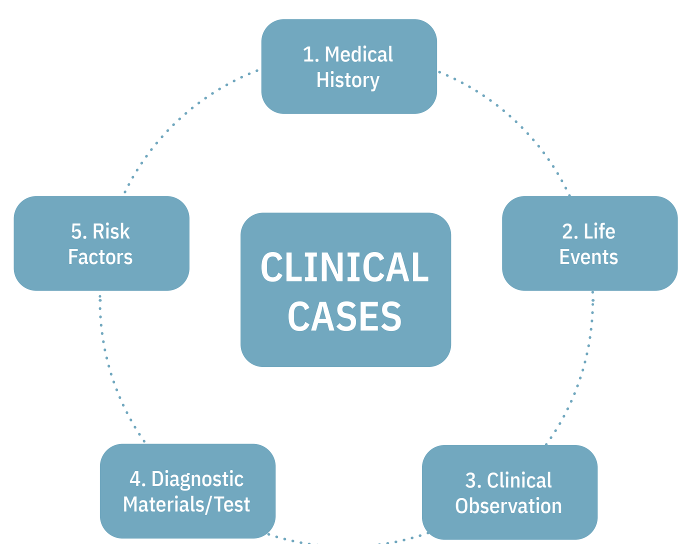
WHY NO ADHD?

SYMPTOMS ARE TRANSVERSAL TO MANY DISORDERS

Generally, the specialist must explore typical symptoms of ADHD and PTSD:

- Onset symptoms and identifies life events
- Inattention: investigate the type of underlying thought.
- Often seems to not listen the caregiver: dissociation symptoms?
- Hyperactivity: it always happens? Does he/she show hyperactivity in all social/scholar/family situations? How long has hyperactivity been present? Do you have hyperarousal?
- Trouble sleeping: frequent nightmares? How long have you been having trouble sleeping?

IN OUR CLINICAL EXPERIENCE:



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1. MEDICAL HISTORY:

Psychological tests and questionnaires are standardized measures of a psychological variables such as behavior, intelligence, emotional functioning or school ability. The tests/questionnaires support psychiatric/psychologist diagnosis and the specialist can help himself more in orienting the developmental profile of the child/adolescent

Example: Report Case (A. 15 years old)

*A. was born from a **normal pregnancy**, for emergency caesarean section (for reported beatings received), good condition at birth, placed in incubator, **no-aspiratory distress**, non-jaundice, **birth weight 4800** gr, no information about cranial circumference length and APGAR, breastfeeding up to 2 years old, weaning at 4/6 months without difficulties, take the first steps at 9 months without difficulties, first words at one year then language development in the norm, sphincter control at 12 months. **Regular sleep/wake rhythm**. Good alimentation no selective.*

Example: Clinical Case (G. 15 years old)

*G. was born **preterm in 37th week** from cesarean section for previous. Partial risk pregnancy placenta detachment in the first four months. Familiarity reported for glaucoma and bipolar disorder (along maternal family) and for sensorineural hearing loss (along paternal family). No information about cranial circumference length and APGAR. No sign of peri-neonatal suffering. **Birth weight 2890 gr**. Breastfeeding with weaning at 10 months.*
*Take the first step at 15 months, first words at 8 months. Sphincter control at 3 years with some difficulties. **No regular sleep/wake rhythm.** Good alimentation no selective.*

It's important to start getting information about the school FOR DIFFERENTIAL DIAGNOSIS

About school:
*Preschool: **separation anxiety and poor social initiative***
*Primary school (I and II classes): **no difficulties in learning, no reported hyperactivity behaviors or inattention problems***
Primary school (III – V classes): lowered academic performance, outbursts of anger, inattention, disorganization
Middle school: oppositional and provocative disorder, inattention, bullying, he failed the second class.
High school: poor respect for the rules, vandalism, theft, inattention

About school:
Preschool: difficulty tolerating frustration, inconsolable crying and restlessness.
Primary school (I and II classes): hyperactivity behaviors or inattention problems, some difficulties in learning.
Primary school (III – V classes): hyperactivity behaviors or inattention problems, disorganization
Middle school: oppositional and provocative disorder, inattention and poor compliance
High school: oppositional and provocative disorder, inattention problems, disorganization, bullying.

