

“Working with Trauma in Refugee Youth”

Addressing Invisible Injuries: Child Neglect, Exploitation,
and Emotional Abuse Conference

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Immigrants differ by ...

Immigration Status

■ **Legal Immigrant**

-This status usually comes with the guarantee of employment or to join family members. Legal immigrant with special status.

■ **Refugee/Asylee.**

-Usually unplanned; they often have a long and difficult journey; may have lost family members, usually have experienced physical/emotional trauma.

-Asylum is a status that an immigrant applies for and has to have a hearing in immigration court to present their case

■ **Undocumented/under documented**

May be economic migrants, fleeing conditions of war, or students who overstay visas.

Definitions

- **Refugee:** “a person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution” (UNHCR, 2002b).
 - Difference between **refugees** and **asylum seekers**.
- **Unaccompanied minor (UAM):** Someone “under 18 years who is separated from both parents or by law or by custom, is responsible for doing so” (UNHCR, 1997).

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Children of war: The Grim Statistics

- In 40 countries, children under 12 years of age are used as soldiers.
- Millions of children have been disabled by war, landmines, and other instruments of war.
- Worldwide, there are 13.5 million refugees and 17 million internationally displaced people, of whom 80% are women and children.

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Children of war: The Grim Statistics

- More than half the children of war are under age 18 years.
- 5,000 children become refugees each day.
- More than half of all refugees admitted to the U.S. are children, but there are few programs dedicated to helping children deal with the trauma of war and displacement.

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Phases of Refugee Experience

(Papadopoulos, 2001).

- Three broad phases of the refugee experience:
 1. Preflight,
 2. Flight, and
 3. Resettlement



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Preflight

- Time prior to refugee's escape.
- Onset of political violence and/or war.
- At the societal and community levels, there is:
 - Social upheaval.
 - Increasing chaos in their region.
 - Limited access to schools.
 - Face threats.
 - Cope with devastating events.
- Refugee youth may:
 - Witness violence.
 - Engage in it.



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Preflight Stress

- An estimated 300,000 children under 18 years of age have had combat experience
(child Soldiers, 2001).
 - Fought and enrolled in armed forces.
- Front line combat puts child soldier at risk for:
 - a. Rape.
 - b. Torture.
 - c. War injuries.
 - d. Substance abuse.
 - e. Depression.
 - f. Anxiety and suicidal ideation
 - g. Losses: friends, family members, trust, moral perspective ...

(UNICEF, 2002).



Flight

- Great uncertainty about the future.
- Refugees must survive:
 - Displacement from their homes.
 - Transit or transitional placement.
- Often at the mercy of external sources.
- During this phase, children;
 - are born
 - endure psychological development
 - are separated from parents and/or caregivers

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Some youths reported:

“We just survived on wild fruit and drinking stagnant water. We ate whatever meat that was leftover from a lion”

(Luster, Qin, Bates, Johnson and Rana, 2008).

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Flight Stress

- Stressful, unstable and unpredictable phase.
 - For children, it might mean:

1. Separation from Caregivers

- No identified guardian.
- No adult supervision.
- Orphans.
- Insecurity.
- Moral deprivation.
- Abuse.
- Malnutrition.



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Youth separation story/experience.

“My family did not give me up saying something like we don’t love you. There was no choice. I had to go.”

(Luster, Qin, Bates, Johnson and Rana, 2008).

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Flight and Processing Stress

2. Refugee Camps.

- Severe deprivation.
- Everything is scarce.
- Safety is not guaranteed.
- Schools may not exist.
- Traumatic events.
- Abuse – physical, emotional, psychological etc
- Suicide (or witnessed suicidal attempt).
- Witness acts of violence.
- Long waits
- Anxiety over future

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- A majority of youth describe the great distress they experienced, such as:

“It happened to me. I went through that. I was hospitalized because of depression and mental illness.”

(Luster, Qin, Bates, Johnson and Rana, 2008)

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Resettlement

- **Refugee children enter into the U.S.**

- Excited



- Hopeful

- Afraid

- Bewildered



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Resettlement

- **After arrival in the U.S. Refugee children experience:**

- Intergenerational value conflict.
 - Role reversal/ambiguity.
 - Inadequate educational preparation.
 - Language barriers (importance of adequate interpreters)
 - Family conflict.
 - Inadequate parental figures.
 - Racial discrimination.
 - Family reunification.
 - Surrogate family issues.
 - New lifestyle.



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After arriving in the U.S. refugee children may experience stress as result of:

- Receiving bad news from home.
- Peer pressure.
- Residency in low income/high crime areas.
- Pressure to excel in school.
- Exploitation/abuse.
- Unpredictability of life events.
- Hostile school environment.
- Feelings of inadequacy.
- Cognitive limitations.
- Detention camps/legal system.



