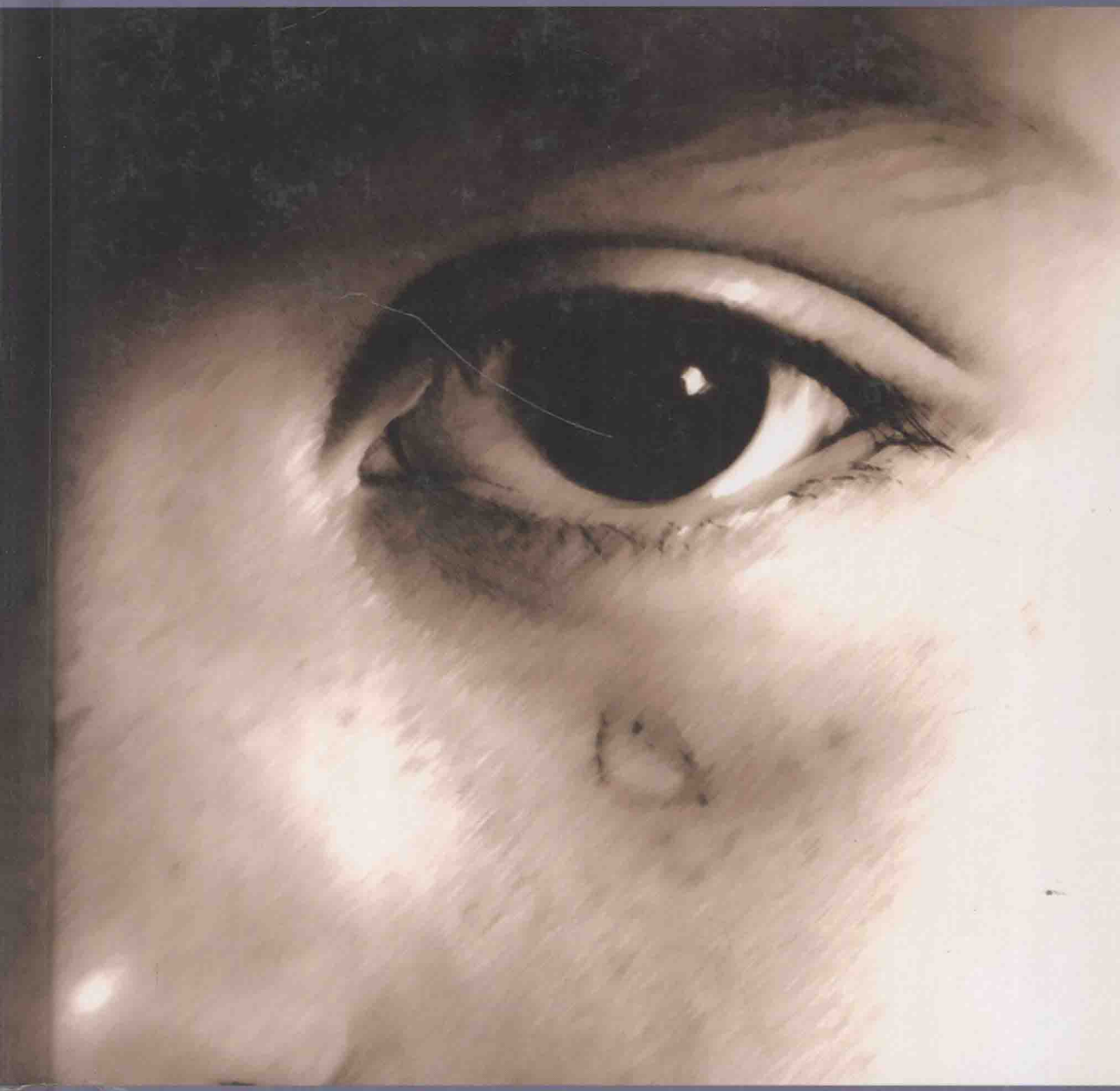
Post-Traumatic Syndromes in Childhood and Adolescence

A Handbook of Research and Practice



Edited by Vittoria Ardino

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WILEY-BLACKWELL
A John Wiley & Sons, Ltd., Publication

This edition first published 2011

Wiley-Blackwell is an imprint of John Wiley & Sons, formed by the merger of Wiley's global Scientific, Technical, and Medical business with Blackwell Publishing.

Registered Office
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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9600 Garsington Road, Oxford, OX4 2DQ, UK
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Library of Congress Cataloging-in-Publication Data

Post-Traumatic syndromes in childhood and adolescence / edited by Vittoria Ardino.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-470-99769-7 (cloth)
1. Post-Traumatic stress disorder in children. 2. Post-Traumatic stress disorder in adolescence. I. Ardino, Vittoria.
[DNLM: 1. Stress Disorders, Post-Traumatic. 2. Adolescent. 3. Child. WM 170 P859 2010]
RJ506.P55P676 2010
616.85'21–dc22

2010010077

A catalogue record for this book is available from the British Library.