Some developmental aspects that can support differential diagnosis during this first part of evaluation.
Particularly:
- Sleep/wake rhythm in the first years of life
- Weight at birth
- Pre-partum difficulty

2. LIFE EVENTS:

The specific aims of the diagnostic assessment of the child/teenager are to identify the stated reasons and factors leading medical examination. The specialist obtains an accurate profile of the child's developmental functioning since the early years.

Example: Report Case (A. 15 years old)

-At 8 years old: half-brother 16 years old (whom his mother had with another man) was a murder victim perpetrated by the boy's father. A. witnessed the murder.
- Numerous ***episodes of conflict are reported intra family with frequent moments of aggression from the father towards the mother that the boy witnessed.***
- A. was brought in community where he stayed for about 8 months. He returned home with disinvestment academic study.
- At 12 years old: he lives in family home for 12 mouths.
- Subsequently: A. was brought in community with difficult repeated episodes of verbal and physical hetero-aggressiveness, escapes from the community with provocative adult figures, attitude of prevarication towards teenagers.

Performed blood tests in April 2020 with dyscontrol, irritability and flattening and affective flattening. ECG in the norm, for indication with Risperidone therapy insertion, not started.

NB. Restrictions period by Covid-19 he reported improvement in adaptive skills in the community context.

Example: Clinical Case (G. 15 years old)

-Reported parental stress with difficulty managing the child at home.
-Frequent punishments and episodes of physical and/or verbal aggression of parents in the face of lack of respect for the rules or during the performance of homework.

It is important to identify life events in the child's developmental history. However, this does not mean that all children get to have a PTSD profile

3. CLINICAL OBSERVATION:

A clinical observation is used by skilled specialists, doctors, psychologists, therapists in order to collect information about their patients or clients. They are observations of behavior from the clients that are used in order to determine a diagnosis and treatment plan. Typically notes are taken during the interaction with the clients or in some cases immediately after. Good clinical observation combined with a good knowledge of the developmental psychopathology becomes central to a correct diagnostic framework.

Example: Clinical Case (A. 15 years old)

A. appears shy and introverted. He makes himself available for dialogue with the specialist and shows good respect for the rules. The mood appears slightly bent. He doesn't object to the operator's requests. He reports that he does not like school and is not interested in continuing his studies. He reports the desire to go home to his mother

Example: Clinical Case (G 15 years old)

G. appears calm, willingly accepts the evaluation context and collaborates in the proposed activities. The boy shows ***oppositional and provocative behavior****. Tendency to blame the others and* ***difficulties in respecting the rules****. There is an easy distractibility and difficulty in tolerating frustrations. Response to the positive reinforcement present.*

It would be good to make more than one clinical observation since it is not always possible to identify the real symptoms of the child in the first meeting

4. MATERIAL-DIAGNOSTIC TESTS

Psychological tests and questionnaires are standardized measures of a psychological variables such as behavior, intelligence, emotional functioning or school ability. The tests/questionnaires support psychiatric/psychologist diagnosis and the specialist can help himself more in orienting the developmental profile of the child/adolescent

Example: Clinical Case (A. 15 years old)

