

# Supporting the Child Dog Bite Victim

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*"Dog bites are the second most costly public health problem in the United States with half of all Americans being bitten in their lifetime". - Hoff GL, Cai J, Kendrick R, Archer R. 2005. Emergency department visits and hospitalizations resulting from dog bites, Kansas City, MO, 1998-2002. Mo Med 102(6):565-8. Other references available upon request; References documented where necessary, however for most information verified, please see CDC reports including yet not limited to: Fatal and Non-fatal injuries, 1999-2012; CDC records: Dog bite injuries, reports in United States, 1998-2011.*

## **Introduction, general and statistical information:**

Dog bites are one of the most common traumas experienced by people of all ages, more than War trauma even, yet there remains little in the literature which addresses the psychological consequences or the caregiver support of such traumatic experiences.

The basic, statistical information regarding children per the 2011 CDC account, reveal that for reported dog bites, Fifty percent are eight years of age or younger, with boys being the victims 61% versus girls (33%). Additionally, per the CDC accumulated data, from 2005-2011 with respect to the five-to-nine age range group, dog bites have consistently remained in the ten leading causes of non-fatal, traumatic injuries, although the actual numbers of bites to children have declined to a degree in the United States, since 2008 (review of data, CDC statistical accounts, all non-fatal, traumatic injuries, 2005-2012) with 2012 accounts indeterminate at this time.

Further information bears out, with respect to other potentially traumatic or injurious events which also affect large numbers of children, that the 7.9 million U.S. children who received emergency medical care for what is termed "unintentional" injuries, overall (APA, 2008) that these occurrences comprise motor vehicle crashes, falls, fires, dog bites, near drowning, unintentional poisoning, insect stings, bicycle injuries and others; and as a separate grouping, more than 400,000 for injuries sustained due to violence, apparently relating to community as opposed to home violence, although this is not clearly differentiated in this document (APA, 2008 Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents). These are staggering numbers of course, in particular when one considers the four and one half million, reported dog bites per year per the CDC reports. Of those 4.5 Million reported, nearly nine hundred thousand of those bitten (roughly 889,000, about one-fifth, or 20%) required medical attention. Of those necessitating medical attention, 31,000 required reconstructive surgery as a result of the dog attack for all age groups (or 3.5% of those requiring medical attention). Given the substantiality of the CDC and APA data this would

suggest if one's child has suffered this particular, traumatic experience that, as a parent one is certainly although not alone, and may seek help with Doggone Safe ([www.doggonsafe.org](http://www.doggonsafe.org)) as well as other, alternative organizations. In addition this may indicate that specific, mental health care is more likely to be available for your child and, if needed, yourself and your family.

Comparing dog bite as a violence to exposure to community violence, the CDC estimates rates of witnessing community violence for children range widely from 39% to 85%, dependant primarily upon living arrangement (rural versus urban locations, for example). The rates for any, actual victimization in childhood are 66%, however that of exposure to sexual abuse is estimated to range from 25% to 43% seemingly, comprising a fairly, substantial majority. Statistically, exposure to natural disasters for youths are lower than that of other traumatic experiences, however once a disaster has materialized, large portions of the population will be exposed simultaneously. Children and adolescents have likely comprised a considerable proportion of the nearly 2.5 billion people affected worldwide by disasters in the past decade. In any event, exposure to dog bite or mauling is not only common, additionally the likelihood of development of Post Traumatic Stress Disorder or other Anxiety or Mood disorder, is not significantly altered from that of exposure to community violence or that of natural disaster.