This book is published in the following electronic formats: ePDF [9780470669297]; Wiley Online Library [9780470669280]

Typeset in 10.5/13pt Galliard by Aptara Inc., New Delhi, India.
Printed and bound in Singapore by Fabulous Printers Pte Ltd

1 2011

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Vittoria Ardino is currently Senior Lecturer in Forensic Psychology at the London Metropolitan University (UK) where she teaches psychology of criminal behavior. She is also the President of the Italian Society for the Studies of Traumatic Stress and a board member of the European Society for Trauma and Dissociation and the European Society for Traumatic Stress Studies. Her research interests bridges clinical and forensic psychology with a focus on post-traumatic stress reactions in offender populations. She has presented in various international conferences and published a book and several articles about early trauma and violence. She also delivers consultancy in UK and Italy.

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Foreword

Christine A. Courtois

Trauma and exposure to trauma are ubiquitous in contemporary society. Available data document a high probability of direct exposure/experience at some time over the course of the lifespan for the average child and adult, as well as increased vulnerability and risk factors for some that make traumatization more likely. *Age is a primary risk factor* for all forms of victimization, whether intrafamilial or within the community (Finkelhor, 2008). Children and adolescents are more likely to be victimized than adults due to a number of vulnerabilities that accompany age; these include personal aspects such as their size, physical and developmental immaturity, dependence, and relative powerlessness; family aspects such as parental availability and ability, and their relative health, mental health, and family structure; and community aspects such as poverty and degree of violence. Additionally, media and instantaneous electronic communication have exponentially increased the possibility of indirect exposure. These make it possible to learn about, share or vicariously experience traumas that were not personally experienced, exposure that occurs in addition to any other that is more personal or direct. If that is not enough, in recent years we have learned that it is possible to be traumatized directly through these same electronic means (cyberbullying, cyberstalking, cyber-sexual predation, exposure to pornography, etc.) and that a high percentage of children and adolescents have already been exposed to victimization of this sort. Taken together, these create a much compounded circumstance of vulnerability and traumatization, one that adults might have trouble processing, much less children.

To date and with some exceptions, children have been almost an afterthought in traumatic stress studies and certainly in the development of diagnostic formulations. The primary focus over the course of the twentieth century has been on combat trauma and its consequences. The current diagnosis of

Post-Traumatic Stress Disorder (PTSD) reflects findings about the consequences of warfare on late adolescent/adult men who had been trained for such exposure. At present, there is no diagnosis of PTSD in children in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*) (APA, 2000) although there is mention of how PTSD might manifest differently in children. It is only recently that attention has shifted to childhood trauma and how it might differ from trauma experienced by adults. In particular, as the unique vulnerabilities and risk factors of children (starting within their own families in the form of child abuse and neglect and attachment disturbances) have been recognized, the potential developmental impact of such traumatization has been similarly recognized.

This book is a result of this recognition and is a broad compendium of information about children, their vulnerability to trauma, and the various post-traumatic syndromes that can occur in its wake, including those that co-occur with the criteria of "traditional" PTSD and those that are additional to these (currently identified as complex traumatic stress reactions; Courtois & Ford, 2009) and encompassed within the proposed diagnosis of Developmental Trauma Disorder (van der Kolk, 2005). It surveys the progress that has been achieved in almost three decades of scientific study and focuses on child-centered vs. adult-centered consequences and, in particular, on their developmental impact. This is of critical importance because this is what has not been attended to in the traditional conceptualization of PTSD. The book's focus provides recognition of the different, age- and stage-related ways that children might react to traumatization that are different from those of adults. It also acknowledges that childhood traumatization within a family or other relational context is often repetitive, may be chronic, involves betrayal, and may span developmental epochs. In this way, such ongoing exposure has high potential to impact and even to derail the child's development in a variety of life spheres. The recent findings regarding the biophysiological effects of trauma on children and those of attachment studies have attested to how traumatization truly has a mind–body impact on the developing child. Judy Herman wrote that PTSD enters the child's personality (Herman, 1992) and we now know that it enters the physiology as well.

This book points its readers toward the ecology of the traumatization of children and offers strategies for assessment and treatment from an ecological perspective. It explicitly recognizes that to accurately treat the traumatized child, the trauma needs to be considered (this almost goes without saying but a common finding is that children are routinely diagnosed as ADHD, bipolar, depressed, oppositional-defiant, or conduct-disordered without awareness of or attention to the possibility that their symptoms are, in fact, post-traumatic/dissociative and need direct treatment), and that available protective factors need recognition and boosting. Unrecognized trauma and untreated effects put children at risk for additional distress over the lifespan and makes them vulnerable to revictimization (the latter is especially the case for those

who were subjected to incest or other forms of sexual abuse). It is critical that mental health professionals begin to understand much of the material that is included in this text so that they can increase their awareness and expand their range of interventions. The treatment of children is itself preventive: it has the potential of saving the individual from additional post-traumatic distress and victimization; furthermore, it interrupts the intergenerational transmission patterns that have been identified that support what has become known as the cycle of violence, a major step in safeguarding the next generation.

