

EARLY INTERVENTION WITH TRAUMATIZED CHILDREN

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With the events of September 11th, childhood trauma has come to the forefront of national attention. One of the common psychiatric outcomes of trauma is Posttraumatic Stress Disorder (PTSD). Despite the fact that certain vulnerabilities may contribute to the development of PTSD in traumatized youth, the existence of an identifiable stressor provides a unique opportunity for early intervention. Cognitive Behavioral Treatment (CBT) interventions are considered by many to be the mainstay of treatment of children and adolescents with PTSD. More severe cases of PTSD are often treated with medications in the community. In this article we present a CBT program—developed by our site—STAIR—and provide useful guides and rationales for clinicians to work with when treating this population. We will also briefly review the available literature on the psychopharmacologic interventions to help guide the physician when confronted with such treatment decisions.

KEY WORDS: PTSD; trauma; children; CBT; medication.

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INTRODUCTION

Posttraumatic Stress Disorder (PTSD) officially found its way into the psychiatric nomenclature in 1980 with the publication of the Diagnostic and Statistical Manual of Mental Disorders-Third Edition. Yet it was not until 1987, with the advent of DSM-III-R, that an alternate presentation was acknowledged on the basis of age. Interestingly, reports of children with clinical features of reexperiencing, avoidance, and hyperarousal following stressors date back to the 1930's (1,2).

PTSD requires exposure to a serious event, which must be outside the range of normal human experience. In children, the exposure to high index stressors increase the risk for developing PTSD (3). Repeated exposure to these stressors further increase the risk of PTSD (4).

A variety of serious stressors have been linked to the development of PTSD, which include sequestration (5), crime (6), burns (7), dam collapses (8), earthquakes (9), train accidents (10), and hurricanes (11).

A number of noxious elements experienced by children living in the inner city have led investigators to study the rates of stress exposure and the consequent development of PTSD in their samples. Fitzpatrick and Boldizar (12) reported that 70% of youth in an inner city sample were exposed to at least one serious stressor. Silva et al. (13) reported that 59 percent of their sample were also exposed to similar stressors. In the Fitzpatrick and Boldizar (12) study, 27 percent of those exposed developed PTSD as compared to 22% in the Silva et al. (13) sample. The rate of developing PTSD in these two studies are remarkably similar to those of Deykin and Buka (14) and Giaconia et al. (15).

Most children and adolescents in the New York City metropolitan area were witness to the terrorist attacks of September 11, 2001, in one way or another. The Board of Education survey (16) conducted 6 months after the terrorist attacks found that 64% of children in the New York City schools had experienced at least one significant traumatic event previous to 9/11. The most common events were having seen someone killed or seriously injured (40%) and the violent or accidental death of a family member (25%). This information told us two important things. First, the majority of children in public schools were vulnerable to the development of posttraumatic stress symptoms as a previous history of trauma is an identified risk factor. Secondly, and perhaps more importantly, the history of interpersonal violence among many children and youth suggested that short-term crisis intervention might not be an adequate intervention for these multiply traumatized children. Pine and Cohen (17) have concluded that much of the data in the child mental health field indicate that the optimal initial treatment

for traumatized children must include a cognitive behavioral treatment (CBT) approach.

In the following sections we will present an example of a CBT model named, *The Skills Training in Affect and Interpersonal Regulation*, developed by Cloitre et al. (18). The presentation will incorporate a guide and useful insights for treating clinicians, based on our clinical experience and research. We will also provide a summary of the literature available on the pharmacologic treatment of traumatized youth who develop stress related psychopathology.

The Skills Training in Affect and Interpersonal Regulation with Narrative Story Telling (STAIR/NST) program is a treatment procedure developed at the Institute of Trauma and Stress at the New York University Child Study Center. A pilot study conducted with twenty multiply traumatized youth has warranted further investigation of the utility of this treatment program. Children and adolescents who are displaying clinically significant levels of anxiety, depression, and maladaptive behaviors, which are indicative of posttraumatic stress disorder, may be recruited through school and community based organizations and clinics. A brief description of the program's approach to treatment, potential benefits, and expected reactions to treatment is provided prior to requesting the consent of the child and caregiver. A pretreatment interview or session also enables the therapist to determine whether or not a particular individual is appropriate for this treatment protocol.