#### **A Note to the Caregiver:**

The use of the term "personal" throughout this writing with respect to the child survivors traumatic dog bite or attack is purposeful, my own opinion, not referenced in the literature to my knowledge, and the rationale behind such terminology is illustrative of the uniqueness of the experience and the difference between such a trauma versus other traumas occurring to children. The child who has survived the dog attack as opposed to those who experience a natural disaster or community violence for example, certainly may as individuals experience their trauma as 'personal'. However in the former example, the children have been exposed *en masse*, as described above, statistically and have brought about in the United States and other Nations, numerous and sundry communities of aid to such children. With children exposed to community violence, again which may feel as a personal trauma, there exist Government as well as private, both for profit and nonprofit, organizations in place to assist such children with additional, legal barriers, whatever their efficacy may be, in order to protect such traumatized children. For the child dog bite victim, resources do exist, although are present for the caregiver to discover via word of mouth or internet, typically, without Government or legal assistance.

Despite the statistic that the child survivor of a dog bite is not alone in his experience like the victim of violence, he remains isolated and solitary with respect to his trauma, hence and to some degree, on one level, I use the term "personal".

The use of my term 'personal trauma' is not necessarily with regards to the type of injury sustained although, it may be in some cases as simple as that. Generally these terms point to a larger picture with respect to dog bites as more of a social problem as well as the often, lack of interpersonal peer group support for the survivor. This is similar to for example, the child survivor of sexual abuse until roughly the early 1980's after the National Abuse Coalition had been created and subsequently Megan's Law in 2004. Once the topic became open for healthy discussion by whomever the abuse survivor trusted, she became less isolated, and was better able to heal from her trauma. Following that, it became less "personal" in my opinion, and more of a "trauma". Dog bite Laws and support are in their infancy with the children survivors being, as in the sexual abuse survivors of more than a decade ago, those who are now isolated despite the prevalence. Hence my use of "personal", with the multilevel of meaning and significance.

## **Part II**

### **If Your Child has been bitten**

#### **Mental Health Care:**

In order to be accommodating in a healthy manner after such a trauma it may be important for your child to seek mental health assistance after an attack if deemed warranted by you as the parent. However, and not as obvious to most adults, it may also be important to discuss such medical options as well with the child survivor, dependent upon multiple issues, to include the child's age, yet also dependent upon the presence or absence of residual problems relating to the attack, which are topics addressed further in this document. These matters would be no different than if, as a parent you had discovered that your child had experienced a form of community violence or sexual assault, for example. Under such circumstances safety measures would be of paramount importance in order to protect any child. Dog bites and attacks are not significantly different, as far as traumatic experiences are concerned and may carry similar, weighty long-term effects as aforementioned. However the child, as with the sexually abused victim, has experienced a traumatic loss of control of their body among other issues. Such discussion might be a prudent course of action at a minimum in order to inform them, if not allow them the choice, should this be a reasonable course of action, of the necessity for mental health guidance.

Children and families are not always emotionally or financially prepared for treatment when it is offered and some may prefer not to engage in treatment at all. Whether in the immediate aftermath of a dog bite or if ongoing symptoms are identified by a professional, the help offered by mental health professionals may not come available at the appropriate time for that

child or family. For example, if one's child has been attacked, and there is an ongoing legal matter precluding mental health needs for the survivor and family, due to time or financial constraints yet the child is exhibiting conduct or school performance problems, such issues may to a degree, go unnoticed by the family. Not due to any faults or blame however, such unobserved behavioral changes would be quite common under the circumstances. Once the hypothetical legal matter has been resolved at least a year or several years have passed, which at that point, in this example, the survivor has aged and developed in a pathological manner with, now far more resistant mental health difficulties. Psychiatric treatment may be of import, particularly when traumatic events have led to other stressors or secondary traumas, such as when the family may be focused on coping with other problems before they have the energy or resources to turn to mental health needs, as in the previous example.

As aforementioned, if there are symptoms of a certain severity in the child survivor, if any family member suffers from psychiatric distress, if the child themselves wish to seek treatment for any reason whatsoever, or finally, if a professional takes note of issues which are problematic and offers appropriate referral, the most prudent course would be to avail the child and family of such assistance regardless of the secondary stressors such as ongoing medical or legal matters. By symptoms of certain severity, this means psychological or behavioral indicators or changes in the child that are interfering with their social or school functioning such as failing to attend to personal hygiene, poor school performance, or alterations in their interactions with their peers (isolation from, or aggression toward), to name a few examples.

