References & Further Reading: Trauma in Children & Young People

Key references are boxed

Assessment and diagnosis

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders 4th ed: Text Revision. (DSM-IV-TR).* Washington, DC: Author.

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Meiser-Stedman, R et al (2009). Development and validation of the Child Post-Traumatic Cognitions Inventory (CPTCI) *Journal of Child Psychology and Psychiatry*, 50:4, 432-440.

Ohan, J.L., et al. (2002). Ten-year Review of Rating Scales. IV: Scales Assessing Trauma and its Effects. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(12), 1401-1422.

Saigh, P.A., et al. (2000). The children's PTSD Inventory: development and reliability. *Journal of Traumatic Stress*, 13(3), 369-380.

Scheeringa, M.S., et al. (2003). New findings on alternative criteria for PTSD in preschool children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(5), 561-570.

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PTSD and other responses

Meiser-Stedman, R. (2002). Towards a Cognitive-Behavioral Model of PTSD in Children and Adolescents. *Clinical Child & Family Psychology Review*, 5(4), 217-232.
Posttraumatic stress disorder in children and adolescents has been studied only for the past 15-20 years and is the subject of a burgeoning corpus of research. Much research has focused on examining whether children and adolescents have the same responses to trauma as those experienced by adults. Many of the research tools used to investigate children's responses are taken from measures designed for use with adults, and these measures have proven to be useful. However, it has not been established that children's responses to traumatic events are related to the same underlying processes as are adults' responses. The possible application of 2 recent cognitive models of PTSD in adults to understanding PTSD in children and adolescents is discussed in this paper, within the context of what is already known about children's reaction to trauma and existing theoretical accounts of childhood PTSD. Particular attention is paid toward the nature of children's memories of traumatic events and how these memories relate to the re-experiencing symptoms of PTSD, and cognitive processes that may play a role in the maintenance of PTSD. It is proposed that the adoption of a more specific cognitive-behavioral framework may be beneficial and lead to better treatment outcomes.

Salmon, K. & Bryant, R.A. (2002). Posttraumatic stress disorder in children. The influence of developmental factors. *Clinical Psychology Review*, 22, 163-188.
Despite the prevalence of childhood trauma, there are currently no developmentally oriented cognitive theories of posttraumatic stress disorder (PTSD). This paper outlines the definitional issues of PTSD in children, reviews the incidence of PTSD in children, and compares PTSD profiles in children and adults. We propose that a cognitive theory of childhood PTSD needs to accommodate developmental factors, including knowledge, language development, memory, emotion regulation, and social cognition, in addition to contextual factors such as family interactions. Implications of these developmental factors for assessment and treatment of traumatized children are discussed

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Saigh, P.A. (1991). The development of posttraumatic stress disorder following four different types of traumatization. *Behaviour Research & Therapy*, 29(3), 213-216.

Trickey, D., et al. (2012). A meta-analysis of risk factors for PTSD in children and adolescents. *Clinical Psychology Review*, 32, 122-138.

Early intervention

Hobfoll, S.E., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry: Interpersonal and Biological Processes*, 70(4), 283-315.
Given the devastation caused by disasters and mass violence, it is critical that intervention policy be based on the most updated research findings. However, to date, no evidence-based consensus has been reached supporting a clear set of recommendations for intervention during the immediate and the mid-term post mass trauma phases. Because it is unlikely that there will be evidence in the near or mid-term future from clinical trials that cover the diversity of disaster and mass violence circumstances, we assembled a worldwide panel of experts on the study and treatment of those exposed to disaster and mass violence to extrapolate from related fields of research, and to gain consensus on intervention principles. We identified five empirically supported intervention principles that should be used to guide and inform intervention and prevention efforts at the early to mid-term stages. These are promoting: 1) a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, and 5) hope.

Rose, S., et al. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, Issue 2.
Background Over approximately the last fifteen years, early psychological interventions, such as psychological 'debriefing', have been increasingly used following psychological trauma. Whilst this intervention has become popular and its use has spread to several settings, empirical evidence for its efficacy is noticeably lacking. This is the third update of a review of single session psychological "debriefing", first having been undertaken in 1997. ***Objectives*** To assess the effectiveness of brief psychological debriefing for the management of psychological distress after trauma, and the prevention of post traumatic stress disorder. ***Selection criteria*** The focus of RCTs was on persons recently (one month or less) exposed to a traumatic event. The intervention consisted of a single session only, and involved some form of emotional processing/ventilation, by encouraging recollection/reworking of the traumatic event, accompanied by normalisation of emotional reaction to the event. ***Data collection and analysis*** 15 trials fulfilled the inclusion criteria. Methodological quality was variable, but the majority of trials scored poorly. Data from 6 trials could not be included the meta-analyses. These trials are summarised in the text. Main results Single session individual debriefing did not prevent the onset of post traumatic stress disorder (PTSD) nor reduce psychological distress, compared to control. At one year, one trial reported a significantly increased risk of PTSD in those receiving debriefing (OR 2.51 (95% CI 1.24 to 5.09). Those receiving the intervention reported no reduction in PTSD severity at 1-4 months (SMD 0.11 (95%CI 0.10 to 0.32)), 6-13 months (SMD 0.26 (95%CI 0.01 to 0.50)), or 3 years (SMD 0.17 (95%CI -0.34 to 0.67)). There was also no evidence that debriefing reduced general psychological morbidity, depression or anxiety, or that it was superior to an educational intervention. ***Authors' conclusions*** There is no evidence that single session individual psychological debriefing is a useful treatment for the prevention of post traumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease. A more appropriate response could involve a 'screen and treat' model (NICE 2005).