The major objectives of the STAIR program comprise the identification and labeling of feelings, the development of emotion regulation skills, practice with handling distress-inducing interpersonal situations, and mastery of self-esteem/self-efficacy building tasks. Essentially, adolescents are taught coping skills for labeling and managing emotions and for better navigating interpersonal relationships prior to imaginal exposure. The acquisition of a comprehensive set of skills to handle the effects of traumatic experiences may empower the youth and enable them to cope effectively if and when faced with distressing situations in the future.

The STAIR program is designed to be conducted over the course of sixteen weeks or sessions. The first ten sessions of this program focuses on providing psychoeducation and building skills in emotion regulation, cognitive processing and/or restructuring, and interpersonal relationships. The development of competence with these skills is a probable prerequisite to success with the Narrative Story telling, a form of imaginal exposure, which is to take place during the latter six treatment sessions. The STAIR program can be administered by either individualized treatment or group therapy sessions. The particular modalities

utilized are selected according to the needs of the individual. The NST component is conducted in individual sessions to reduce risk of re-traumatization or secondary traumatization which can occur in group settings (19). Differences between the needs of younger children and adolescents are expected; group treatment is typically more successful with older children and adolescents.

Children are trained in emotional, cognitive and behavioral coping methods prior to the process of modified imaginal exposure. Take home assignments are supplied so that children can practice their new skills at home and report their progress for evaluation with the therapist.

PSYCHOEDUCATION

Psychoeducational aspects of this program focus on the rationale for gradual exposure to traumatic experiences, particularly in regards to evaluating the impact of the event on the youth's sense of self and beliefs about the world. Typically, traumatic experiences undermine an individual's sense of mastery and competence and generate views about the world as a dangerous place. The central goal of the treatment is to help reassert, enhance or develop the youth's sense of competence and to help him identify both internal and external resources for coping with difficulties. The purpose of the skills development component is to help the youth experience mastery in day to day life events and enhance functioning. The second component of treatment, NST, has the same goal, but in this instance specifically addresses obtaining mastery over the feared memories of traumatic events. By addressing and making meaning of a traumatic history, the individual gains mastery over the experience. The sum effect of these two treatment components is to enhance the youth's overall sense of competence and beliefs in their ability to successfully manage the inevitable life stressors that lay ahead.

The first session with the youth focuses on initiating the therapeutic relationship and establishing a hopeful foundation for treatment. During this session, the rationale for participation in this treatment will be explained along with probable and typical benefits associated with treatment; essentially what the youth may expect and hope to accomplish. Psychoeducation will also be incorporated to increase the youth's awareness of his/her situation with respect to that of other adolescents. Building a positive rapport with the youth will make possible the expression of feelings and thoughts regarding the experience of trauma in a safe place.

Psychoeducation elucidates the reasons behind various emotional cognitive and behavioral responses to trauma. This knowledge assists

youth in understanding and substantiating their emotional reactions to traumatic events. The course of psychoeducation will begin with instruction in how to identify and label qualitatively different feelings. A typical sequence for this training involves the identification of salient emotions and where they occur in the body. However, emotions such as anger and fear have similarities in terms of their corresponding physical manifestations. Therefore, participants in conjunction with their therapists can delineate the circumstances that tend to elicit particular emotions. The composition of short stories, pictorial identification, and discussions of real-life experiences can all be utilized in order to elucidate the connections between events and feelings. A concrete ability to distinguish between individual emotions sets the stage for teaching individuals to differentiate between thoughts and emotions.

Evaluation of the developmental status of each child or adolescent will enable the therapist to determine the appropriate method(s) needed to bring forth an understanding of how and why thoughts occur. Of vital importance is teaching each individual to comprehend that thoughts are intangible experiences that occur as a result of both internal and external stimuli. The therapist can ask the client to describe what thoughts make them happy or sad and what parts of their bodies correspond with these changes. Considering the notion that other person's thoughts differ from their own in reaction to similar events or situations generate opportunities to broaden a child's emotional scope. Moreover, individual emotional reactions or interpretations of events are often reflected in actions that may or may not be appropriate; examples of harmful behaviors to oneself and others will be discussed. It is also important for each participant to learn that although their thoughts have considerable influence over their emotions, they themselves have control over these thoughts. The ability to discriminate between feelings and thoughts helps pave the way for the child's training in affect regulation.