If treatment is not feasible or necessary at that time, it is important for the caretaker to inform children and other family members about the psychiatric treatment options and to advise the child that treatment is available to them in at any time in the future, in the event that they feel more receptive or require it at a later time. Treatment options should include both psychiatric, meaning an M.D., who is a physician, Board certified in Psychiatric Medicine as well as a therapist. A therapist includes a psychologist which is a PhD in psychology, or a social worker which is usually an MSW or LCSW, among others. The treating provider, if possible, should not only be specialized in the care of children, yet also have experience with treating traumatized individuals, which depending upon where one is located is not always possible. Most importantly, maintain the options for treatment open for the child essentially until adulthood, also for yourself and your family. It is a prudent course of action to keep the contact information readily available and accessible as well.

### **Acute and Chronic Phases:**

The basic issue is that after any, single trauma in a child particularly those age nine and older, is that most are resilient and will recover emotionally within weeks to a few months. This is not to say that they have 'forgotten' what has happened or that it does not distress them, it simply means that they have coped with the event and usually require no further assistance or attention to the matter, emotionally. The most effective strategy one can offer their child in the immediate aftermath is to be supportive in whatever needs fit the manner of the child's

necessity of the time if they initiate such actions. Depending upon the age of the child, some examples might include re-playing the dog bite with their toys, talking about a bad dream of the attack, or how they are treated by others, for younger children. Talking about the attack itself and how they feel about it, might occur in older children. Another strategy is to remain problem-focused on the present in the initial phase of healing. Discussing initially with the child, in a compassionate yet problem solving manner their current issues such as social problems, where their scars are concerned, without deliberating the future of surgeries or wearing makeup if it is a younger child, can be a way to remain problem-focused, for example. The idea being to allow the child to develop their own method of coping with the parents support, devoid of judgment or opinions and without becoming overly concerned with the future, or complicating their concerns with the parents own feelings. The child can learn to make their own decisions about their bodies for example, again in a safe environment with their caregiver. Should the child survivor have difficulties with problem-solving during this acute or immediate phase after the trauma, despite the caregivers efforts, it may be important to revisit the option to seek mental health guidance at that time for assistance, such that the child may still be able to maintain their own independence in control-related matters.

### **Part III**

#### **Other Associated Variables with respect to the child survivor:**

Depending upon the age of the child many behavioral changes after an attack may evolve as they cope in the best manner they are able, given that their central nervous system remains undeveloped until around age twenty-one, along with their recent, shocking and personal traumatic experience. Age-related conduct and emotional issues having more similarities, and which may essentially may be divided into groups, with the youngest being infants and toddlers up to about eight years of age; Young children being Nine years of age into roughly their middle teens, usually between age 12-17 for boys and age 11-17 for girls, coinciding with their pubertal changes; And lastly, older children who are pubescent, again in their middle teens until age 18 to 21 depending upon many factors, such as actual maturity level, other mental illnesses or developmental delays. Regardless of the age category, such changes may continue based on several factors, which may include younger age, female gender, previous trauma (dog bite or other), additional psychiatric disorders (Attention disorders, depression), and problems associated with one or more parent (alcoholism, depression). However the primary factors which affect long-term problematic mental illness or behavioral difficulties in children after dog bites include age under age nine, and whether or not one or both parents behave in supportive ways.

