

T RAUMA- AND STRESSOR-RELATED DISORDERS

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Introduction

Trauma is a lasting adverse effect on an individual caused by an event that involves threat or danger. Events are not traumatic simply because they involve violence; instead, an individual's perception of threat or danger is what can cause trauma (Berliner, 2013). According to the DSM-5, trauma can result when an individual directly experiences an adverse event, witnesses that event, or learns about it from others.

Exposure to trauma is very common. Each year, approximately 60 percent of children experience at least one trauma, with about 22 percent of these youth experiencing four or more different types of traumas (Finkelhor, as cited by Berliner, 2013). Because a significant number of youth experience some type of traumatic incident during childhood, it is critical to identify definitions of, risk factors for, and outcomes from exposure to trauma (Copeland, Keeler, Angold, & Costello, 2007).

Early researchers noted that exposure to trauma may lead to feelings of anxiety, helplessness, dissociation (detachment of the mind from emotion), and behaviors, including hypervigilance (watchfulness or awareness of one's surroundings over and above what is normal), efforts to avoid re-experiencing the traumatic event, and even self-inflicted injury (Yates, 2004; Thomas, 2003). While these symptoms may be consequences of trauma, they do not always occur following trauma. Additionally, risk factors can moderate the influence of trauma as well as the development of psychopathology.

Trauma- and stressor-related disorders are those disorders precipitated by events or circumstances that overwhelm the child or adolescent and that often threaten or cause serious injury, neglect, or death (American Psychiatric Association [APA], 2015). This section will discuss trauma- and stressor-related disorders and focus on the assessment and treatment of these disorders.

Definitional Considerations

Beginning in the 1970s, psychologists began to examine the experiences of individuals who have experienced traumatic events, with research focusing on both soldiers returning from war and rape victims (Copeland, Keeler, Angold, & Costello, 2007). This work has contributed greatly to the understanding of psychopathology (van der Kolk et al, 2005). However, early research was limited in that it focused almost exclusively on individuals in the military who experienced traumatic events outside of their home community and ignored the experiences of traumatic events in everyday life, including their effects upon children (Karam & Ghosn, 2003). Additionally, early definitions of trauma emphasized the individual directly experiencing the violent act, such as military personnel in war or rape victims (Copeland, Keeler, Angold, & Costello) and discounted the distress experienced by those who did not directly experience the trauma, such as a family member witnessing domestic violence (Evans, Davies, & DiLillo, 2008). The definition of trauma was subsequently broadened due to the recognition that indirect experiences can be traumatic, youth also experience trauma, and youth respond to trauma differently than adults (Carrion, Weems, Ray, & Reiss, 2002).

Recent Changes from the DSM-IV to the DSM-5

In 2013, the American Psychiatric Association released the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. The *DSM-5* reorganized trauma- and stressor-related disorders into a new category. Changes were made to differentiate these disorders from anxiety disorders as well as restructure and modify various factors and symptoms (Jones & Cureton, 2014). Posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) were formerly categorized as anxiety disorders but are now included as trauma- and stressor-related disorders. This category reconceptualizes various diagnoses as stress-response syndromes in reaction to specific triggering events (Kurtz, 2013). The diagnoses now included in the trauma- and stressor-related disorder category are:

- PTSD
- ASD
- Adjustment disorder
- Reactive attachment disorder (RAD) (diagnosed only in children)
- Disinhibited social engagement disorder (DSED) (diagnosed only in children)
- Other specified trauma- and stressor-related disorder
- Unspecified trauma- and stressor-related disorder

The most significant changes in the *DSM-5* were to the PTSD and ASD criteria, including the removal of the *DSM-IV* requirement of feelings of “fear, helplessness, or horror” in reaction to the traumatic event (APA, 2013; APA, 2000). Changes relative to just PTSD include the inclusion of two new variations (Preschool subtype and Dissociative subtype) and the addition of new symptom clusters. Additional changes included in the *DSM-5* will be discussed in the paragraphs that follow.

The *DSM-5* is a manual for assessment and diagnosis of mental health disorders and does not include information for treatment of any disorder. In the future, more evidence supporting treatments of disorders with *DSM-5* classifications will be available as clinical studies utilizing *DSM-5* criteria are completed. As a result, this *Collection* will reference studies that utilize *DSM-IV* diagnostic criteria to explain symptoms and treatments.

Prevalence

It has been difficult to come to a consensus on the prevalence of trauma among children. Evans, Davie, and DiLillo (2008) estimate that each year 4.8 million acts of violence are committed against women and 2.9 million acts of violence are committed against men. Not only do these experiences have a profound effect on these individuals, they may also affect others, including children exposed to this violence. It is

estimated that each year 17.8 million children are exposed to domestic violence, either as witnesses or as targets (Evans, Davies, & DiLillo). Moreover, retrospective data suggests that 20 to 40 percent of adults witnessed domestic violence as a child or adolescent (Evans, Davies, & DiLillo).

Two-thirds of American children and adolescents report experiencing trauma, with 33 percent of youth experiencing multiple traumas before reaching adulthood (Cohen & Mannarino, 2015). In a large epidemiological study of trauma and PTSD in youth, 68 percent of 16 year olds reported exposure to at least one traumatic event (Copeland, Keeler, Angold, & Costello, 2007). Of those, 37 percent reported exposure to multiple traumas and almost six percent reported exposure to at least one traumatic event in the last three months (Copeland, Keeler, Angold, & Costello). While shocking, this rate is consistent with the rate of trauma exposure reported in other studies (Green et al., 2000).