Affect Regulation

Emotion regulation is an essential coping mechanism for children and adolescents to learn. Depending on the developmental stage of the child, they will have varying levels of success in mastering the ability to identify emotional responses to events and instruction has to be adjusted accordingly. Affect regulation relies on an individual's aptitude for recognizing and acknowledging the influence of their thoughts and actions on the experience of emotion. The capacity to distinguish between helpful and hurtful or distressing thoughts and actions is essential. Helpful thoughts are those that cause the child to experience content or a neutral emotional state. Distressing or hurtful thoughts will typically elicit

negative emotional reactions. As an example, the therapist can explain that believing you are bad and deserve to lose a parent will probably cause you to feel helpless and unhappy. Furthermore, negative thoughts that are global and imply a perceived lack of control, such as "all adults are vicious and will always want to hurt me" will also contribute to the preservation of negative thought processes. Such beliefs are extremely harmful and may inhibit or dampen the therapeutic procedure. The therapist can counterbalance these negative notions by providing emotional support as well as age appropriate explorations about other ways to view the world and by developing safe tests of these new ideas in the "real world" that are likely to be successful. Such tests provide experiential evidence of alternative and more positive ways of viewing self and the world. Continuous guidance in challenging and altering negative cognitive schemas encourages the development of confidence and assist in preparing each participant for difficult tasks, such as learning to initiate and respond to social interactions in appropriate, positive, and self-protective ways.

Interpersonal Skills Development

The use of role-plays to portray and afford opportunities for practice with difficult interpersonal situations is an extremely helpful tool for preparing youth to deal with comparable situations in real life. This may in turn lead to the development of confidence in their ability to handle socially distressing situations. A compilation of written, verbal, and pictorial scenarios can be presented for review by the individuals; role-plays can be tremendously effective for adolescents in group therapy. An example of such a scenario is as follows. A student passes you in the hallway and mutters an offense or curse. You need to determine if the insult was directed at you and decide whether to fight, ignore, or confront this person in a nonoffensive manner. Participants are encouraged to describe their interpretation and decision making process before acting. Once the interaction has begun, it is allowed to run its course for a limited time while observers can keep track of their comments or thoughts about the situation. During this training, each person is also able to exercise new skills in a safe environment while also receiving feedback for his/her performance. Moreover, events that transpire during treatment will facilitate the use of these skills and offer the therapist the chance to perform continuous evaluations of the treatment process.

Pleasurable events scheduling is a system by which individuals are permitted to determine the frequency of a positive event. With a

preordered schedule of positive events, children can more readily handle less pleasurable events such as relating the trauma experience in therapy.

Incorporating Additional Skills

The core interventions of STAIR are 1) the identification of beliefs about self and the world and modification of these schemas in a more positive or benign way 2) instantiation of these beliefs through alternative behaviors via role plays. In addition, it is necessary to identify and develop several other coping skills, tailored to each individual, that support their efforts in emotion regulation. Because emotion regulation is key to successful interpersonal functioning, it is very important to strengthen emotion management skills. These can include cognitive strategies such as self-talk (e.g., “I know this anxiety will pass” “I can just walk away”), and positive imagery, social strategies (e.g., walking away from a hostile situation or talking to friends) and behavioral strategies such as deep breathing or muscle relaxation.

Relaxation skills are useful for dealing with situations of acute distress and also can be easily implemented during the imaginal exposure to the traumatic memories that is embedded in the Narrative Story Telling. A particularly useful method for physical relaxation is diaphragmatic/deep abdominal breathing. Diaphragmatic breathing has produced promising results in the therapeutic process. However, since diaphragmatic breathing may cause difficulty for younger individuals, therapists may simplify the task by asking the child to lie on his/her back with an object placed across the abdomen. Children are then be instructed to take deep breaths so that the object moves with each inhalation and exhalation. An alternate method of instruction is to advise the individual to inhale while curling their arms towards their chest and making strong fists with their hands. The opposite movement is made with each exhalation. Thus, deep breathing is accomplished and a slower pace is achieved by the length of time needed to move the limbs.