In particular, younger children, those nine and under in particular, may abruptly, after the attack, develop new bodily complaints (stomachaches, headaches for example) and fear of being separated from their parents (separation anxiety or some of the symptoms), yet other,

new changes may occur as they attempt to manage this latest stressor in their lives which may or may not include a physical transformation such as scars, in addition to the emotional burdens of the event. Also, at any age they may develop sleep disturbances (trouble getting to, staying asleep or early awaking). Although not all children become fearful of dogs after dog attacks, similarly not all children are phobic of riding in a car after surviving a motor vehicle crash, yet phobias of not only dogs, yet other fears that were not present previously (open or closed spaces, social fears other than that of separation anxiety) may become manifest at this time. In addition, other signs may develop at any age, such as observable sadness, even if the child is unable to articulate the emotion, a loss of interest in their previously enjoyed activities, decline in schoolwork, obstinate conduct toward the caregiver, teachers or peers; anger or temper issues and irritability, as well as other changes in conduct which may be more subtle.

Many changes may become manifested as what is known as 'negative symptoms' which are more difficult to perceive and communicate to healthcare professionals. Such changes may be behaviors such as socially withdrawing, seeming emotionally 'distant' in that the child may state that or appear as though they no longer "feel anything" whether sadness or joy; or seem cold, detached or virtually robotic in their interactions. Should such negative symptoms occur the child survivor requires mental health attention regardless of the presence or absence of any other symptoms as soon as possible, if not already done so and the professional need be alerted to such emotional symptoms. These 'negative' symptoms are not always, yet certainly associated with Post Traumatic Stress Disorder in a substantial percentage of traumatized individuals.

### **Emotional and control issues:**

Outside of educating oneself what is important for the parent to accomplish is to listen quietly, compassionately and without judgment and to encourage the child to speak whenever they wish ideally, about the event. Despite the caregivers very real and significant feelings about the trauma, which may involve guilt, anger, frustration, fear, worry, and can include PTSD as well as other mental health issues as a result of their own trauma, and all of which need be dealt with privately with the parents own mental health provider, is to keep in mind that the child has suffered a significant and personal trauma as well, has a multitude of feelings regarding this event; as does the parent who is usually better equipped, emotionally to handle such adult-related events. Yet with respect to a child under the age of twenty-one, the nervous system is un-developed and in most cases, has far less life experience to cope with traumatic events. In addition, it may be beneficial to keep in mind that the child has suffered not only a tremendous personal event, yet also a loss of control at a young age when coping with such adult issues is simply not in their emotional repertoire. If one can reflect upon one's own state of mind at a

similar age with the assistance and approval of one's therapist, it might be beneficial to consider not only for the child survivor yet also for oneself.

When possible and when the decision does not interfere with the child's physical wellbeing, giving them back some of that control can be quite valuable to the survivor. For example, if at some point scar revision as a result of the attack becomes an issue as a result of the child's medical assessment and depending upon the age and maturity of the survivor, at least a voice in the matter should be considered valid. Oftentimes children receive reconstructive operations, without their voices being heard, due to the physician's discretion primarily and also parental distress about their child's scars or deformity, a reminder to the caretaker yet not necessarily to the survivor, of the traumatic experience. Certainly this is true for a variety of pediatric surgical situations, however with dog bite survivors there remains a significant difference. For example, a child receiving a tonsillectomy, appendectomy, and so forth has not experienced an extreme traumatic event. In addition, the hypothetical child in this example is receiving a surgical procedure necessary to sustain life, as opposed to the dog bite survivor who would be the recipient of a non-emergency, elective operation. In any event, in such circumstances a reasonable manner to approach the topic, depending upon the age and the individual child, would be to simply in an age-appropriate manner, ask if the revisions are within their wishes at the present time and how they feel about their scars. It is a very personal issue and providing them with some control again can be for many children, of vital import. The matter is certainly one that is regarding the traumatic event to the child at least, and involves their own body, regardless of their age.

Additionally, once it is medically reasonable, subsequently reestablishing usual household routines can be of benefit for the survivor and also the caretaker. Disruption of school, playtime and vacations may exacerbate and even draw further pathologic attention to disturbing issues that are of concern to the child and family as well. Reinstitution of patterns are, as in any commotion, a beneficial practice. Along similar lines are to include avoidance, if possible, of interference of legal issues or those of loss, to the child.