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Acknowledgments

This book would not have been possible without the contributions of researchers and clinicians who devoted their professional commitment to the understanding of childhood post-traumatic reactions. I am extremely grateful to all contributors who provided their expertise, experience, and knowledge to this work.

I would also like to acknowledge experts in the trauma field who I have met through ESTSS (European Society for Traumatic Stress Studies). Since I became involved in this society, they have been an incredible source of knowledge, providing a personal challenge to learn and reflect more on trauma and its consequences. Special thanks to Antonia Bifulco, Paola Di Blasio, Miranda Olff, Brigitte Lueger-Schuster who have continuously supported my professional growth.

Among those deserving special credit are the students who contributed ideas, activities, insightful questions to my research on trauma and PTSD in delinquency Special thanks go to my editor Karen Shield at Wiley-Blackwell for her skills and warm support during this process and Maxim Shrestha for his support during the editing process.

Vittoria Ardino
October 2010

Contents

About the Editor ix

Contributors xi

Foreword xv
Christine Courtois

Acknowledgments xix

Introduction 1
Vittoria Ardino

PART I ASSESSMENT 13

Chapter 1 Evaluation and Diagnosis of PTSD in Children and Adolescents 15
Kathleen Nader

Chapter 2 Vulnerability and Resilience in Childhood Trauma and PTSD 43
Scott D. Cicero, Kate Nooner, and Raul Silva

PART II CONTEXT-SPECIFIC REACTIONS TO TRAUMA 61

Chapter 3 The Impact of Lower Magnitude Stressors on Child and Adolescent Development: The Family Context 63
Don Catherall

Chapter 4 Stories of Children and Adolescents from Other Cultures: The Trauma of Migration 77
Dalila Rezzoug, Thierry Baubet, and Marie Rose Moro

Chapter 5 Post-Traumatic Stress Related to Pediatric Illness and Injury 91
Elena Camisasca

PART III NEUROBIOLOGY, MEMORY AND DISSOCIATIVE PROCESSES 111

Chapter 6 Neuropsychological Underpinnings of PTSD in Children and Adolescents 113
Helen Z. MacDonald, Jennifer J. Vasterling, and Ann Rasmusson

Chapter 7 Why and how People Forget. Why and how People Forget Sexual Abuse. The Role of Traumatic Memories 135
Kathryn A. Becker-Blease, Anne P. DePrince, and Jennifer J. Freyd

Chapter 8 Dissociation in Traumatized Children and Adolescents 157
Eli Somer

PART IV FORENSIC ASPECTS 175

Chapter 9 The Role of PTSD in Understanding Child Allegations of Sexual Abuse 177
Paola Di Blasio, Sarah Miragoli, and Rossella Procaccia

Chapter 10 Exposure to Violence, Post-Traumatic Symptomatology, and Criminal Behaviors 199
David W. Foy, James Furrow, and Shauna McManus

Chapter 11 Post-Traumatic Stress in Antisocial Youth: A Multifaceted Reality 211
Vittoria Ardino

PART V PSYCHOSOCIAL INTERVENTIONS 231

Chapter 12 Schools as a Context of Trauma Prevention 233
Barbara Oehlberg

Chapter 13 A City-Wide School-Based Model for Addressing the Needs of Children Exposed to Terrorism and War 243
Ruth Pat-Horenczyk, Danny Brom, Naomi Baum, Rami Benbenishty, Miriam Schiff, and Ron Avi Astor

Chapter 14 Helping Children after Mass Disaster: Using a Comprehensive Trauma Center and School Support 255
Brigitte Lueger-Schuster

PART VI THERAPEUTIC MODELS 273

Chapter 15 Use of Somatic Experiencing Principles as a PTSD Prevention Tool for Children and Teens during the Acute Stress Phase Following an Overwhelming Event 275
Peter Levine and Maggie Kline

Chapter 16 EMDR and the Challenge of Treating Childhood Trauma: A Theoretical and Clinical Discussion with Case Examples 297
Barbara Wizansky

Chapter 17 Recent Advances in Cognitive-Behavioral Therapy for Traumatized Children and Teenagers 323
Dirk Flower and Stefania Grbcic

Chapter 18 A Constructivist Perspective on Post-Traumatic Stress in Children and Adolescents 345
Kenneth W. Sewell and Keith R. Cruise