Identifying Positive Beliefs About Self and Building Self-Esteem

Many multiply traumatized children have negative beliefs about themselves. These may have originated from the traumatic events but often have generalized across many situations and aspects of their functioning (i.e., “something bad happened to me, so I must be bad”). In STAIR,

specific activities are incorporated into the treatment to address this issue. This is particularly important as a preparation for conducting effective imaginal exposure. The narration of traumatic events often invokes negative beliefs about the self (“I am a loser,” “I am hateful, ugly”). It is important that positive beliefs about self have already been identified and concretized through various examples of success or the creation of successful experiences during STAIR. This permits the youth to more easily confront the potentially hidden negative beliefs that may emerge during the narration and to balance them realistically against their successes.

Each adolescent or child composes a list of positive self-statements that directly counter negative thoughts that surface within and outside of therapy. For example, if a student receives a bad test grade, instead of resorting to the opinion that they are inherently unintelligent, an alternate self-statement can resemble the following, “It is too bad that I didn’t do well this time, I will have to try harder for next time and get a better grade, just like I have done before.” Every time a negative thought enters their mind, the youth must consider the entire situation in order to generate a positive counter reply. A virtual reservoir of positive statements increases the probability of positive interpretations of events if participants are able to stabilize more extreme negative reactions and tap into newly available cognitive resources.

Composing a list of positive self-statements provides a fitting segue for personalized self-esteem and self-efficacy building tasks. These tasks can be accomplished in both individual and group treatment modalities. In the individual setting, therapists can focus on helping children and adolescents to realize their self-worth through discussion of personal achievements, secret talents, special social, physical, or cognitive abilities that may already be present or have the potential for exploration. In other words, individuals can fashion small goals for themselves in therapy and pursue these before their next session. Tasks can also be selected and completed during the therapeutic sessions so that guidance and continuous praise for both effort and achievement are provided. For example, a role-play can involve an emotionally taxing episode with a significant other, which when resolved can be very emotionally satisfying and physically relieving. More tangible and simpler tasks can include working with short puzzles, creating a visual, verbal, or written masterpiece (according to individual standards) or making a list of individual efforts and outcomes when helping oneself or others during the period between sessions. Increased participation and success can help foster feelings of and belief in the positive aspects of developing self-esteem and self-efficacy.

NARRATIVE STORY TELLING

Narrative Story Telling (NST) is a variation of imaginal exposure. It involves the recreation of parts or whole of the traumatic memory in words with a beginning middle and end. The results of this treatment process indicate a reduction in symptomatology as well as an alteration in cognitive schemas. The proposed method by which this works seems to be that in creating both words and images associated with the trauma, the individual accesses the cognitive schemas constructed to interpret the situation during the trauma experience and can reevaluate the accuracy of these beliefs. The telling of the trauma in a narrative form provides coherence to an often fragmented emotionally and cognitively disorganized experience. As the experience is organized, beliefs, particularly interpersonal schemas are revealed. These beliefs are evaluated in hindsight and often a more benevolent view of self emerges. The story is retold several times with the new appraisal in place (e.g., "I was weak because I could not help my brother escape" versus "I was only five years old and did the best I could"). The repeated telling of the story with detailed sensory-perceptual images provides continued exposure to feared stimuli which are not inherently dangerous (a blue sky or smoke) facilitating habituation.

Reduced fear of the memory of the trauma is reinforced by the acknowledgements, as appropriate, that the feared event is over. Creating a distinction between a terrorizing past and the safer present is a key aspect of narrative story telling. The narrative has intrinsic to it the idea of a timeline with the traumatic event being firmly placed in the past. As the story progresses towards the present, increasing emotional and cognitive distance from the past is reinforced. The story works to view the present as different and safer than the past and also allows imagining of the future as different still, instilling a sense of hopefulness about the possibility of change.

NST facilitates the discussion of personal trauma experiences in a safe environment, bolstered by the support of the therapist. Support will be provided regardless of the child's feelings, thoughts, and behaviors during treatment. Initial sessions focus on the relaying of facts with attention to maintaining the composure of the youth by not requiring lengthy and detailed accounts of the traumatic experience. However, the therapist may request that a specific element of the experience be imagined in detail. Each piece may be processed individually and then refashioned until an entire framework of the experience has been created and partially processed. Eventually, greater levels of exposure occur when the child is asked to both imagine and recount worse

moments in their traumatic experience. The therapist can suggest the use of supplemental techniques for the child to accomplish this reconstructing process. For example, the child can write a story about what happens, demonstrate with puppets, or provide a verbal narrative. The therapist may also prompt the child through the narrative process by asking them questions about the sequence of events, what they saw, heard, or felt during these times. In order to guide children through more difficult moments of recollection, many therapists utilize emotional barometers to monitor levels of emotional distress and modify their questions accordingly.