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Stallard, P., et al. (2006). A randomised controlled trial to determine the effectiveness of an early psychological intervention with children involved in road traffic accidents. *Journal of Child Psychology and Psychiatry*, 47, 127-34.

Therapy

Smith, P., et al. (2010). *PTSD: Cognitive Therapy with Children and Young People.* Routledge.

Cohen, J.A., et al. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents.* Guilford Press.

Bennett, K., et al. (2013). CBT age effects in child and adolescent anxiety: an individual patient data meta-analysis. *Depression and anxiety*, 30, 829–841.

Appleton, P.L. (Ed.) (2008). *Children's Anxiety – A Contextual Approach.* Routledge.

Cohen, J.A., et al. (2009). CBT for Children and Adolescents. In Foa et al (Eds.) *Effective Treatment for PTSD: Practice Guidelines from the ISTSS.* Guilford Press. [Practice Guidelines available from www.ISTSS.org]

Fuggle, P., Dunsmuir, S., & Curry, V. (2012). *CBT with Children, Young People & Families*. Sage.

Gillies, D. et al. (2012) Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. *Cochrane Database of Systematic Reviews* 2012, Issue 12.

Grave, J. & Blissett, J. (2004). Is cognitive behavior therapy developmentally appropriate for young children? A critical review of the evidence. *Clinical Psychology Review*, 24, 399–420

Gupta, L. & Zimmer, C. (2008). Psychosocial intervention for war-affected children in Sierra Leone. *The British Journal of Psychiatry*, 192, 212–216.

Home Office, Crown Prosecution Service and Department of Health (2001). *Provision of Therapy for Child Witnesses Prior to a Criminal Trial - Practice Guidance*. CPS. Also available at www.cps.gov.uk

National Collaborating Centre for Mental Health (2005). *Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. National Clinical Practice Guideline No 26*. London, National Institute for Health and Clinical Excellence (NICE)

Scheeringa, M.S. (1999). Treatment for post-traumatic stress disorder in infants and toddlers. *Journal of Systemic Therapies*, 18 (2), 20-31.

Sburlati, E. S., et al. (2011). A model of therapist competencies for the empirically supported cognitive behavioral treatment of child and adolescent anxiety and depressive disorders. *Clinical Child and Family Psychology Review*, 14, 89–109.

Stallard, P. (2006). Psychological interventions for post-traumatic reactions in children and young people: A review of randomised controlled trials. *Clinical Psychology Review*, 26(7), 895-911.

Stallard, P. (2002). *Think Good Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People*. John Wiley & Sons. (And the accompanying Clinician's guide)

Trickey, D. (2013). Post-traumatic Stress Disorders. In Graham & Reynolds (Eds.) *Cognitive Behaviour Therapy for Children and Families 3rd Edition*. CUP.

Neurological and biological impact of psychological trauma

McCrory, E., et al. (2010). Research Review: The neurobiology and genetics of maltreatment and adversity. *Journal of Child Psychology and Psychiatry*, 51(10), 1079-1095.

The neurobiological mechanisms by which childhood maltreatment heightens vulnerability to psycho- pathology remain poorly understood. It is likely that a complex interaction between environmental experiences (including poor caregiving) and an individual's genetic make-up influence neurobiological development across infancy and childhood, which in turn sets the stage for a child's psychological and emotional development. This review provides a concise synopsis of those studies investigating the neurobiological and genetic factors associated with childhood maltreatment and adversity. We first provide an overview of the neuroendocrine findings, drawing from animal and human studies. These studies indicate an association between early adversity and atypical development of the hypothalamic- pituitary-adrenal (HPA) axis stress response, which can predispose to psychiatric vulnerability in adulthood. We then review the neuroimaging findings of structural and functional brain differences in children and adults who have experienced childhood maltreatment. These studies offer evidence of several structural differences associated with early stress, most notably in the corpus callosum in children and the hippocampus in adults; functional studies have reported atypical activation of several brain regions, including decreased activity of the prefrontal cortex. Next we consider studies that suggest that the effect of environmental adversity may be conditional on an individual's genotype. We also briefly consider the possible role that epigenetic mechanisms might play in mediating the impact of early adversity. Finally we consider several ways in which the neurobiological and genetic research may be relevant to clinical practice and intervention.

