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Abstract

Post-traumatic stress disorder in children and adolescents has only been researched for the past fifteen to twenty years. Despite the estimates from state and local child protective services that approximately 896,000 children were victims of child abuse or neglect in 2002 (National Clearinghouse on Child Abuse and Neglect, 2002), the vast majority of research and techniques used in the assessment and treatment of children and adolescents has stemmed from research focused on adults. This report will provide a summary of current perspectives on the definition, assessment, and treatment of PTSD in adolescents.

POSTTRAUMATIC STRESS DISORDER

IN CHILDREN AND ADOLESCENTS

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Post-traumatic stress disorder in children and adolescents has only been researched for the past fifteen to twenty years. Despite the estimates from state and local child protective services that approximately 896,000 children were victims of child abuse or neglect in 2002 (National Clearinghouse on Child Abuse and Neglect, 2002), the vast majority of research and techniques used in the assessment and treatment of children and adolescents has stemmed from research focused on adults. This report will provide a summary of current perspectives on the definition, assessment, and treatment of PTSD in adolescents.

All people are exposed to varying levels of trauma throughout their lives and often times they are able to adapt, but when children or adolescents are exposed to a significant and overwhelming trauma, it is generally more difficult for them emotionally and psychologically. Consequently, they are more vulnerable and may be more predisposed to developing posttraumatic stress disorder (PTSD). PTSD is a concern not only because of the intense suffering associated with its symptoms, but also because of its detrimental effect on biological, psychological, and social development (Davis & Siegal, 2000). This matter is compounded further by the strong correlation of PTSD to disorders such as anxiety, suicidal ideation, ADHD, psychotic disorders, and mood disorders, according to Davis and Siegal. In this paper, the author will define PTSD and explain how it is often displayed by children and adolescents, review different ways that PTSD can be assessed, and discuss several treatment approaches.

Definition of Posttraumatic Stress Disorder

Diagnosing Posttraumatic Stress Disorder

Making the diagnosis of posttraumatic stress disorder (PTSD) is relatively new to the counseling and psychiatric field. Because of this, each Diagnostic and Statistical Manual of Mental Disorders revision since 1980 has contained a change in the diagnostic criteria (Cohen, 1998). The Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV-TR) (APA, 2000) currently identifies five criteria in the diagnosis of PTSD.

The primary criteria is exposure to a traumatic event in which the person experienced, witnessed, or was confronted with an event that caused an actual or perceived threat of death or serious injury to self or others. The person's response to this event(s) involved an intense fear, or a sense of helplessness or horror. In children this is often expressed as a disorganized or agitated behavior.

Second, the traumatic event is re-experienced in one or more of the following ways. It could surface as a recurrent or intrusive memory of the event, which may include images, thoughts and perceptions. Children will often utilize repetitive play, such as reenacting a car accident they were in while playing with toy cars, to express themes or vivid memories of the traumatic event. Children may also have recurring dreams about traumatic events, but these dreams eventually generalize to an unrecognizable content, such as a monster (Brooks & Siegel, 1996). Children may also feel as if the traumatic event is recurring. This can be experienced through a sense of reliving the experience, illusions, hallucinations, and/or dissociative flashbacks. They may also experience intense psychological distress after being exposed to an internal or external cue that brings back memories of the traumatic event.

The third criteria is a persistent avoidance of reminders of the trauma and a numbing of general responsiveness, as evidenced by three or more of the following: avoiding thoughts, feelings, or conversations associated with the trauma; avoiding activities, places, or people that trigger memories of the event; or being unable to recall an

important part of the traumatic event. Children may stop doing things that were once an important part of life, begin to feel detached from people and stop believing in the future.

The fourth symptom is increased arousal, with at least two of the following: a difficulty falling or staying asleep, being irritable or having angry outbursts, being unable to concentrate, being hypervigilant, or having an inflated startle reaction. The fifth criterion is that criteria two, three, and four have been experienced for at least one month. The final criteria is that the traumatic event has precipitated a significant enough level of stress to impair the social, occupational, or another important area of functioning for that person.