Multiple exposures to traumatic memories have been shown to aid in the decrease of anxiety and avoidance of trauma cues. Through repeated exposure and cognitive restructuring children will eventually realize that recounting their experience is not equivalent to reliving events and will have developed methods of interpreting the experience in a more acceptable manner, both cognitively and emotionally. Children and youth are very astute and may begin to feel empowered by their capacity to control their own responses to upsetting thoughts. As emotional responses decrease in severity, children will become more tolerant of trauma cues and less anxious about confronting future situations that may produce individual or interpersonal distress.

TERMINATION

The final two sessions of this program are designed to include parental/caregiver involvement in the therapeutic process. Heretofore, the parent witnesses the therapeutic process through interactions with the child at home. During these final two sessions, guidelines for caregiver-child interactions are established to promote mutually beneficial communication processes and a supportive relationship that can be sustained outside of therapy.

The termination of any treatment process is often difficult for children and adolescents. This is especially the case for children who have experienced loss due to trauma or other unfortunate circumstances. Therapists can take care to prepare individuals for the inevitable parting with some mention of the fact that the treatment process is coming to an end. Emphasis can be placed on the achievements made by each participant during the treatment process while also indicating how newly acquired skills can be applied to maintain and promote a healthy lifestyle. To further increase comfort with the termination of the therapeutic intervention, the therapist may proffer a list of available resources or

referrals for additional services if needed. Some therapists also suggest one or more follow-up sessions to take place approximately one month or at regular intervals following the final session.

PSYCHOPHARMACOLOGICAL INTERVENTIONS

Psychopharmacological interventions for PTSD in children and adolescents are primarily considered to be adjunctive to psychosocial treatment modalities (20). The pharmacodynamics and pharmacokinetics of the different medications used to treat adult onset PTSD have not been researched extensively in children and adolescents. The different studies conducted over the years on the psychopharmacology of this anxiety disorder appear to be guided by specific target symptoms, rather than the condition itself. Open label studies are available in the medical literature and at least one double-blind study with a positive outcome has been published on the treatment of PTSD in children. Draw backs to these studies include modest samples sizes. Recent studies on the use of the Selective-Serotonin-Reuptake-Inhibitor agents (SSRIS) have shown promise in the treatment of this anxiety disorder. In general, early intervention with medication should be reserved for the more extreme cases or as is more common as an adjunct to other forms of treatment. The other indication may well be guided by the treatment of existing comorbid conditions. Despite this preface it is important for clinicians to understand that failure with other treatments often leads to the initiation of psychopharmacologic interventions.

We will present the information currently available in the literature regarding the psychopharmacologic intervention of children and adolescent with either acute stress reactions or the more classic posttraumatic stress disorder. A case study published by Horrigan in 1996 (21) focused on the treatment of chronic nightmares associated with the traumatic events experienced by a 7 year-old female. The child was experiencing nightmares related to episodes of physical abuse and domestic violence for a long period of time. The nightmares persisted after three months of therapy. At this point in treatment, clonidine 0.05 mgs. was started. After three weeks, the medication was changed to guanfacine due to breakthrough nightmares. The patient was treated with a maximum daily dose of 0.5 mgs of guanfacine at bedtime. The results of this study indicated that the nightmares were suppressed during the seven weeks of treatment and no side effects were reported.

Other authors have also studied the effect of alpha 2 agonists on the treatment of PTSD (22). Clonidine was administered in doses ranging

from 0.1 to 0.2 mgs/day in seven subjects suffering from PTSD related to physical and/or sexual abuse and neglect. The children were started on medication after one month of receiving other treatment modalities. Target symptoms included sleep disturbances, impulsivity, aggression and autonomic hyperarousal, which were assessed on a weekly basis by teachers and physicians. The authors reported moderate to great improvement of symptoms with the treatment. Transient sedation during the first week of treatment and a decrease in arterial blood pressure were the most commonly reported side effects.