Consequences Associated with Trauma

Experiencing trauma can lead to a broad range of potential psychological outcomes. However, it is important to note that, while the factors discussed in this section may be consequences of trauma, they do not always occur following trauma, and trauma is not a necessary precondition for psychopathology (APA, 2013). Additionally, exposure to trauma does not dictate later psychopathology; individual differences as well as risk factors influence the development of its symptoms.

Studies have shown, however, that trauma exposure is associated with increased risks of medical and mental health problems, including PTSD, depression, anxiety, substance abuse, and attempted and completed suicide (Cohen & Mannarino, 2015). The National Child and Traumatic Stress Network (NCTSN) found that many children exposed to trauma exhibit several forms of posttraumatic symptoms that “are not captured by standard PTSD, depressive, or anxiety disorder diagnoses” (2003). With more specific criteria for youths with PTSD symptoms, the prevalence rates may become more clear (APA, 2013). Specifically, 50 percent or more of the children surveyed who had been exposed to trauma exhibit difficulties in the domains of affect regulation, attention, concentration, negative self-image, impulse control, and aggression/risk-taking (NCTSN). One-third of the children exposed to trauma exhibited problems with somatization (a process when mental and emotional stresses becoming physical), attachment, conduct disorder or oppositional defiant disorder, sexual interest/activity/avoidance, and/or dissociation (NCTSN). Childhood psychopathology related to trauma can manifest differently in children and adolescents than in adults. Children exposed to trauma exhibit a wide variety of symptoms and domains of impairment.

Children exposed to trauma also have an elevated risk for cognitive outcomes such as difficulties with attention, executive functioning, planning, and learning (NCTSN, 2003). Some children and adolescents exposed to trauma may exhibit physical or physiological differences. These difficulties may include hypersensitivity to physical contact, numbness, problems with coordination and balance, and somatization. Children and adolescents exposed to trauma are more prone to additional medical problems such as asthma, autoimmune disorders, and pseudoseizures (NCTSN). These youth may also exhibit a lack of sustained curiosity, have problems processing new information, have difficulties with language, and have impairments in auditory, visual, or spatial perception and comprehension (NCTSN). Children exposed to trauma may experience difficulties forming attachments and may have distrust of and/or uncertainty about those around them. This can lead to many other interpersonal difficulties, such as issues with setting appropriate boundaries (NCTSN).

Children and adolescents exposed to trauma may also experience negative outcomes related to emotion. Children may have difficulties with affect regulation, which may make it difficult for them to identify and describe feelings and internal experiences. They may also experience dissociative symptoms, such as depersonalization and derealization (i.e., alteration in the perception of the external world so that it seems unreal), and may even have amnesia for state-based events. Also, many youth exposed to trauma

experience low self-esteem, shame or guilt, disturbances of body image, and/or lack of a predictable sense of self (NCTSN, 2003). Table 1 summarizes the potential difficulties children and adolescents may have after exposure to trauma.

The Adverse Childhood Experiences (ACE) study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and its impact upon later-life health and well-being. The study was a collaboration between the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Health Appraisal Clinic in San Diego (CDC, 2014). More than 17,000 Health Maintenance Organization (HMO) members underwent a comprehensive physical examination and provided detailed information about their childhood experience of abuse, neglect, and family dysfunction. The ACE study found that certain experiences are major risk factors and can be linked to illness and poor quality of life. These health and social problems arose because of adverse childhood experiences. The ACE study suggests the more traumatic experiences a youth has, the more likely they will have serious mental health issues when they are adults. According to the CDC, higher ACE scores are linked to serious social, cognitive, and physical impairments later in life. This study revealed the long-lasting effects of trauma.

Categories

In addition to the many symptoms identified in previous sections, the *DSM-5* defines the disorders specifically related to trauma exposure. These diagnoses may be applied to both youth and adults if their behavior is consistent with the criteria set forth in the *DSM-5*. Table 2 provides a brief summary of these disorders.

Posttraumatic Stress Disorder (PTSD)

Children with PTSD show symptoms including, but not limited to, worrying about dying, insomnia, angry outbursts, and acting younger than their ages (AACAP, 2010). The manifestation of PTSD can be different in every child or adolescent (APA, 2013). Some youth experience PTSD through fear-based re-experiencing, while others have dysphoric mood states. PTSD can also manifest as arousal and reactive-externalizing symptoms (APA).

PTSD underwent some major changes in the *DSM-5*. For example, the criteria as to what constitutes a traumatic event are more explicit. The *DSM-5* also presents a wider range of what constitutes sexual violence. In addition, the individual's response to the event — intense fear, helplessness or horror, according to *DSM-IV* — has been deleted because that criterion proved to have no utility in predicting the onset of PTSD (APA, as cited by Grohol, 2013).

Instead of three major symptom clusters for PTSD, the *DSM-5* now lists four clusters:

1. Recurrent experiences of the event, as in memories, dreams, or flashbacks
2. Amplified arousal, including sleep disturbances and reckless behavior
3. Avoiding thoughts, places, and memories about the event
4. Negative thoughts, moods, or feelings (APA, 2013)

The *DSM-5* also included two new subtypes for PTSD. The first is PTSD Preschool Subtype, which is used to diagnose PTSD in children younger than six years of age. PTSD is also now developmentally sensitive, meaning that diagnostic thresholds have been lowered for children and adolescents (Grohol, 2013). The second new PTSD subtype is called PTSD Dissociative Subtype. This is diagnosed when PTSD is seen with prominent dissociative symptoms (Grohol). These dissociative symptoms can be either experiences of feeling detached from one's own mind or body, or experiences in which the world seems unreal, dreamlike, or distorted.

