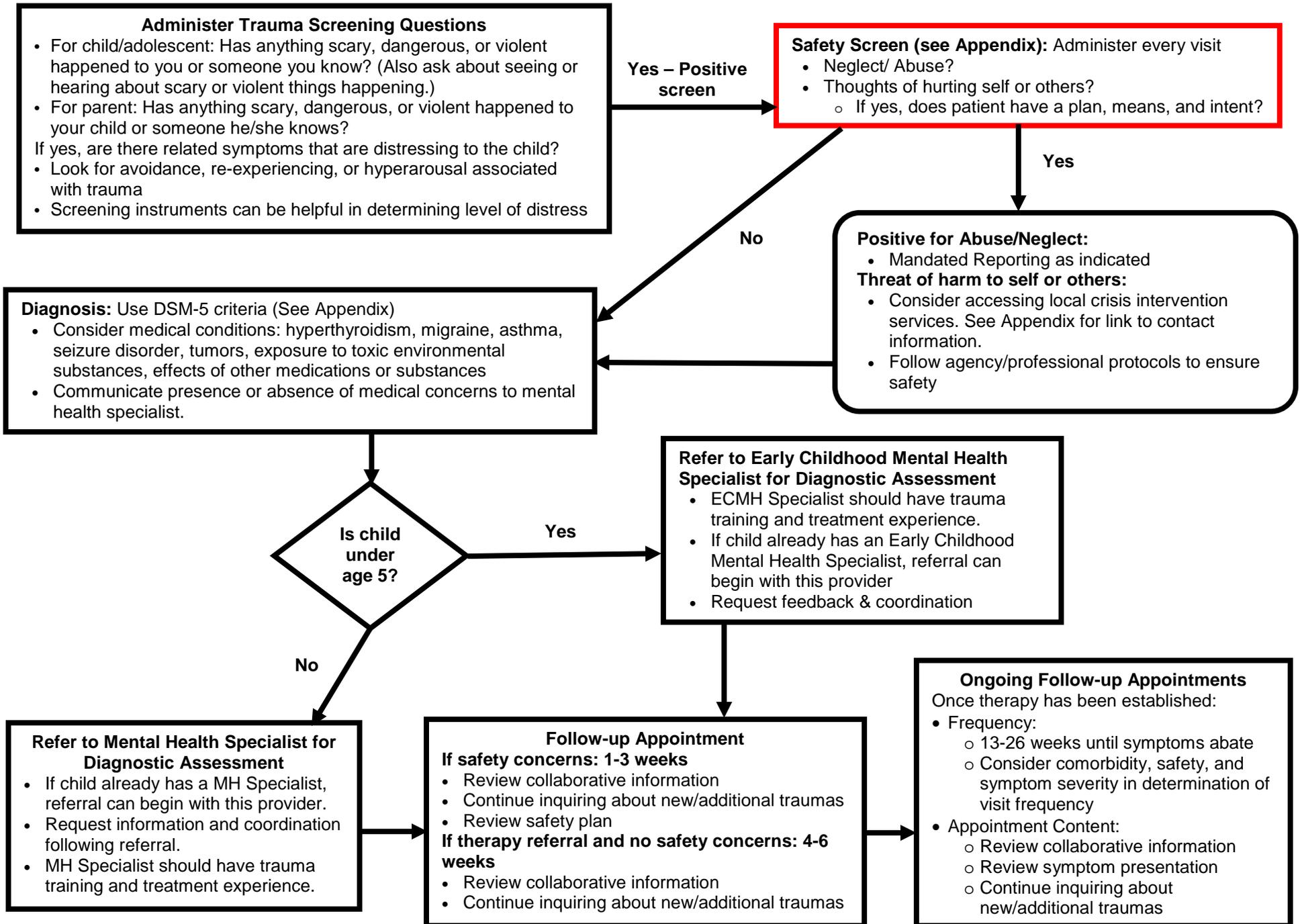


## Trauma Assessment & Treatment



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### Primary References:

American Academy of Child and Adolescent Psychiatry Official Action (2010) – Practice Parameter for the Assessment and Treatment of Children and Adolescents With Posttraumatic Stress Disorder.

[http://www.jaacap.com/article/S0890-8567\(10\)00082-1/pdf](http://www.jaacap.com/article/S0890-8567(10)00082-1/pdf)

American Academy of Child and Adolescents Psychiatry Official Action (2009) – Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents. [http://www.jaacap.com/article/S0890-8567\(09\)60156-8/pdf](http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf)

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5<sup>th</sup> ed.)*. Washington, DC: Author.