Chapter 19 Trauma Systems Therapy: Intervening in the Interaction between the Social Environment and a Child's Emotional Regulation 373
B. Heidi Ellis, Glenn N. Saxe, and Jennifer Twiss

Chapter 20 PTSD in the Context of Childhood Endangerment: Implications for Assessment and Treatment 391
Patricia McKinsey Crittenden and Daniele Poggioli

Chapter 21 Compassion Fatigue, Vulnerability, and Resilience in Practitioners Working with Traumatized Children 417
Charles R. Figley, Cheri Lovre, and Kathleen Regan Figley

Chapter 22 Future Directions in Conceptualizing Complex Post-Traumatic Stress Syndromes in Childhood and Adolescence: Toward a Developmental Trauma Disorder Diagnosis 433
Julian D. Ford

Afterword 449
Giovanni Liotti

Index 453

Introduction

Vittoria Ardino

Trauma exposure is a significant mental health concern that impacts on children and adolescents in complex ways (Harris, Putnam, & Fairbank, 2006). Younger victims of extreme stress can be seriously affected by the overwhelming challenge of trauma and thus may enter the world with limited cognitive, affective, and behavioral baggage resulting in a spectrum of post-traumatic outcomes. It is commonly understood that youth display a wide range of post-traumatic reactions, including Post-Traumatic Stress Disorder (PTSD) a controversial and yet considerably investigated disorder that may follow a traumatizing experience.

PTSD was formally included in the list of psychiatric disorders in 1980 with the publication of *DSM-III* (American Psychological Association (APA), 1980) and the identification of a triadic cluster of symptoms (reexperiencing, avoidance, and hyperarousal) documented in Vietnam veterans and in rape victims (Perrin, Smith, & Yule, 2000), and later applied to adult civilians.

The first mention of PTSD in children and adolescents had already appeared in the early years of the twentieth century (Saigh & Bremner, 1998); yet decades of studies have demonstrated that children can develop PTSD along with other post-traumatic syndromes. In 1976, Leonore Terr conducted a seminal study on children's reactions to trauma prior to the publication of *DSM-III*. In that year, 26 schoolchildren and their bus driver living in Chowchilla, California, were kidnapped and buried alive in a van for a long period of time before escaping. Terr's important work established that traumatized children exhibited a unique constellation of signs and symptoms in order to master their experience (Terr, 1979). Next, the revised version of *DSM-III* clarified that the diagnosis of PTSD was applicable to children who had "experienced an event outside the range of usual human experience ... that would be markedly distressing to almost anyone" (*DSM-III-R*; APA, 1987).

Post-Traumatic Syndromes in Childhood and Adolescence: A Handbook of Research and Practice, First Edition. Edited by Vittoria Ardino. Published 2011 by John Wiley & Sons, Ltd.

The fourth edition of *DSM* and its revision (APA, 2000) refined consistently the diagnostic criteria for PTSD clarifying Criterion A as follows:

> The person has been exposed to a traumatic event in which both of the following have been present:
>
> 1. The person has experienced, witnessed, or been confronted with an event or events, that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
> 2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed by disorganized or agitated behavior.

This redefinition emphasizes the threatening nature of the traumatic event and the subjective reaction to such an experience, rather than focusing on an event outside any ordinary occurrence as was stipulated in *DSM-III*. Experts also attempted to better clarify diagnostic criteria of PTSD in children and adolescents (i.e. disorganized and agitated behavior in Criterion A.2), noting that repetitive and thematic play, traumatic reenactment, and nightmares focused on both traumatic and nontraumatic content among children's specific reactions. The myriad of studies on child trauma and the revision of diagnostic criteria demonstrate that researchers and clinicians have recognized the importance of identifying specific developmental stress reactions, diagnostic systems, and intervention models. However, PTSD and other trauma-related disorders in children and adolescents have been less extensively studied than in adults leaving the diagnostic systems, and intervention models problematic and the identification of symptoms often developmentally inaccurate and still adult-centered, especially for chronic and complex traumatization (Carrion et al., 2002; Levendosky et al., 2002).

Chronically traumatized children display a conglomeration of trauma-related symptoms that imply pervasive problems of self-regulation and together with attachment relationships, dissociation, depersonalization, and impulse discontrol cannot be considered as "PTSD-only" reactions, but as complex trauma reactions. Complex PTSD (CPTSD) (Herman, 1992; van der Kolk, 1996) is a clinical formulation (which may be included in the proposed *DSM-V* expected out in 2011), which refers to the results of prolonged exposure to trauma and, usually, within a care-giving relationship. Research and intervention in children and adolescents with CPTSD is even more in its infancy and requires further investigation into the necessary multimodal assessment and the use of various psychometric instruments to screen for a variety of issues (Cook et al., 2003; Cook et al., 2005). Likewise, complex trauma interventions that address safety, self-regulation, and the integration of the traumatic experience need to be considered and further investigated (Cook et al., 2005).