Table 1
Summary of Potential Outcomes of Trauma in Children and Adolescents

Domain	Potential Difficulties
Physical/Physiological	<ul style="list-style-type: none"> • Hypersensitivity to physical contact • Numbness • Problems with coordination and balance • Increased somatization
Medical	<ul style="list-style-type: none"> • Asthma • Autoimmune disorders • Pseudoseizures • Sleep disturbances • Disordered eating
Cognitive	<ul style="list-style-type: none"> • Attention • Executive functioning • Learning • Lack of sustained curiosity • Problems processing new information. • Difficulties with language • Impairments in auditory, visual, or spatial perception and comprehension
Attachment/ Relationships	<ul style="list-style-type: none"> • Distrust of and/or uncertainty about those around them • Difficulties with boundaries • Interpersonal difficulties
Behavioral	<ul style="list-style-type: none"> • Behavioral (impulse) control • Self-destructive behavior • Aggression • Difficulty complying with rules • Oppositional behavior • Excessive compliance
Emotional	<ul style="list-style-type: none"> • Affect regulation • Dissociative symptoms (e.g., depersonalization or derealization) • Amnesia • Low self-esteem • Shame or guilt • Disturbances of body image • Lack of a predictable sense of self

Source: NCTSN, 2003.

Children suffering from PTSD symptoms following a trauma should be treated quickly. The earlier the intervention, the more effective are the treatments (AACAP, 2010). The greatest emphasis should be placed on establishing an environment in which the child feels safe (AACAP). An evaluation by a child and adolescent psychiatrist should be sought for any child showing reoccurring problems handling a traumatic event.

Table 2
DSM-5 Disorders Affecting Children and Adolescents Exposed to Trauma

Disorder	Description
Post-traumatic Stress Disorder (PTSD)	PTSD Re-experiencing, avoidance, and hyper-arousal symptoms following a traumatic event that are diagnosed at least four weeks after trauma exposure.
	Preschool Subtype Recreating trauma in play; ongoing dreams or nightmares related or unrelated to the traumatic event; avoiding activities or places that trigger memories of the trauma; and fear, guilt, and sadness, or withdrawing from friends and activities. Symptoms present for at least one month.
	Dissociative Subtype Symptoms of PTSD combined with depersonalization, ongoing feeling of detachment from the body or mind, and derealization (regularly feeling that one’s surroundings are unreal, dreamlike, or distorted).
Acute Stress Disorder (ASD)	Dissociative, re-experiencing, avoidance, and hyper-arousal symptoms following a traumatic event that are diagnosed after lasting two days to four weeks after trauma.
Adjustment Disorders	Emotional and behavioral symptoms in response to an identifiable stressor, such as termination of a relationship or a persistent painful illness.
Disinhibited Social Engagement Disorder (DSED)	This disorder is diagnosed only in children. Children with DSED exhibit overly familiar and comfortable behavior with relative strangers.
Reactive Attachment Disorder (RAD)	This disorder is diagnosed only in children. RAD affects infants and very young children. A child with RAD has a pattern of showing disturbed and developmentally inappropriate attachment behaviors. The child rarely or minimally turns to an attachment figure for comfort, support, protection, and nurturance.
Other Trauma- and Stressor-Related Disorders	This category applies when symptoms characteristic of a trauma- and stressor-related disorder do not meet the full criteria for any of the disorders included in the trauma- and stressor-related disorders diagnostic category.
Unspecified Trauma- and Stressor-Related Disorder	This category also applies when symptoms are characteristic of, but do not meet the full criteria for, any of the disorders included in the trauma- and stressor-related disorders diagnostic category. However, this category is used when the clinician chooses not to specify why the criteria are not met or there is insufficient information, such as during an emergency room visit.

Source: APA, 2013.

PTSD Preschool Subtype

The following bullet points outline the specific symptoms that are present with PTSD Preschool Subtype:

- Recreating trauma in play/recurrent dreams of the trauma;
- Ongoing nightmares with or without recognizable content about the traumatic event;
- Avoiding activities or places that remind the child of the trauma; and
- Exhibiting fear, guilt, and sadness, or withdrawing from friends and activities (APA, 2013).

These symptoms cause major distress to the child; impair relationships with parents, family members, and/or friends; and affect the child's behavior in school (APA, 2015).

PTSD Dissociative Subtype

In addition to meeting PTSD diagnostic criteria, a child or adolescent with PTSD Dissociative Subtype must also have symptoms of either depersonalization or derealization (APA, 2013). Depersonalization is an ongoing feeling that the youth is detached from his or her body or mind. Derealization is the recurring experience that the youth's surroundings are unreal, dreamlike, or distorted (APA). There may be a link between childhood sexual abuse and dissociation that may help mediate psychiatric symptoms and risk-taking behaviors in this population (Ginzburg et al., 2006; Kisiel & Lyons, 2001).

Acute Stress Disorder (ASD)

According to the *DSM-5*, symptoms of ASD are experienced during or immediately after trauma and may last for a maximum of four weeks before the diagnosis must be reassessed. The duration of symptoms is at least three days, but no longer than four weeks (APA, 2013). If the symptoms persist past four weeks, the youth may be then diagnosed with PTSD if the criteria are met. However, a youth may be diagnosed with PTSD without having been previously diagnosed with ASD. Any symptoms manifesting immediately following the trauma that are resolved within three days do not meet the criteria for ASD (APA). The manifestation of the disorder differs in every individual, but typically consists of anxiety that includes some form of re-experiencing the trauma or reactivity related to the trauma (APA).

Approximately 50 percent of individuals with ASD may later develop PTSD (APA, 2015). Recognizing acute stress symptoms in children and adolescents is a critical first step in the path towards preventing PTSD.