The specialist administers the following tests:
- WISC-IV:
Total IQ 78; Verbal Comprehension Index 84; Reasoning Index Perceptual 82; Working Memory Index 88; Processing Speed Index 79.
- ABAS-2:
Composite General Index: below the mean (Composite Score: 77, 6th centile)
Conceptual Adaptive Domain: below the mean (Composite Score: 72, 3rd centile)
Social Adaptive Domain: below the mean (Composite Score: 70; 2nd centile)
Practical Adaptive Domain: in mean (Composite Score: 94, 34th centile)
- CBCL 6-18 (clinical and borderline scores are listed)
Rule Breakage Behavior: pT.87
Aggressive Behavior: pT.95
Internalizing Problems: pT.66
Externalizing Problems: pT.88
Total Problems: pT.75
Affective Problems: pT.66
Attention Deficit/Hyperactivity Deficiency Issues: pT.73
Opposition-Problems: pT.80
Conduct Issues: pT.90
Stress Post-Traumatic Stress Problems: pT.68
- CPRS (clinical and borderline scores are listed):
Opposition: pT.80
Anxiety/Shyness: pT.77
ADHD: pT.68
Inattention: pT.73
Hyperactivity-impulsive behavior: pT.70
- Academic skills
General difficult in read, write and calculation
- TSCC:
Absence of post traumatic clinical outcomes
- IES:
hyperarousal: clinical
- K-SADS-5:
Anxiety and dysfunctional behavior with response to difficulty in adapting caregivers over time (C-GAS: 50)

Example: Clinical Case (G 15 years old)

- SPM: QI 110
- ABAS-2:
Composite General Index: below the mean (Composite Score: 64, 1th centile)
Conceptual Adaptive Domain: below the mean (Composite Score: 70, 2rd centile)
Social Adaptive Domain: below the mean (Composite Score: 68; 2nd centile)
Practical Adaptive Domain: below the mean (Composite Score: 78, 7th centile)
- CBCL 6-18 (clinical and borderline scores are listed)
Anxiety/Depression: pT.68
Somatic symptoms: pT.66
Attention problems: pT.77
Rule Breakage Behavior: pT.90
Aggressive Behavior: pT.88
Internalizing Problems: pT.70
Externalizing Problems: pT.77
Total Problems: pT.75
anxiety Problem: pT.67
Internalizing Problems: pT.66
Externalizing Problems: pT.88l
Total Problems: pT.75
Attention Deficit/Hyperactivity Deficiency Issues: pT.88
Opposition-Problems: pT.90
Conduct Issues: pT.91
Stress Post-Traumatic Stress Problems: pT.69
- CPRS (clinical and borderline scores are listed):
Opposition: pT.80
Cognitive problem: pT.70
Hyperactivity: pT.69
Anxiety/Shyness: pT.65
ADHD: pT.82
Inattention: pT.90
Hyperactivity-impulsive behavior: pT.66
- Academic skills
General difficult in read, write and calculation
- K-SADS-5
Oppositional-provocative disorder and attention deficit hyperactivity disorder (C-GAS: 45)

It may happen that both ADHD and PTSD children score significant clinical scores in the same areas investigated. For this reason, the tests used must never be taken into consideration without taking into account the whole development profile

5. RISK FACTORS for Psychopathology

Psychological tests and questionnaires are standardized measures of a psychological variables such as behavior, intelligence, emotional functioning or school ability. The tests/questionnaires support psychiatric/psychologist diagnosis and the specialist can help himself more in orienting the developmental profile of the child/adolescent.

Example:

Case Report (A. 15 years old)
Individual Risk Factors
Parents' lack parenting skills
Parental thoughts and emotions that tend to support or justify maltreatment behaviors
Family Risk Factors
Social isolation
Parenting stress, poor parent-child relationships, and negative interactions
Community Risk Factors
Concentrated neighborhood disadvantage, and poor social connections

Example:

Case Report (G. 15 years old)
Family Risk Factors
Familial from maternal line for ADHD

Families are not always able to report what are the risk factors even if requested by the clinician. in this case It is also good to be supported by a good clinical observation

Example: P. born in 2012 First visit in July 2018 (6 years) for relational closure and hyperactivity, sent by the teachers of the kindergarten

Anamnesis

Second of two children. Normal Pregnancy. Natural birth. PN 3150 gr. Not referred to perinatal suffering. Breastfeeding up to two years. Normal weaning. Developmental steps: autonomous walking at around 14 months; marked language delay with first words at 3 and a half-year. Never performed rehabilitation treatment. Insertion in the regular nursery school. Good socialization even if the mother has always reported little expression of emotions, irritability, impetuous and sometimes hetero-aggressive behavior towards equals.