Loof et al. (23) used carbamazepine to treat 28 subjects diagnosed with PTSD and chronic sexual abuse histories. Some of the patients from this study also had concomitant symptoms of Depression and Attention Deficit Hyperactivity Disorder (ADHD). Symptoms experienced by these children include intrusive thoughts, flashbacks, sensory perceptual disturbances and nightmares. The inpatients chosen for this open study were between 8 and 17 years of age. They were treated with carbamazepine at doses ranging from 300 to 1200 mgs a day. The results of this study were encouraging and indicated that 22 out of the 28 subjects treated with carbamazepine became asymptomatic during the study while the remaining six subjects were found to be significantly improved.

Famularo et al. (24) completed another open study on the treatment of PTSD in children and adolescents, which reported significant differences on symptoms pre- and posttreatment with propranolol, a non-selective beta-blocker agent. Up to 2.5 mgs/kg/day of propranolol was administered to 11 patients (ages 6–12) with acute symptoms of PTSD including autonomic hyperarousal. The medication was given for four weeks and tapered over the fifth week.

A single, randomized, double-blind clinical study has been published (25) using imipramine versus chloral hydrate on 25 survivors of burn wounds who developed symptoms consistent with Acute Stress Disorder (ASD). ASD symptoms are similar to PTSD symptoms and include anxiety, nightmares, agitation and sometimes depression which last for four weeks or less (26). Patients treated in the study were 2 to 19 years old. During the length of the study, patients received up to 100 mgs. a day of imipramine or 25 mgs/kg (maximum of 500 mgs/day) of chloral hydrate at night. Results indicated an 83% response rate to imipramine as compared to a 38% response to chloral hydrate. The results were similar for those patients who received imipramine after being treated with chloral hydrate earlier in the study.

More recent studies conducted by Seedat et al. (27,28) revealed a considerable response to treatment of PTSD symptoms with the SSRI,

citalopram. Both studies were of open label design. In the first study (27), eight subjects were observed during 12 weeks of treatment while they received 20 mgs. of citalopram per day. The SSRI was tolerated well and no significant side effects were reported. Another study published by the authors (28) included 24 subjects, ages 10 to 18 that were prescribed 20 to 40 mgs. of citalopram a day during 8 weeks. This sample was compared to 14 adults, ages 20 to 52, who were also receiving citalopram for PTSD symptoms. Some of the exclusion criteria included having comorbid conditions such as Bipolar, Psychotic or Substance Abuse disorders. Fifty four percent of the children and adolescent population studied responded to treatment. The side effects most commonly seen were reportedly mild and included headaches, gastrointestinal discomfort, diarrhea and sleeping disturbances.

In summary, though the results of these reports are encouraging, it should be kept in mind that only one study was done under double-blind conditions. Further placebo-controlled, double-blind trials with larger sample sizes are required. The need for additional studies to determine the utility of different types of psychopharmacological agents in the treatment and stabilization as well as relapse prevention of symptoms arising from traumatic experiences in children and adolescents cannot be underscored. Future directions in the field of psychopharmacologic intervention should investigate what symptom clusters (reexperiencing, arousal or avoidance) are most amenable to particular interventions. As Pine and Cohen (17) have alluded to, and as often is the practice, treatment may be guided by results obtained in adult studies.

REFERENCES

1. Bender L, Blau A: The reaction of children to sexual relations with adults. *American Journal of Orthopsychiatry* 7:500-518, 1937.
2. Bodman F: War conditions and the mental health of the child. *British Medical Journal* 11:486-488, 1941.
3. March J: What constitutes a stressor? The "criterion A" issue, In *Posttraumatic Stress Disorder: DSM-IV and Beyond*. Edited by Davidson J, Foa E. Washington, DC: American Psychiatric Press, Inc, 1992.
4. Kilpatrick DG, Resnick HS, Saunders BE, et al: Rape, other violence against women and posttraumatic stress disorder: Critical issues in assessing the adversity-stress- psychopathology relationship, in *Adversity, Stress, and Psychopathology*. Edited by Dohrenwend BP. New York, Oxford University Press, pp. 161-176, 1998.
5. Terr LC: Chowchilla revisited: The effects of psychic trauma four years after a school bus kidnapping. *American Journal of Psychiatry* 140:1543-1550, 1983.
6. Pynoos RS, Nader K: Children who witness the sexual assaults of their mothers. *Journal of the American Academy of Child and Adolescent Psychiatry* 27:567-572, 1988.