When looking at a possible diagnosis of PTSD with children and adolescents, it is important to remember that they may not be able to verbally report diminished interest in significant activities and constriction of affect. It is also important to remember that these symptoms need to have arisen after experiencing a traumatic event. Often children express the symptoms they feel in a somatic format (Alexander, 1999).

Single Episode versus Recurrent or Long Standing Episode

In order to meet the criteria for PTSD, an individual must experience PTSD symptoms for a minimum of four weeks. Symptoms lasting less than one month are categorized as acute, and those lasting longer than three months are considered chronic (Davis & Siegal, 2000).

According to Davis and Siegal (2000), it is also important to look at the type of traumatic event. A one time event, such as an accident or the experiencing or witnessing of a traumatic event, is often identified as a single episode trauma. A recurrent trauma occurs

when the person is repeatedly exposed to a physically or emotionally damaging situation such as abuse. It is often common to see single episode sufferers remember the event clearly and exhibit a change in personality or numbing of expression, whereas recurrent sufferers often become almost amnesiac, blocking out years of their life.

A new category has been considered for PTSD symptoms for victims with prolonged exposure to abuse. "Complex PTSD is based on the premise that victims develop personality changes, including deformations of relatedness and identity, dissociation, somatization, and profound depression" (Davis & Siegal, 2000, p.136). It has been found that child and adolescent abuse survivors are not only vulnerable to falling into abusive relationship patterns, but are also susceptible to repeat incidents of harm, both self inflicted and from others.

Biological Aspects of PTSD

There has been an increasing amount of research looking at PTSD in its connection to several physiological systems. The premise of this theory is that human beings have evolved over time to maintain homeostasis in a variety of different places and situations. However,

"There is a limit to the amount of stress that any organism can adapt to while maintaining homeostasis. Beyond that point, the very psychobiological mechanisms that typically allow us to function well under stress may act in ways that contribute to, maintain, or even cause disease" (Cohen, Perel, DeBellis, Friedman, & Putnam, 2002, p. 92).

Understanding the body's typical reaction to stress and adaptation, and then comparing this to a person's experience of PTSD symptoms, could help counselors provide more effective treatments. Exposure to stressors that have overwhelmed the individual's system could leave that person in a constant state of hyper arousal. The body is stuck in a flight, fight or freeze response that can be triggered with only a small precipitating event.

Risk Factors

Not every person exposed to a traumatic event will develop PTSD. Furthermore, an event that might prompt a PTSD diagnosis in one individual may not have that similar effect on another person. It is hard to tell what role poverty, deprivation, oppression, and family disorganization play into the susceptibility of developing PTSD (Foa, Keane, & Friedman, 2000). It is also difficult to tell what role social supports, resilience, and coping skills play in combating the development of PTSD.

There are several risk factors that have been identified in making a child or adolescent more vulnerable to PTSD, including childhood sexual or physical trauma, low self-esteem, separation of one's parents before age ten, a prior psychological disorder, a psychiatric disorder in the first degree of relatives, and being female (Davis & Siegal, 2000). According to Davis and Siegal (2000), many people also take a more individualized look at risk factors. These authors noted that, "PTSD is likely to develop when a trauma is inconsistent with a victim's pre-trauma schemas of the world as safe and herself as invulnerable, or when the trauma primes existing schemas of the world as dangerous and the self as vulnerable" (p.140).

Prevalence

Community studies indicate that there is a lifetime prevalence for PTSD ranging from 1%-14% for the general population (Davis & Siegal, 2000). However, the presence or absence of war and war veterans in a region can play a significant role on the lifetime prevalence. A study by Amaya-Jackson and March (1995) found that 43% of adolescents that experienced a trauma like rape, assault, or sudden injury by age 18 developed PTSD. Weine, Becker, Levy, Edell, and McGlashen (1997) found that of the 75 inpatient adolescents they interviewed, 81% reported at least one traumatic event in their childhood. Thirteen percent of those interviewed were victims of physical abuse, 16% were victims of sexual abuse, and 19% were victims of sexual abuse.