Life events P. lives with his mother, grandmother and maternal aunt. Conflictual relationship between the brother 19 years old, who lives with P. until the age of 13, and P.'s mother who is not the natural mother of the firstborn.

The P.'s parents split up in October 2017 as result of a violent argument between the oldest son and the father; the mother leaves home to protect the child from these discussions. The oldest child is left to live with his father. Patrick sees his father every fortnight. The mother reports that after being the weekend from his father the child during the night feeling itchy at the base of the coccyx up to get bruises. Days later the child was in the bathroom and while Mom wiped Patrick has made repeatedly willy touching movements.

Questions about where had seen this gesture, the child initially reluctant responds that it was the older brother when the father was not present in the house.

Clinical Diary

1st visit

Clinical Examination

The child is partially available. It presents marked restlessness on the attentional, motor level and impulsiveness Adequate language in the lexical and immaturity in morphosyntactic component. No difficulties on the motor level

Material	Results	NOTE
Leiter 3 (Cornoldi et al., 2016)	No verbal IQ: 78	
ABAS-2 Adaptive Behavior Assessment System – Second Edition	General Adaptive level: 10° centile Conceptual: 32° centile Social: 27° centile Practical: 3° centile	
CBCL 6-18_Child Behavior Questionnaire (CBCL 6-18; Achenbach, 2001)	- Activity: T score 23 - Social competences: T score 32 Syndromic scales: - Anxiety and depression: T score 62 - Withdrawal and depression: T score 66 - Somatic complaints: T score 53 - Social problems: T score 51 - Thought problems: T score 50 - Attention problems: T score 57 - Rules violation behavior: T score 50 - Aggressive behavior: T score 50 General scales: - Internalization: T score 63 - Outsourcing: T score 40 - Total Problem Scale: T score 50 Scales based on the DSM IV classification: - Affective problems: T score 56 - Anxiety problems: T score 65 - Somatic problems: T score 57 - Attention problems and hyperactivity: T score 51 - Oppositional-provocative problems: T score 50 - Conduct problems: T score 50 - Slow cognitive processing problems: T score 68 - Obsessive-compulsive problems: T score 55 - Post-traumatic stress problems: T score 62	Even if in reality the child is sent for externalizing symptoms, the scales that are clinical are those of internalizing disorders.
TSCYC (John Briere, 2001)	Anxiety: T score 71 Depression: T score 56 Anger: T score 41 Post Traumatic-Intrusion: T score 44 Post Traumatic-Avoidance: T score 110 Post Traumatic -Arousal: T score 58 Post Traumatic -Tot: T score 73 Dissociation: T score 45 Sexual concern: T score 46	

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Material	Results	NOTE
K-SADS-PL (Kaufman, 2004) - diagnostic interview for the assessment of psycho-pathological disorders in children and adolescents.	Irritability anxiety disorder with feelings of despair and cried for apparently trivial situations; easy suggestibility in front of sudden noises. Some episodes restless sleep during the development period of a week alternating with periods of regular sleep. Irregular supply with intermittent appetite since he started school. He need reassurance in new situations and at home with his mother for homework, from the elementary. Isolations traits and easy distractibility with episodes of daydreams, in a month appears 1/2 times a week. They are always associated traits of the disorder attention deficit hyperactivity disorder characterized by loss of objects, motor restlessness, impulsiveness, he passes from one activity to another. Intolerance for frustration. He asks things insistently, and sometimes tells lies to strong daydream.	The symptoms of emotional dysregulation associated with traits of anxiety also from separation are detected. There are moments of enchantment that recall the avoidance symptoms. The symptoms of ADHD fit into this anxious and attachment responsive, reactive functioning
C-GAS (Children Global Assessment Scale)	pg.60	
Diagnosis Adaptation disorder to reassess the cognitive profile **Treatment** Individual psychotherapy (also with EMDR approach) Therapy in the mother-child relationship		
FOLLOW-UP		
WISC-IV - Wechsler Intelligence Scale for Children, Fourth Edition (tara ita Orsini et al., 2012)	IQ Total: 96 Verbal Comprehension Index: 84 Perceptual Reasoning Index: 100 Working Memory Index: 103 Processing Speed Index: 106	
ABAS-2 Adaptive Behavior Assessment System – Second Edition	Conceptual: 47° centile Social: 10° centile Practical: 34° centile General Adaptive level: 30° centile	