7. Saxe G, Stoddard F, Courtney D, et al: Relationship between acute morphine and the course of PTSD in children with burns. *Journal of the American Academy of Child and Adolescent Psychiatry* 40(8):915–921, 2001.
8. Green BL, Korol M, Grace M, et al: Children and disaster: Age, gender, and parental effects on PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry* 30:945–951, 1991.
9. Pynoos RS, Goenjian A, Tashjian M, et al: Posttraumatic stress reactions in children after the 1988 Armenian earthquake. *British Journal of Psychiatry* 163:239–247, 1993.
10. Millgram NA, Toubiana Y, Klingman A, et al: Situational exposure and personal loss in children's acute and chronic reactions to a school disaster. *Journal of Traumatic Stress* 1:339–352, 1988.
11. Garrison CZ, Bryant ES, Addy CL, et al: Posttraumatic stress disorder in adolescents after Hurricane Andrew. *Journal of the American Academy of Child and Adolescent Psychiatry* 34:1193–1201, 1995.
12. Fitzpatrick KM, Boldizar JP: The prevalence and consequences of exposure to violence among African-American Youth. *Journal of the American Academy of Child and Adolescent Psychiatry* 32(2):424–430, 1992.
13. Silva RR, Alpert M, Munoz DM, et al: Posttraumatic stress disorder: Stress and vulnerability in children and adolescents. *American Journal of Psychiatry* 157(8):1229–1235, 2000.
14. Deykin EY, Buka SL: Prevalence and risk factors for posttraumatic stress disorder among chemically dependent adolescents. *American Journal of Psychiatry* 154(6):752–757, 1997.
15. Giaconia RM, Reinherz HZ, Silverman AB, et al: Traumas and posttraumatic stress disorder in a community population of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry* 34(10):1369–1380, 1995.
16. Board of Education: The initial report to the board of education concerning the psychological effects of 9/11 on NYC school children. ARC, CU School of Public Health and the New York State Psychiatric Institute, May 6, 2002.
17. Pine DS, Cohen JA: Trauma in children and adolescents: Risk and treatment of psychiatric sequelae. *Biological Psychiatry* 51(7):519–531, 2002.
18. Cloitre M, Davis L, Mirvis S, et al: Working With Multiply Traumatized Youth: STAIR/NST, Treatment Manual unpublished manuscript.
19. Cloitre M, Koenan K: Interpersonal group process treatment for CSA-related PTSD: A comparison study of the impact of borderline personality disorder on outcome. *International Journal of Group Psychotherapy* 51:379–398, 2001.
20. Cohen J: Practice parameters for the assessment and treatment of children and adolescents with post traumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(9):997–1001, 1998.
21. Horrigan J: Guanfacine for PTSD nightmares (letter). *Journal of the American Academy of Child and Adolescent Psychiatry* 35:975–976, 1996.
22. Harmon R, Riggs P: Clonidine for post traumatic stress disorder in preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry* 35:1247–1249, 1996.
23. Loof D, Grimley P, Kuller F, et al: Carbamazepine for PTSD (letter). *Journal of the American Academy of Child and Adolescent Psychiatry* 34:703, 1995.
24. Famularo R, Kinscherff R, Fenton T: Propanolol treatment for childhood post traumatic stress disorder, acute type. *American Journal of Disorders in Children*, 142:1244–1247, 1988.

25. Robert R, Blakeney P, Villareal C, et al: Imipramine treatment in pediatric burn patients with symptoms of acute stress disorder; A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry* 38:873–882, 1999.
26. Kaplan HI, Sadock BJ: *Textbook of Clinical Psychiatry*, 2nd ed. New York, Lippincott Williams & Wilkins, 1996.
27. Seedat S, Lockhat R, Kaminer D, et al: An open trial of citalopram in adolescents with post traumatic stress disorder. *International Clinical Psychopharmacology* 16:21–25, 2001.
28. Seedat S, Stein D, Ziervogel C, et al: Comparison of response to a selective serotonin reuptake inhibitor in children, adolescents and adults with post traumatic stress disorder. *Journal of Child and Adolescent Psychopharmacology* 12:37–46, 2002.