Adjustment Disorders

Adjustment Disorders are emotional and behavioral symptoms in response to an identifiable stressor (APA, 2013). Examples of stressors include, but are not limited to, ending of a romantic relationship, persistent pain with increasing disability, living in a high-crime neighborhood, or experiencing a natural disaster (APA). The diagnosis should be reevaluated if the symptoms persist for more than six months following the termination of the stressor. The prevalence of adjustment disorders varies widely depending on the population studied (APA). Adjustment disorders represent a simple response to some type of life stress, which may or may not be traumatic (Grohol, 2013).

Adjustment disorders are quite common in children and adolescents (Johns Hopkins Medicine, n.d.). For more information on Adjustment Disorders in youth, please refer to the Adjustment Disorders Section of the *Collection*.

Disinhibited Social Engagement Disorder (DSED)

Disinhibited Social Engagement Disorder (DSED) is a pattern of behavior in which a child exhibits inappropriately familiar behavior with strangers (APA, 2013). The disorder is symptomized by violations

of normal social boundaries, such as reduced reticence in approaching and interacting with unfamiliar adults, unusually familiar behavior (verbal or physical), diminished checking with caregiver when venturing away in unfamiliar settings, or willingness to go off with unfamiliar adults (APA). DSED stems from extremely insufficient care of the child (APA). DSED is rare, even in children who have been severely neglected (APA). Lubit et al. (2013) outline the signs that suggest the presence of DSED. These signs include:

- Signs of physical maltreatment, undernutrition, and rashes;
- Excessive hunger and/or thirst;
- Flattened back of the head; and
- In the most severe cases, growth retardation.

Onset for DSED is typically before age five, and it may continue for life unless the child is treated and able to form new attachments (Lubit, et al.). Prevalence rates for DSED are not specifically known. However, in high-risk populations, including severely neglected children placed in foster care or institutions, approximately 20 percent exhibit signs of DSED (APA, 2013).

Reactive Attachment Disorder (RAD)

RAD is characterized by a consistent pattern of emotionally withdrawn behavior by the child towards his or her caregiver (APA, 2013). A child with RAD rarely seeks comfort when distressed and rarely responds to comfort if given (APA). Children with RAD exhibit limited emotional responses, are often bewildered or confused, and have unexplained episodes of sadness and irritability. They may also be unhygienic and have underdeveloped motor coordination (APA; Lubit, et al., 2013). RAD stems from extremely insufficient care of the child (APA). RAD symptoms are very similar to those exhibited by children with Autism Spectrum Disorder, and children exhibiting these symptoms should be evaluated for both disorders. RAD is relatively rare and tends to occur in situations where a young child was exposed to neglect before being placed in foster care or in an institution (APA).

Prevalence rates for RAD are not specifically known. However, in high-risk populations, including severely neglected children placed in foster care or institutions, almost 10 percent exhibit signs of RAD (APA, 2013).

Other Trauma- and Stressor-Related Disorders

This category applies when symptoms are characteristic of, but do not meet the full criteria for, any of the disorders included in the trauma- and stressor-related disorders diagnostic category (APA, 2013).

Examples of presentations that can be identified using this specification include the following:

- Adjustment-like disorders lasting more than six months without prolonged duration of the stressor;
- Adjustment-like disorder with delayed onset of symptoms that occur more than three or more months after the stressor;
- *Ataque de nervios* (attack of the nerves), a cultural syndrome among Latin Americans;
- Cultural syndromes; and
- Persistent complex bereavement characterized by severe and persistent grief and mourning reactions.

Unspecified Trauma- and Stressor-Related Disorder

This category also applies when symptoms are characteristic of, but do not meet the full criteria for, any of the disorders included in the trauma- and stressor-related disorders diagnostic category (APA, 2013).

However, this category is used when the clinician chooses not to specify why the criteria are not met for a specific disorder or there is insufficient information, such as in an emergency room setting (APA).

Comorbidity

Children and adolescents exposed to trauma very often experience other kinds of problems. Those with ASD or PTSD may have symptoms of despair and hopelessness to the extent that they may meet criteria for a major depressive episode, and thus a major depressive disorder diagnosis may be more appropriate. Other youth with ASD or PTSD may experience guilt over their trauma, feeling as though they played a role. Some studies have found that as many as 75 percent of adolescents diagnosed with PTSD have at least one comorbid diagnosis of either major depressive episode or substance abuse/dependence (Kilpatrick et al., 2003). The *DSM-5* estimates that those with PTSD are more than 80 percent more likely to meet diagnostic criteria for one or more other mental disorders (APA, 2013). Studies have also shown that alcohol and other substances may be used to cope with symptoms of trauma-related anxiety (Jellinek, Patel, & Froehle, 2002). However, the use of substances can ultimately worsen symptoms and certain substances can actually generate anxiety symptoms. Another study of preschool-aged children with PTSD who had been exposed to Hurricane Katrina found that 89 percent had at least one comorbid disorder, with oppositional defiant disorder (ODD) and separation anxiety disorder (SAD) being the most common (Scheeringa & Zeanah, 2008).

Many of the behaviors seen in traumatized children fall in *DSM-5* diagnoses other than PTSD and ASD. Thus, discussions of comorbidity must be tempered with the knowledge that youth exposed to trauma may exhibit impairment across a broad range of domains, as discussed previously and outlined in Table 1.

Assessment

Early identification and treatment of traumatized children can prevent these potentially serious and long-term negative outcomes. Any attempt to define problematic posttraumatic stress in youth must clearly define what constitutes the more normal response to difficult events, loss, and trauma. Assessing the impact of trauma using current definitions of trauma may not properly screen for those children and adolescents who go on to develop psychopathology.