Material	Results	NOTE
CBCL 6-18_Child Behavior Questionnaire (CBCL 6-18; Achenbach, 2001)	Syndromic scales: - Anxiety and depression: T score 67 - Withdrawal and depression: T score 73 - Somatic complaints: T score 57 - Social problems: T score 60 - Thought problems: T score 51 - Attention problems: T score 59 - Rules violation behavior: T score of 50 - Aggressive behavior: T score of 53 General scales: - Internalization: T score 70 - Outsourcing: T score 50 - Total Problem Scale: T score 60 Scales based on the DSM IV classification: - Affective problems: T score 65 - Anxiety problems: T score 65 - Somatic problems: T score 61 - Attention problems and hyperactivity: T score 56 - Oppositional-provocative problems: T score 55 - Conduct problems: T score 50 - Slow cognitive processing problems: T score 65 - Obsessive-compulsive problems: T score 55 - Post-traumatic stress problems: T score 69	
TSCYC - Trauma Symptom Checklist for Young Children (tara ita a cura di Pessina et al., 2015)	Anxiety: T score 58 Depression: T score 52 Anger: T score 41 Post Traumatic-Intrusion: T score 43 Post Traumatic-Avoidance: T score 78 Post Traumatic -Arousal: T score 65 Post Traumatic -Total: T score 65 Dissociation: T score 64 Sexual concern: T score 46	Post traumatic symptoms are decreasing.
Diagnosis Adaptation disorder in positive evolution In normal cognitive profile **Treatment** Individual psychotherapy (also with EMDR approach) Therapy about the mother-child relationship		

Reasoning on the case

- The diagnosis made was not ADHD but considered a reaction to environmental stress conditions
- Fundamental in the diagnosis was based on multidimensional structure, because the child met DSM 5 criteria for ADHD and not those for PTSD
- The positive clinical trend confirmed that the dysfunctional nucleus was the post traumatic contents and the response to stress
- It was therefore important to focus the treatment on the emotional regulation component and on attachment rather than on behavior management (as in ADHD)

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Example: A born in July 2013. First visit in October 2019 (6 years) for hyperactivity and disruptive behavior and oppositional defiant disorder, sent by the teachers of primary school

Anamnesis

Adopted at the age of 3 and a half (first up to the age of a year and a half he was with his mother in conditions of promiscuity then in a family home).

At the time of adoption reported agitation and aggression especially towards the figure maternal, presence of escape behaviors, hyperactivity, difficulty in following shifts and rules and marked traits of opposition.

Previous diagnosis of post-traumatic stress disorder in another service at 5-year.

Linguistic development apparently normal.

Sphincter control acquired at the time of adoption.

At the entrance to elementary school he reported worsening of behavioral aspects with an increase in aggression hetero direct with pantoclastic crisis and escape behaviors and hyperactivity.

In the last few months, the adoptive parents had gone through a period of crisis with the possibility of separation, then returned.

Clinical Diary

1st visit

Clinical Examination

No motor or language disorders. The child presents marked emotional and motor dysregulation with adult-morphic aspects, tendency to enter into symmetry with adults. Tendency to use swear words. Opposition, mistrust, poor tolerance to rules and frustration.