Co-Morbidity

Having a diagnosis of PTSD by age eighteen significantly increases the comorbidity of disorders like depression, anxiety, suicidal ideation, dissociative disorders, and alcohol or drug dependence (Davis & Siegal, 2000). According to Davis and Siegal (2000), depressed patients with a history of sexual abuse appear to be at a higher risk for developing PTSD than depressed youth who were not sexually abused. Despite the DSM IV's detailed explanation for the evaluation and diagnosis of PTSD, there is still much debate with regard to what constitutes the diagnosis of this disorder, particularly when it comes to the criteria for what makes an event traumatic.

Assessment

Before implementing appropriate interventions with children and adolescents who have experienced trauma, it is important to develop and use accurate assessments. Strand, Sarmineto, and Pasquale (2005) reviewed 35 current assessment and screening tools available to counselors. These assessments fall into three primary categories: those that measure history of exposure and assess impact, those that only measure history of exposure, and those that assess the symptom distress in relationship to exposure to a traumatic event(s). The type of assessment chosen would depend on the age of the client and whether the interview is with the child or caregiver. It is also important to consider the most appropriate interview format: self report, structured interview, semi-structured interview, or survey format.

Unfortunately, most of the assessments reviewed by Strand, Sarmiento and Pasquale were written within the past five years, so there is not an abundance of research supporting their use. Cohen (2001) identified some valid and reliable self-report assessment tools. These include the PTSD Reaction Index, PTSD Symptom Scale Interview for Children, and the Children's PTSD Checklist.

It is generally recommended that the counselor interview both the child and the care provider. If one care provider is considered to be the potential perpetrator, than another caregiver should be interviewed. It is also important to ask the child directly about the PTSD symptoms as they relate to the stressor (Cohen, 1998). Often counselors do not ask children directly about their PTSD symptoms, perhaps out of a fear that they will draw

out feeling that the child has forgotten about or because of their own inadequacies about precipitating a painful discussion.

Differential Diagnosis

When looking for the differential diagnosis it is important to remember that in PTSD, the stressor must be of an extreme nature, whereas in an adjustment disorder, the stressor could be of any severity (Cohen, 1998). In acute stress disorder, the symptoms must occur and resolve within four weeks of the traumatic event (DSM-IV-TR, 2001). If avoidance, numbing, or increased arousal were present prior to exposure to a traumatic event, a diagnosis of PTSD may not be appropriate after the stressor (Cohen, 1998). It may be necessary to question the child and caregiver carefully to determine whether there was a specific stressor that triggered the symptoms or if the child already had symptoms and a traumatic event just amplified them.

Treatment

Most studies on the treatment of PTSD have centered on cognitive behavioral therapy (CBT), the most common therapeutic technique used with children and adolescents.

Cognitive Behavioral Therapy

The CBT approach to treating children and adolescents is no different than treating other childhood emotional or psychological disorders (Foa, Keane, & Friedman, 2000). It is generally a blend of cognitive and behavioral techniques; which includes stress

management, relaxation, assertiveness training, and the exploration and correction of inaccurate beliefs and/or perceptions.

A study by Cohen, Deblinger, Mannarino, and Steer, R (2004) compared the use of a trauma-focused cognitive behavioral therapy (TF-CBT) to a child centered therapy in 200 sexually abused children with posttraumatic symptoms. In this TF-CBT model the therapists focused on teaching skills to increase the expression of feeling; teaching coping skills; providing education on the relationship between, thoughts, feelings and behavior; and coaching on cognitively processing the abuse experience. The sessions were joint sessions with both child and parent present. There was an additional psycho-educational component that looked at child sexual abuse and body safety, as well as parent management skills.

The results of this study showed that the children that received the TF-CBT treatment, as compared to the child centered therapy, demonstrated a significantly stronger improvement with regard to decreasing PTSD symptoms, depression, behavioral problems, shame, and abuse-related attributions (Cohen et al., 2004). The biggest limitation to this study is that it did not provide any indication to what part of the TF-CBT aided in the positive results.