Cohen, Kelleher, & Mannarino (2008). *Identifying, treating, and referring traumatized children: The role of pediatric providers*. Archives of Pediatric and Adolescent Medicine, 162(5), 447-452.

PracticeWise (2015). Evidence-Based Youth Mental Health Services Literature Database.

## Appendix

### Resources:

American Academy of Child & Adolescent Psychiatry – Bullying Resource Center

[https://www.aacap.org/AACAP/Families\\_and\\_Youth/Resource\\_Centers/Bullying\\_Resource\\_Center/Home.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Bullying_Resource_Center/Home.aspx)

American Academy of Child & Adolescent Psychiatry – Child Abuse Resource Center

[https://www.aacap.org/AACAP/Families\\_and\\_Youth/Resource\\_Centers/Child\\_Abuse\\_Resource\\_Center/Home.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Child_Abuse_Resource_Center/Home.aspx)

American Academy of Child & Adolescent Psychiatry – Disaster Resource Center

[https://www.aacap.org/AACAP/Families\\_and\\_Youth/Resource\\_Centers/Disaster\\_Resource\\_Center/Home.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Disaster_Resource_Center/Home.aspx)

### List of Clinicians Trained in Trauma-Focused Cognitive Behavioral Therapy:

<http://www.cehd.umn.edu/fsos/projects/ambit/provider.asp>

### Safety Screen:

Some questions to assess potential threat of harm to self: Children and adolescents may be asked the following diagnostic questions (Jacobsen et al., 1994).

- “Did you ever feel so upset that you wished you were not alive or wanted to die?”
- “Did you ever do something that you knew was so dangerous that you could get hurt or killed by doing it?”
- “Did you ever hurt yourself or try to hurt yourself?”
- “Did you ever try to kill yourself?”

\*If the threat assessment (i.e., Safety Screen) indicates risk of harm to self or others, educate families on the appropriate care options and safety precautions including removal of firearms from the home and securing all medications, both prescription and over-the-counter.

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**Warning Signs of Suicide:** (Developed by the U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA; 2011).

These signs may mean someone is at risk for suicide. The risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Threatening to hurt or kill oneself or talking about wanting to die or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting recklessly or engaging in risky activities – seemingly without thinking
- Feeling trapped – like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

**Minnesota Mental Health Crisis Contact Numbers:** <http://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/childrens-mental-health/resources/crisis-contacts.jsp>

**Current Evidence-Based Traumatic Stress Treatments include:** Cognitive Behavior Therapy (CBT), CBT with Parents, Exposure, and Child-Parent Psychotherapy (CPP)

**Elements of effective traumatic stress treatment include:** psychoeducation, exposure, cognitive processing, narrative, relaxation, personal safety skills, maintenance/relapse prevention, communication skills, modeling, activity selection, assertiveness training, emotional processing, problem solving, relationship/rapport building, goal setting, insight building, and monitoring.

### **DSM-5 Posttraumatic Stress Disorder Criteria:**

**Note:** The following criteria apply to adults, adolescents and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
  2. Witnessing, in person, the event(s) as it occurred to others.
  3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

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4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

**Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

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1. Irritable behavior and angry outburst (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
  2. Reckless or self-destructive behavior.
  3. Hypervigilance.
  4. Exaggerated startle response.
  5. Problems with concentration.
  6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

### Posttraumatic Stress Disorder for Children 6 Years and Younger:

- A. In children 6 years or younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
  2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.  
**Note:** Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.
  3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.
- B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).  
**Note:** Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.
  2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).  
**Note:** It may not be possible to ascertain that the frightening content is related to the traumatic event.
  3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.
  4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
  5. Marked physiological reactions to reminders of the traumatic event(s).
- C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

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### **Persistent Avoidance of Stimuli**

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).
2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

### **Negative Alterations in Cognitions**

3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
  4. Markedly diminished interest or participation in significant activities, including constriction of play.
  5. Socially withdrawn behavior.
  6. Persistent reduction in expression of positive emotions.
- D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
  2. Hypervigilance.
  3. Exaggerated startle response.
  4. Problems with concentration.
  5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- E. The duration of the disturbance is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.
- G. The disturbance is not attributable to the physiological effects of a substance (e.g., medical or alcohol) or another medical condition.