Cohen, J.A., et al. (2002). Treating Traumatized Children: Clinical Implications of the Psychobiology of Posttraumatic Stress Disorder. *Trauma, Violence and Abuse*, 3(2), 91-108

There is growing evidence that child maltreatment and posttraumatic stress disorder result in numerous neurobiological alterations in children and adolescents, including abnormalities in brain structure and functioning. This article reviews several psychobiological systems with regard to their functioning under normal stress and in the presence of posttraumatic stress disorder, with a focus on recent research findings in children and adolescents, and the implications these findings have on clinical intervention for traumatized children. The importance of early identification and treatment of traumatized children and the need to empirically evaluate psychopharmacological interventions for childhood posttraumatic stress disorder are discussed in detail. Research and policy priorities are also addressed.

Gunnar, M. & Quevedo, K. (2007). The Neurobiology of Stress and Development. *Annual Review of Psychology*, 58, 145-173.

Perry, B.D., et al. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits". *Infant Mental Health Journal*, 16(4), 271-291.

Bereavement

Dowdney, L. (2000). Annotation: Childhood Bereavement Following Parental Death. *Journal of Child Psychology and Psychiatry*, 41(7), 819 - 830.
Psychological outcomes in children who have experienced the death of a parent are heterogeneous. One child in five is likely to develop psychiatric disorder. In the year following bereavement children commonly display grief, distress and dysphoria. Non specific emotional and behavioural difficulties among children are often reported by surviving parents and the bereaved children themselves. The highest rates of reported difficulties are found in boys. This review identifies the moderating and mediating variables that lead to some children being more vulnerable to disturbance than others following parental death. Limitations and gaps in the bereavement literature are identified. Theoretical and methodological advances that are necessary for a coherent account of childhood bereavement are identified.

Dyregrov, A. (2008). *Grief in Children: A Handbook for Adults. 2nd Edition*. London: Jessica Kingsley.

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Trickey, D. (2005). Young people bereaved by suicide: what hinders and what helps. *Bereavement Care Journal*, 24(1), 11-14.

Refugees and asylum seekers

Barenbaum, J., et al. (2004). The psychosocial aspects of children exposed to war: practice and policy initiatives. *Journal of Child Psychology and Psychiatry*, 45(1), 41-62.
The atrocities of war have detrimental effects on the development and mental health of children that have been documented since World War II. To date, a considerable amount of knowledge about various aspects of this problem has been accumulated, including the ways in which trauma impacts child mental health and development, as well as intervention techniques, and prevention methods. Considering the large populations of civilians that experience the trauma of war, it is timely to review existing literature, summarize approaches for helping war-affected children, and suggest future directions for research and policy.

Ehntholt, K.A. & Yule, W. (2006). Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry*, 47(12), 1197–1210.
Background: Increasingly clinicians are being asked to assess and treat young refugees, who have experienced traumatic events due to war and organised violence. However, evidence-based guidance remains scarce. **Method**: Published studies on the mental health difficulties of refugee children and adolescents, associated risk and protective factors, as well as effective interventions, particularly those designed to reduce war-related post-traumatic stress disorder (PTSD) symptoms, were identified and reviewed. The findings are summarised. **Results**: Young refugees are frequently subjected to multiple traumatic events and severe losses, as well as ongoing stressors within the host country. Although young refugees are often resilient, many experience mental health difficulties, including PTSD, depression, anxiety and grief. An awareness of relevant risk and protective factors is important. A phased model of intervention is often useful and the need for a holistic approach crucial. Promising treatments for alleviating symptoms of war-related PTSD include cognitive behavioural treatment (CBT), testimonial psychotherapy, narrative exposure therapy (NET) and eye movement desensitisation and reprocessing (EMDR). Knowledge of the particular needs of unaccompanied asylum-seeking children (UASC), working with interpreters, cross-cultural differences, medico-legal report writing and the importance of clinician self-care is also necessary.

Lustig, S.L., et al. (2004). Review of child and adolescent refugee mental health. *Journal of American Academy of Child and Adolescent Psychiatry*, 43(1), 24-36.

Websites

The National Child Traumatic Stress Network (www.nctsnet.org). An American based network that provides excellent resources for parents, schools, the media and professionals, including a manual for psychological first aid.

The Children and War Foundation (www.childrenandwar.org) Provides group manual for intervention, training and copies of measures.

International Society for Traumatic Stress Studies (www.istss.org) An American based society, offering various resources, including downloadable versions of their treatment guidelines.