Interfering problems, such as matters of loss, may include of the loss of the family dog if this is the attack culprit. The decision of course, should be made on a case by case basis certainly, with the child's opinion heard as usual and when in doubt, taken into consideration. The strength of their ballot so to speak, as with any loss, being more so depending upon their age and maturity level, rather than their physical injury level or immediate, emotional components. A reasonable rule of thumb is to seek professional guidance on this issue, if it arises, as such a decision warrants perhaps, outside objective thoughts and considerations beyond that of the authority figures who may be acting to some degree, out of, understandably their own anxiety. In addition, seeking some professional mediation may dampen any potential ill feelings within the family dynamics during a time when cohesion is of far more import.

### **Caregiver/Parental concerns:**

Parents are affected by their children's exposure to traumatic events and their own responses and behaviors may often adversely affect the child. If a parent begins to feel sad, anxious, or begins to experience any behavioral changes themselves, these changes in conduct as with any situation, would quite likely affect the child survivor as well. Taking care of oneself as at any time is essential to taking care of one's child during such a difficult time.

Every child reacts to trauma in his or her own way and it is imperative to listen and attempt to understand their unique perspective and concerns and take those to heart. As a parent, as with anything relating to the safety of one's family, being knowledgeable with respect to the survivors issues, are imperative matters of concern which are significant, weighty issues. In addition, arming oneself with a supportive, emotionally healthy manner and demeanor with an open attitude, for enduring stability is the most beneficial approach for the child, yet also for oneself. In order to accomplish such feats after ones child has suffered any trauma, in particular one with the statistical data as presented above, requires substantial coping abilities within oneself. If the parent suffers from a pre-existing condition, depression or anxiety disorder, in particular PTSD, then seeking a mental health care provider is essential for the caregiver immediately after the attack. Generally it is the caregiver more so than the child survivor at some point who understandably, requires psychiatric and oftentimes psychological assistance, given the burdens and suffering of the uniqueness of the parental trauma after their child has been bitten.

### **Conclusion:**

As aforementioned, children can benefit by coping using their own methods which they've used previously for other stressful situations. Children particularly those age nine and older, are resilient and the use of their own coping is one of the reasons for such resiliency. During their lives they may have managed with a variety of issues such as parental divorce, new siblings, relocation, or illnesses of parents, family members, peers or themselves, and so forth. Although to the average adult such events may not seem as though they are major stressors comparable to the dog attack, these experiences have often provided the child with insurmountable obstacles yet also with invaluable skills along with their caregivers, which they need at this time, post-dog bite. While handling their struggle with their new, traumatic occurrence, using their accustomed and familiar skills they are able to adapt these proficiencies and develop improved competencies as a result. With the aid of supportive, healthy parental guidance the child survivor can learn and evolve their preexisting coping strategies. Those who find this early

phase problematic require professional assistance, which is best sought through a mental health provider who with the parents, may lead them through a new set of coping strategies that the child can then incorporate into their repertoire of expertise of adapting to their new, unique set of situations that have now arisen as a result of their traumatic experience.

### **About Dr. King**

*Michelle R. King, M.D. is a recently, retired physician, who was nearly mauled to death as an eleven-year old child, with subsequent, multiple reconstructive operations. She went on to undergraduate, graduate and medical schools, then residencies in Family Medicine, Neurology and Psychiatry. More recently, over the last two decades, she worked primarily with PTSD patients, predominantly with combat veterans from the Vietnam and Korean Wars. In her private office Dr. King has worked with both traumatized Veterans as well as distressed civilians as a result of dog bites and attacks, as well as those who are survivors of the violent, modern world. Dr. King continues to this day rescuing homeless and abused dogs.*