Another study by Deblinger, Steer, and Lippman in 1999 researched the use of cognitive behavioral therapy on 100 sexually abused children suffering from post-traumatic stress disorder. This study revealed that cognitive behavioral approaches were successful

for treating preschool children, and also for treating school aged children when the non-offending parent is included in the treatment.

Eye Movement Desensitization and Re-processing

Eye movement de-sensitization and re-processing (EMDR) is sometimes considered an off shoot of cognitive behavioral techniques. This method combines exposure to the traumatic event with cognitive therapy. During the therapy the clients are directed in repetitive eye movements by the counselor (Foa et al., 2000). Clients are asked to recall certain aspects of the traumatic events while visually moving their eyes back and forth under the direction of the therapist. There is a belief that these eye movements, which are similar to what people experience during REM sleep, help clients process traumatic events.

EMDR is generally not considered effective as a one session therapy. In fact, it is generally recommended that the therapist have a minimum of at least 12 sessions to work with the patient. Thordarson, Maxfeild, Fedoroff, and Lovell (2003) described how the EMDR sessions unfold. In the first session the client is introduced to a Safe Place, a place created by the client and described in great detail to help develop a familiarity to the place. The client will utilize this place as a coping strategy throughout the duration of the treatment. In the next phase of treatment the therapist will guide the client in processing the traumatic event. The client is asked to recall memories as well as the negative self statements related to the experience. The client reports his or her feelings and experiences.

As each negative emotion is experienced, it will become the focus of the re-processing.

This continues until there is no distress evoked in the client by the traumatic memory.

EMDR is often questioned by researchers because studies have not been able to consistently prove that EMDR is more effective than other therapy techniques. In recent history EMDR has incorporated other techniques, such as a bilateral finger tapping, as an acceptable alternative to the eye movements (Davidson & Parker, 2001).

Creative Therapies

Creative therapies consist of using music, dance, drama or poetry in psychotherapy. The creative activity is used as a medium to recreate the feelings and experiences of the traumatic event, in a safer and less concrete environment. Creative therapies often provide an entry into the traumatic event on an implicit, rather than explicit level (Foa et al., 2000). Creative therapies have been found to be useful in helping patients with PTSD symptoms increase their self-esteem and hope, as well as display more pro-social behaviors. They also help the patient reduce feelings of shame and guilt by taking the traumatic memories and making the feelings less intimidating to express and seeing a positive potential outcome.

An example of a creative therapy would be a therapist using a sand tray activity. A sand tray can provide the client with a tactile experience where the individual can create his or her own world and characters and can approach difficult memories and emotions through story and imagination, providing an outlet and an opportunity to make progress without directly discussing the traumatic events or feelings.

Creative therapies have been found to be particularly useful with three primary populations: children who are unable to focus long enough to have a direct discussion of their personal experiences; children who find it difficult or overwhelming to verbally express their feelings; and highly intellectual children who use language to obstruct their processing of the traumatic event (Foa et al., 2000).

It is important that a counselor considering a creative therapy take the time to be appropriately trained in the technique. Creative approaches are widely used by counselors, although there is relatively little empirical data studying its efficacy or success rates with clients (Foa et al., 2000). With the limited research that has been done on the effectiveness of creative therapies, it is generally recommended that the creative therapy not be done in a stand alone format, and that other therapy modalities be implemented in the treatment plan (Foa et al., 2000).

Pharmacotherapy

With an increasing amount of research indicating that certain treatment modalities are effective in decreasing PTSD symptoms, a person may wonder why pharmacological approaches are considered. First, despite the lack of extensive research studying pharmacological approaches with youth diagnosed with PTSD, it is used 95% of the time during treatment (Cohen, 2001). Second, even after successful therapeutic modalities have been implemented, many youth still display symptoms. Third, alternative treatment modalities need to be found for youth who do not achieve symptom alleviation through therapy or for children that are not able to attend therapy. Counselors do not treat

individuals for trauma; they treat the behavioral and/or emotional symptoms that appear in some children and adolescents after having been exposed to a traumatic event.