Material	Results	NOTE
WPPSI-III - Wechsler Preschool and Primary Scale of Intelligence, Third edition (tara ita a cura di Sannio Fancello and Cianchetti, 2008)	Total IQ: 116 IQ Verbal: 100 IQ Performance: 102	
ABAS-2 Adaptive Behavior Assessment System – Second Editionw	General Adaptive level: 16° centile Conceptual: 13° centile Social: 21° centile Practical: 21° centile	

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Material	Results	NOTE
CBCL 6-18_Child Behavior Questionnaire (CBCL 6-18; Achenbach, 2001)	- Activity: T score 35 - Social competences: T score 29 - Scholar competences: T score 40 - Total Skills: T score 28 Syndromic scales: - Anxiety and depression: T score 72 - Withdrawal and depression: T score 50 - Somatic complaints: T score 53 - Social problems: T score 60 - Thought problems: T score 58 - Attention problems: T score 61 - Rules violation behavior: T score 72 - Aggressive behavior: T score 86 General scales: - Internalization: T score 65 - Outsourcing: T score 77 - Total Problem Scale: T score 72 Scales based on the DSM IV classification: - Affective problems: T score 65 - Anxiety problems: T score 68 - Somatic problems: T score 57 - Attention problems and hyperactivity: T score 62 - Oppositional-provocative problems: T score 77 - Conduct problems: T score 76 - Slow cognitive processing problems: T score 50 - Obsessive-compulsive problems: T score 60 - Post-traumatic stress problems: T score 64	There is a mixture with aspects of anxiety and humoral dysregulation associated with disruptive and oppositional provoca-tive behaviors.
TSCYC (John Briere, 2001)	Anxiety: T score 68 Depression: T score 54 Anger: T score 84 Post Traumatic-Intrusion: T score 75 Post Traumatic-Avoidance: T score 58 Post Traumatic - Arousal: T score 61 Post Traumatic - Tot: T score 65 Dissociation: T score 45 Sexual concern: T score 79	

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Material	Results	NOTE
K-SADS-PL (Kaufman, 2004) - diagnostic interview for the assessment of psycho-pathological disorders in children and adolescents.	Reactive attachment disorder characterized by episodes of unjustified irritability, repeated changes by primary caregivers that have limited its ability to develop stable attachments, persistent lack of social stimulation appropriate to chronological age (up to the age of four and a half). The exposure to direct and indirect threatening events for which recurrent unpleasant memories are present are associated sensations that can be traced back to unpleasant events in which A. seems to act as if the previous events were recurring (abandonment and separation from the reference figures). Marked physiological reactions to internal or external triggers that symbolize some aspect of the traumatic event. Persistent negative emotional state (anger and fear), behavior reckless or self-destructive and hetero aggressive (in particular towards the female figures), hypervigilance concentration problems and exaggerated alarm responses. Immediately after the adoption this symptomatology was frequent and associated with alterations of the sleep.	Presence of post-traumatic clinical outcomes, specially anger aggression, intrusive and sexual thoughts.
C-GAS (Children Global Assessment Scale)	pg.50	
DIAGNOSIS Complex post-traumatic disorder Mixed adaptation disorder of conduct and emotions **Treatment** Individual psychotherapy pathway to promote emotional and behavioral regulation (with EMDR approach) Parenting support path Consulting at the school Support teacher AEC Evaluate insertion of pharmacological therapy		
FOLLOW UP FEBRUARY 2020 (4 MONTHS LATER) The planned treatments were carried out Persistent marked dysregulation in all life contexts at the point of reduced school timetable Therapy with Methylphenidate 10 mg is inserted FOLLOW UP APRIL 2020 (2 MONTHS LATER) Good control of behavioral crises at school which however was interrupted due to Covid-19 emergency Important improvements in the intra-family environment.		Merit of the Metifenidato, which reduced to the component of emotional dysregulation and impulsivity or of the Covid-19, which led to reducing the school stress factor and increased the level of attachment by increasing the time spent at home with the parents. The question is still open to me it is paradigmatic that several factors can simultaneously influence.

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