The suggested assessment tools for trauma- and stressor-related disorders are summarized in Table 3. Suggested assessment tools for PTSD are outlined in Table 4.

Not all children who are exposed to trauma are at equal risk for developing PTSD, and children may not meet full criteria for PTSD but may still have distressing and/or impairing symptoms. Accordingly, careful assessment is critical, as is knowledge of normal child development and normative reactions to difficult life events or trauma. One difficulty of assessment is the child's competence or inability to explain the trauma and the resulting psychosocial factors. Parental support and emotional state may affect a child's ability to properly report. Therefore, it is important to promote parental support for both assessment and treatment purposes (Kim, Choi, & Shin, 2011).

Since PTSD is often comorbid with other disorders, assessment typically involves asking about an array of potential problems. Assessment for PTSD in children should also include a medical history and a physical examination within the past 12 months, with special focus on conditions that may mimic PTSD or other anxiety disorders (AACAP, 2010). Assessing PTSD may require using multiple ways of gathering information in order to understand the youth's behavior across the many settings (e.g., school and home). Typically, questionnaires and interviews are used to assess for symptoms of PTSD. Some questionnaires that measure PTSD symptoms in children and adolescents over age seven are the UCLA PTSD Reaction Index, Child PTSD Symptom Scale (CPSS), and the Trauma Symptom Checklist for Children (TSCC) (AACAP). For children under age six, the PTSD for Preschool-Age Children is a checklist administered to caregivers to determine PTSD symptoms (AACAP).

These measures have moderate to strong psychometric profiles, but further expanded normative and clinical group studies of measures are needed (Hawkins & Radcliffe, 2006). However, these measures may be useful starting points for assessing symptoms. The PTSD Checklist/Parent Report, a parent-report measure, has been found to have strong psychometric properties (AACAP, 1998). However, when a parent or caregiver is an alleged perpetrator of child abuse or domestic violence, it is imperative that the clinician interview other caretakers (AACAP).

Table 3
Assessment for All Forms of Trauma- and Stressor-Related Disorders

Measure Type	Name of Measure	Who Completes	What is Learned
Symptom Checklist	Trauma Symptom Checklist for Children (TSCC)	Child/ Adolescent (ages 8-16 years)	Whether a child has acute and chronic posttraumatic symptoms; includes clinical scales and validity scales
Rating Scale	Adolescent-Dissociative Experiences Scale (A-DES)	Child	Presence of dissociation, especially associated with trauma-related distress
Checklist	Child Behavior Checklist and Youth Self-Report	Child, Parent or Teacher	Presence of symptoms including social withdrawal, somatic complaints, anxiety or depression, thought or attention problems, and behavior or aggression problems
Self-Report	Children's Depression Inventory (CDI)	Child	Presence of cognitive, affective, and behavioral signs of depression that signals a psychological response to trauma and perhaps an adjustment disorder
Rating Scale	Child Dissociative Checklist (CDC)	Parent	Presence of dissociative symptoms; children with trauma may score higher than children without
Checklist	Child Sexual Behavior Inventory (CSBI)	Parent	Assesses sexual behavior in children ages 2 - 12
Clinical Interview	Traumatic Events Screening Inventory	Clinician	Assesses the child's experience with traumatic events, including current and previous injuries, hospitalizations, domestic and/or community violence, disasters, accidents, and physical and/or sexual abuse

Sources: Hawkins & Radcliffe, 2006; Southam-Gerow & Chorpita, 2007; NCTSN, 2003; Muris, Merckelbach, & Peeters, 2003; & U.S. Department of Veterans Affairs, 2015.

Structured diagnostic interviews can be particularly helpful in assessing children, particularly when administered independently to the child and parent. When interviewing a child, it is important to use developmentally appropriate language. Two specifically strong diagnostic interviews are the Anxiety Disorders Interview Schedule for Children (ADIS-C) and the Schedule for Affective Disorders and Schizophrenia-Children's Present and Lifetime Version (K-SADS-PL). Both interviews have demonstrated strong psychometric characteristics for anxiety disorders (e.g., PTSD) across many studies

(Hawkins & Radcliffe, 2006; Southam-Gerow & Chorpita, 2007). The ADIS-C includes a PTSD section and can be used with child and parent reports. In the K-SADS-PL, the clinician is asked to integrate parent and child reports, and initially asks whether a variety of traumatic events have occurred recently or in the past and then assesses the criteria for a diagnosis of PTSD in relation to the specific event (Hawkins & Radcliffe). Additionally, the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA) is a semi-structured interview to assess PTSD symptoms in youth. This assessment tool was developmentally modified from an adult version (Hawkins & Radcliffe).

Table 4
Assessment for PTSD

Measure Type	Name of Measure	Who Completes	What Is Learned
Clinical Interview	Anxiety Disorders Interview Schedule – child (ADIS-C) and parent versions (ADIS-P)	Child, Parent	Whether a child meets criteria for PTSD
Clinical Interview	Schedule for Affective Disorders and Schizophrenia-Children’s Present and Lifetime Version (K-SADS-PL)	Child, Parent	Whether a child meets criteria for PTSD
Clinical Interview	Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)	Child/ Adolescent (ages 7-15)	Whether the child has been exposed to trauma, overall symptom severity, and whether a current or lifetime diagnosis of PTSD/ASD is indicated
Rating Scale	UCLA PTSD Reaction Index (Child, Adolescent, and Parent versions)	Child, Adolescent, Parent	Whether a child has trauma exposure, PTSD symptoms (including duration of symptoms)
Rating Scale	Child PTSD Symptom Scale (CPSS)	Child/ Adolescent (ages 8-18)	Frequency of PTSD symptoms in children
Symptom Checklist	Trauma Symptom Checklist for Children (TSCC)	Child/ Adolescent (ages 8-16)	Whether a child has acute and chronic posttraumatic symptoms; includes clinical scales and validity scales
Symptom Checklist	PTSD Checklist – Child and Parent Report versions (PCL-C/PR)	Child/ Adolescent (ages 6-18), Parent	Whether child has symptoms of PTSD; measure does not assess for traumatic events or child functioning

Sources: Hawkins & Radcliffe, 2006; Southam-Gerow & Chorpita, 2007; NCTSN, 2003; Muris, Merckelbach, & Peeters, 2003; & U.S. Department of Veterans Affairs, 2015.