Antidepressant medication. The most common form of pharmacotherapy for adolescents suffering with PTSD is antidepressants. Of the antidepressants that are commonly used, selective serotonin reuptake inhibitors (SSRI's) (Meiser-Stedman, 2002) have the most research supporting their use in treatment. In the late 1990's two large clinical studies were done that looked at the use of an SSRI called sertraline in children and adults. Both of these studies revealed that sertraline effectively reduced symptoms in all three PTSD diagnostic clusters: intrusions, avoidant/numbing, and hyperarousal (Wilson, Friedman, & Lindy, 2001).

There was a similar study done in 2002 by Seedat, Stein, Ziervogel, Middleton, Kammer, Emsley, and Rossouw that administered an SSRI called citalopram to children and adolescents and adults who met the full criteria for PTSD. The children and adults received comparable symptom alleviation according to the scores the subjects received on the Clinician-Administered PTSD Scale and the Clinical Global Improvement Scale. This study indicated that SSRI's are safe and effective treatment of PTSD for children, adolescents, and adults.

Catecholamine drugs have the most empirical evidence supporting their use in the treatment of childhood PTSD (Cohen, 2001). Harmon and Riggs (1996) gave clonidine patches to children with PTSD and found that this medication significantly reduced anxiety, hyperarousal, impulsivity, and depressive symptoms in these children.

PTSD is characterized by a chemical reaction in the brain which leaves an individual's body at a heightened state of arousal. Essentially, the body becomes frozen in the fight or flight mode. This prolonged state of arousal is believed to increase an individual's risk of PTSD (Marmar, Neylan, & Schoenfeld, 2002). There has been some research done on a medication called propranolol (Pitman, Sanders, Zusman, Healy, Cheema, & Lasko, 2002). There is hope that providing this medication soon after a patient's exposure to a traumatic event may help alleviate the symptoms of PTSD prior to them starting by limiting the brain's opportunity to collect and get stuck on highly emotional memories.

Despite the current research studying the use of different types of pharmacotherapy on children and adolescents, most researchers feel that more research is needed to validate what alternatives are best for children and adolescents with PTSD. There has never been a placebo controlled test verifying the validity of this treatment modality on youth (Cohen, 2001). According to Cohen (2001), one of the biggest concerns about treating children with the medications is that most of these treatments have been selected because of their successful track record with adults. What little research has been done on child and adolescent PTSD treatment has been done where all participants received treatment, which derives less empirically sound results (Cohen, 2001).

Practical Application for Practitioners

With the relative newness of PTSD research, especially as it applies to children and adolescents, many practitioners are unsure of where to start when assessing and creating a

treatment plan. One of the first things that practitioners need to decide is their own personal perception on PTSD. Is PTSD a normal reaction to an abnormal stress(ors) in a person's life, or is it a less common disorder with factors that make the person more susceptible and distinct and identifiable abnormalities?

Cohen (1998) looked at the practice parameters for assessing and treating children and adolescents with PTSD. The first thing they suggested was a careful and thorough interview with the child and primary care physician. It is important during this interview stage to ask directly about the symptoms as they relate to the stressor. When making the differential diagnosis it is important to refer to the Diagnostic and Statistical Manual of Mental Disorders, keeping in mind the severity of the stressor and when the numbing and avoidance first started.

There is still much debate with regard to the treatment modality most effective for this population. However, most of the well researched treatment modalities seem to encompass the following components: "a direct exploration of the trauma, use of specific stress management techniques, exploration and correction of inaccurate attributions regarding the trauma, and the inclusion of parents or care providers on the treatment," (Cohen, 1998 p. 1002).

Conclusion

Post-traumatic stress disorder is a complicated and serious mental health problem for many children and adolescents. If not treated appropriately it can leave these youth struggling with unresolved emotions for the rest of their lives. Additional research is

needed to better understand how PTSD impacts children and adolescents. Without focused research, it is difficult for counselors to make educated assessments and implement effective treatment to this in-need youth group.

What is clear is that if not treated appropriately, PTSD can have a devastating effect on a young person. It is important that counselors and caregivers work together and take a comprehensive approach to identifying, assessing, and treating PTSD in children and adolescents.

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