Youth who have experienced trauma within close relationships may have distrust and uncertainty about those around them, particularly if a trusted adult was a perpetrator (NCTSN, 2003). As such, these youth may resist disclosing information because they may fear additional family chaos and may also fear others will perceive them as peculiar. Moreover, youth may exhibit a variety of outcomes after the exposure to trauma including comorbid symptoms. Some symptoms may be externalizing, such as behavior problems

or aggression, and these overt symptoms may attract more clinical attention than internalizing symptoms (NCTSN). Finally, Hawkins and Radcliffe suggest that children who are exposed to a single traumatic event may be different in some ways than children who have been exposed to multiple traumatic events or prolonged stressors (NCTSN). Often, multiple traumas are not assessed, and symptom reporting relies on recalling the most recent traumas (Hawkins & Radcliffe).

Treatments

In the future, more evidence-supported treatments of disorders with *DSM-5* classifications will be available as clinical studies utilizing *DSM-5* criteria are conducted. As a result, this *Collection* will reference studies that utilize *DSM-IV* diagnostic criteria, primarily PTSD, to explain symptoms and treatments.

There are many treatments for PTSD; however, not all have been found to be equally effective. The efficacy of only one family of treatments has been studied thoroughly enough to declare it an evidence-based treatment: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). It is worth noting that TF-CBT has been tested and found to be more effective than other active treatments in treating childhood PTSD symptoms across six separate randomized clinical trials (Cohen & Mannarino, 2008).

Treatments for youth with PTSD are summarized in Table 5.

Psychological Treatments

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been shown to be effective across a number of randomized controlled trials and to be more effective than other treatments (e.g., child-centered play therapy) at improving PTSD, as well as symptoms of depression, shame, and behavioral problems (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Kelleher & Mannarino, 2008; Cohen & Mannarino, 2015). Parents who participated in treatment with their children have also been shown to have improved parenting skills in addition to decreased levels of trauma distress and depression.

The TF-CBT model is based on cognitive and learning theories about the development of traumatic stress in youth, as well as information on effective interventions for adult PTSD and other child anxiety disorders (Cohen, Deblinger, Mannarino, & Steer, 2004). TF-CBT treatment includes core elements that make up the acronym PRACTICE (Cohen, Kelleher, & Mannarino, 2008). Each PRACTICE component builds on skills gained in previous sessions (Cohen, Deblinger, Mannarino, & Steer, 2004). The PRACTICE elements described by Cohen (2008) are as follows:

Psychoeducation provided to children and parents about trauma and PTSD symptoms, while parents are provided with parenting skills to aid in the management of the child's symptoms.

Relaxation skills are provided.

Affective expression and modulation skills are treatment components.

Cognitive coping skills are provided.

Trauma narrative is developed and processed.

In-vivo mastery of trauma reminders is introduced to differentiate between reminders and dangerous cues in the environment.

Conjoint sessions, where the child and parent focus on having the child share his or her narrative and working on family communication, are also included.

Enhancing safety focuses on safety planning in the future.

These components take 12 to 16 sessions (Cohen, Deblinger, Mannarino, & Steer, 2004). Similar to other cognitive-behavioral treatments, parent involvement and knowledge of skills are considered to be important components of treatment so that parents can help children with the skills outside of the therapy sessions.

TF-CBT is most effective with some degree of caregiver involvement (Getz, 2012); however, the treatment can still be effective with limited caregiver participation. Even in circumstances where there is no caregiver involvement, there is data that shows that PTSD improves with TF-CBT (Getz). TF-CBT may not be appropriate when the youth's predominant problems are disruptive behaviors such as defiance, disobedience, aggression, or rule breaking (Child Sexual Abuse Task Force and Research & Practice Core, NCTSN, 2004). Similarly, children who are severely depressed or suicidal, or who have active substance abuse, should first receive treatments specific to those conditions. TF-CBT will often be an appropriate intervention for these children once the above presenting problems have been addressed (Getz).

Although TF-CBT has the most research support, school-based group Cognitive Behavioral Therapy (CBT) has shown some promise in a few studies (Cohen, Kelleher, & Mannarino, 2008; Silverman et al., 2008). School-based group CBT uses PRACTICE components similar to TF-CBT. All elements, except for the individual activity of a trauma narrative, are provided in a group format with parents rarely becoming involved. There is also a teacher education component and peer support component (Cohen, Kelleher, & Mannarino).

For RAD and DSED, treatments have been shown to be beneficial when they emphasize the following in the child/caregiver relationship: psychological safety, stability in the time spent with the child, empathy when listening, permanence of an attachment figure, and emotional availability or attentiveness to the child's needs (Lubit, et al., 2013). A child with RAD or DSED may take a year or longer to trust a caregiver again (Lubit, et al.).

Pharmacological Treatments

While pharmacological treatments (e.g., selective serotonin reuptake inhibitors [SSRIs]) have been found to be useful in treating other anxiety disorders, there is inadequate support for pharmacological interventions in the treatment of PTSD (AACAP, 1998). One study examined the effects of adding the SSRI sertraline to a TF-CBT intervention for PTSD and found that there was minimal evidence of benefit (Cohen, Mannarino, Perel, & Staron, 2007). SSRIs may not be optimal for treatment for children with PTSD who also have hyperarousal symptoms, as SSRIs may lead to irritability, poor sleep, or inattention in some children (AACAP, 2010). For these children, alternative therapy should be considered, including TF-CBT or alternative psychotropic medications (AACAP). Research has shown that employing TF-CBT to treat PTSD prior to adding medication is warranted. In general, if a youth with PTSD is also diagnosed with depression, anxiety, panic and/or ADHD symptoms, clinicians who treat with medication are urged to choose medications based on the evidence for treating the comorbid condition (AACAP, 1998).

Trauma-Informed Care

A new form of care is emerging that takes into consideration trauma that individuals experienced in the past. Trauma-informed care programs are based on recognition that trauma survivors are vulnerable and potentially have triggers that may be aggravated by traditional service approaches. These programs seek to avoid those triggers and to prevent the trauma from reoccurring (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.).

Table 5
Summary of Treatments for Youth with PTSD

What Works	
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Treatment that involves reducing negative emotional and behavioral responses related to trauma by providing psychoeducation on trauma, addressing distorted beliefs and attributes related to trauma, introducing relaxation and stress management techniques, and developing a trauma narrative in a supportive environment
What Seems to Work	
School-based Group Cognitive Behavioral Therapy (CBT)	Similar components to TF-CBT, but in a group, school-based format
Not Adequately Tested	
Child-centered Play Therapy	Therapy that utilizes child-centered play to encourage expression of feelings and healing
Psychological Debriefing	An approach in which youth talk about the facts of the trauma (and associated thoughts and feelings) and then are encouraged to re-enter into the present
Pharmacological Treatments	Treatment with selective serotonin reuptake inhibitors (SSRIs)
Resilient Peer Treatment	Classroom treatment that pairs withdrawn children with resilient peers with a parent present for assistance
Eye Movement Desensitization and Reprocessing Therapy (EMDR)	Therapy that utilizes visual and physical memory imagery while the clinician creates visual or auditory stimulus to reduce negative memory and increase positive memory
What Does Not Work	
Restrictive rebirthing or holding techniques	Restrictive rebirthing or holding techniques that may forcibly bind or restrict, coerce, or withhold food/water from children and have resulted, in some cases, in death; not recommended

The treatments under trauma-informed care mirror those for PTSD, including TF-CBT (NCTSN, n.d.). Because nearly half of all children have had an experience that can be classified as a traumatic experience, trauma-informed care is appropriate because it avoids situations wherein undue stress is placed upon a child by no fault of the clinician (Johns Hopkins Bloomberg School of Public Health, 2014). These triggers are thought to have a negative effect on an affected youth's cognitive performance in the short term as well as long-term effects on physical and cognitive health (Bethell, Newacheck, Hawes, & Halfon, 2014).

Unproven Treatments

There are many treatments for PTSD that have not yet been tested and others that have no research to support their effectiveness. Moreover, some treatments that have been studied have been found to be less effective, not effective, or harmful in treating children with PTSD (Cohen, Kelleher, & Mannarino, 2008). One intervention, psychological de-briefing, in which children are encouraged to talk about the trauma, as well as their thoughts and feelings, before re-entering into the present, has been studied and found to have no significant effects (Cohen, Kelleher, & Mannarino). Nondirective, or child-directed, play and other unstructured treatment approaches are less effective in treating effects of trauma than TF-CBT (Cohen, Kelleher, & Mannarino). Other treatments, such as restrictive rebirthing or holding techniques, have been found to be harmful to children and should not be used (Cohen, Kelleher, & Mannarino).

Cultural Considerations

The understanding of trauma and its outcomes may vary significantly from culture to culture. For instance, Latino children may experience a symptom known as *susto*, meaning “fright” or “soul loss” (APA, 2000). *Susto* can occur following a frightening event and may impact social relationships, appetite, and sleep; enhance feelings of sadness; decrease motivation; and increase feelings of worthlessness (APA).

Research suggests that providers address cultural issues directly with the parents and, if appropriate, with the child they are treating (Cohen, Mannarino & Deblinger, 2006). It is important for therapists to recognize that painful and distressing responses to trauma are universal, even if the specific symptoms vary to some extent from culture to culture (Cohen, Mannarino, & Deblinger). Furthermore, although therapists are not able to change their own cultural background, they can learn about and be respectful of other cultural reactions to traumatic experiences while providing effective psychological treatment for trauma-related psychopathology (Cohen, Mannarino, & Deblinger). As of 2008, TF-CBT treatment materials have been translated into Spanish, Dutch, and German (Cohen, Kelleher, & Mannarino, 2008). TF-CBT is also being culturally adapted for use with African children impacted by human immunodeficiency virus (HIV) (Cohen, Kelleher, & Mannarino).

The information in the following paragraph is derived from the Jim Casey Youth Opportunities Initiative (2011). Many youth in foster care have also experienced traumatic events in their lives due to exposure to psychological or physical abuse, neglect, and dislocation. Researchers and service providers have concluded that the great majority of young people in foster care have experienced trauma in some form as a result of maltreatment and foster care placement. Data from the National Survey of Child and Adolescent Well-Being indicate that high percentages of the caregivers whose children have entered foster care also experience significant stressors in their lives that, in turn, affect the psychological well-being of their children. The foster care experience itself may cumulatively add to the impact of these traumatic events by further traumatizing young people. In addition, because they are removed from family, school, and community, multiple placements contribute to the loss of important relationships and bonds, and youth in foster care are frequently uncertain whether parents, siblings, former caregivers, or friends will return to their lives. This type of ambiguous loss freezes the grief process, prevents closure, and adds to young people’s feelings of insecurity and confusion.

Overview for Families

Children and adolescents experience stressful events, and they may have physical and emotional reactions to the stress. Certain events are more likely to trigger PTSD, including being the victim of or witness to physical or sexual abuse, violence, accidents, and natural disasters, or being diagnosed with a life threatening illness (AACAP, 2011a).

After traumatic events, children may first be angry or confused. If they are repeatedly exposed to an event, they may block or deaden the emotional pain they feel. This process is called dissociation (AACAP, 2011a). Children may also avoid situations or places that remind them of the trauma (APA, 2013). Families may also notice that children who experienced trauma are less emotionally responsive, more depressed or withdrawn, or even detached from their feelings (AACAP).

Sometimes children with PTSD will experience symptoms like recurring memories and bad dreams. Children may even reenact the traumatic event during play. These after effects may elicit similar feelings as those experienced during the traumatic event (AACAP, 2011a). Families should look for the following symptoms:

- Fear of dying early
- Loss of interest in activities
- Physical symptoms like headaches and bellyaches
- Sudden and extreme emotional reactions
- Problems sleeping, both in falling and staying asleep
- Irritability or angry outbursts
- Trouble concentrating
- Acting younger than their age, including thumb sucking, whining, and clinging to an adult
- Increased awareness or alertness to their surroundings
- Repeating behavior that reminds them of the trauma (AACAP, 2011a)

These symptoms may last for months or even years. If a traumatic event occurs, it is best for the family to seek help from a trained clinician as soon as possible.

Young children under age six who experience trauma may recreate trauma in their play (Kids Matter Early Childhood, n.d.). Families should pay attention to the play of a child who is suspected to have experienced trauma, as that may be the only way the child can explain his or her feelings to the family. This is often because the child's speech and vocabulary are still developing (Kids Matter Early Childhood). Families can work together with clinicians to create a sense of safety. Therapy where the child can speak, draw, play, or write about the traumatic event will help, and behavior modification may reduce the fear and worry associated with the trauma (AACAP, 2011a).

Another disorder that families may experience after trauma is reactive attachment disorder (RAD). Children with RAD seem detached from or unresponsive to their families (AACAP, 2011b). Symptoms typically occur around age five, but may occur in infants and continue as the child ages. Parents usually notice some or all of the following symptoms:

- Severe colic or difficulties feeding
- Failure to gain weight appropriately
- Difficulty comforting the child
- A preoccupied or defiant attitude
- Being inhibited or hesitant in social interactions
- Being disinhibited or inappropriately familiar with strangers (AACAP, 2011b)

Frequently, these symptoms occur in children who have been physically or emotionally abused or even neglected. Often, RAD occurs in children raised in hospitals or institutional settings, those who have experienced traumatic loss, or those whose primary caregiver changes frequently (AACAP, 2011b). Children who receive inadequate care are most at risk for RAD. Treatment involves the child and the family. Families who suspect RAD in a child should reach out to a clinician for assistance.

Resources and Organizations

Anxiety Disorders Association of America (ADAA)

8730 Georgia Avenue, Suite 600

Silver Spring, MD 20910

<https://adaa.org/>

Child Welfare League of America (CWLA)

440 First Street NW, Third Floor

Washington, DC 20001-2085

<http://www.cwla.org>

Georgetown University Center for Child and Human Development

Trauma Informed Care

<http://gucchtdcenter.georgetown.edu/TraumaInformedCare.html>

International Society for Traumatic Stress Studies (ISTSS)

111 Deer Lake Road, Suite 100

Deerfield, IL 60015

<http://www.istss.org>

Medical University of South Carolina (MUSC)

Trauma Focused-Cognitive Behavioral Therapy

<http://tfcbt.musc.edu>

National Anxiety Foundation

3135 Custer Drive

Lexington, KY 40517

<http://www.nationalanxietyfoundation.org/>

National Center for Trauma Informed Care

<https://www.samhsa.gov/nctic/about>

National Child Traumatic Stress Network

<http://www.nctsn.net/>

Prevent Child Abuse America

228 S. Wabash Avenue, 10 FL

Chicago, IL 60604

800-CHILDREN (244-5373) or 312-663-3520

<http://preventchildabuse.org/>

Virginia Resources and Organizations

Child Savers Guidance Clinic & Trauma Response

200 North 22nd Street

Richmond, VA 23223

804-644-9590 (Ask for a Trauma Response therapist, if applicable.)

<https://childsavers.org/>

Prevent Child Abuse Virginia

4901 Fitzhugh Avenue, Suite 200

Richmond, VA 23230

E-mail: jschuchert@pcav.org

<http://pcav.org/>

University of Virginia Health System

Children's Hospital

<https://childrens.uvahealth.com/>

Virginia Commonwealth University (VCU)

Center for Psychological Services and Development

<https://cpsd.vcu.edu/>

VCU Medical Center

Virginia Treatment Center for Children

<https://www.chrichmond.org/Services/Mental-and-Behavioral-Health.htm?vtcc=true>

Virginia Department of Behavioral Health Services

<http://www.dbhds.virginia.gov/>

Trauma Informed Care

<http://www.dbhds.virginia.gov/developmental-services/children-and-families/Trauma%20Informed%20Care>

Virginia Polytechnic Institute and State University (VA Tech)

Psychological Services Center

<http://www.psyc.vt.edu/outreach/psc>

Child Study Center

<http://www.psyc.vt.edu/labs/csc>

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DISCLOSURE STATEMENT

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