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TOUCHING/PERSONAL SPACE



What is Trauma?

- A traumatic or life-threatening event that is outside the normal range of daily human experience
- It arises when adult/children experience or witness such an event
- These events confront people with such horror and threat that it may temporarily or permanently alter their capacity to cope, their perception of biological threat and their self-concepts
- Trauma occurs when an actual or perceived threat of danger or loss overwhelms a person's usual coping ability (Beverly James, 1994)

Another definition of trauma...

- Trauma is an acute stress response that one experiences when confronted with sudden, unexpected, unusual human experience.
- Trauma occurs because the event poses a serious threat to the individual's life or physical integrity or to the life of a family member or close friend, or to one's surrounding environment.
- Individuals who may have witnessed the event are also at risk to develop a trauma stress response.
- Trauma produces overwhelming feelings of helplessness and hopelessness.

National child Traumatic Stress Network

Post Traumatic Stress Disorder (PTSD)

Exposure to an event in which both of the following were present.

- Experiences, witnesses, or was confronted with an event or events that involved actual or threatened death or serious injury or threat to the physical integrity of self or others.
- Response involved intense fear, horror, or helplessness.

Source: DSM IV-R

Symptoms of Post Traumatic Stress Disorder

Re-experiencing Symptoms

- Frequent, intrusive thoughts about the trauma
- Flashbacks (Reliving in one's mind and body a terrifying life event as if it were actually happening again.)
- Nightmares
- Psychological Distress at reminders of traumatic event
- Psychological reactions (chills, sweats, palpitations)

Symptoms of Post Traumatic Stress Disorder

Avoidance and Numbing Symptoms

- Avoiding reminders of the event
- Loss of interest in significant activities
- Feeling detached from others
- Emotional numbing
- Sense of foreshortened future
- Difficulty trusting
- Difficulty feeling emotions, like love
- Trouble with relationship

Symptoms of Post Traumatic Stress Disorder

Arousal Symptoms

- Being on the alert for danger
- Feeling anxious, jumpy
- Angry outbursts, irritability
- Difficulty concentrating
- Easily startled
- Sleep disturbances

Complex Trauma - Definition

Simultaneous or sequential occurrences of emotional abuse and neglect, sexual abuse, physical abuse, exposure to domestic or community violence or experienced violence that disrupts the child's security with primary caregivers – experiences that become chronic and typically begin in early childhood (R. Kagan 2004)

Complex Trauma

- Describes the dual problem of children's exposure to multiple traumatic events and the impact of this exposure on immediate and long-term outcomes
- The term *complex trauma* describes the problem of children's exposure to multiple or prolonged traumatic events and the impact of this exposure on their development. Typically, complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment—including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence—that is chronic, begins in early childhood, and occurs within the primary caregiving system.
- Exposure to these initial traumatic experiences—and the resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood.

Childhood Traumatic Grief

- Childhood traumatic grief may occur following a death of someone important to the child when the child perceives the experience as traumatic. The death may have been sudden and unexpected (e.g., through violence or an accident), or anticipated (e.g., illness or other natural causes).
- The distinguishing feature of childhood traumatic grief is that the trauma symptoms interfere with the child's ability to go through the typical process of bereavement. The child experiences a combination of trauma and grief symptoms so severe that any thoughts or reminders, even happy ones, about the person who died can lead to frightening thoughts, images, and/or memories of how the person died.

COMMON DIFFICULTIES ASSOCIATED WITH TRAUMATIC GRIEF, THAT CAN OCCUR ACROSS DEVELOPMENTAL STAGES:

- Intrusive memories about the death: These can appear through nightmares, guilt, or self-blame about how the person died or recurrent or intrusive thoughts about the horrifying manner of death.
- Avoidance and numbing: These can be expressed by withdrawal, the child acting as if not upset, or the child avoiding reminders of the person, the way she or he died, or the event that led to the death.
- Physical or emotional symptoms of increased arousal: These can include irritability, anger, trouble sleeping, decreased concentration, drop in grades, stomachaches, headaches, increased vigilance, and fears about safety for oneself or others.

THREE TYPES OF REMINDERS MAY TRIGGER THEM:

- Trauma reminders: places, situations, people, sights, smells, or sounds reminiscent of the death. These may include the street corner where a fatal accident occurred, the bedroom where a parent died, or the sound of an airplane reminding a child of a mother who died in a crash.
- Loss reminders: people, places, objects, situations, thoughts, or memories that are reminders of the person who died—for example, photo albums or a new coach who has replaced a parent who previously headed a child's sports team.
- Change reminders: situations, people, places, or things reminding the child of changes in his or her life resulting from the death—for example, moving to a new house or having to walk home with a babysitter rather than with an older sibling who died.

TRAUMATIC REACTIONS MAKE IT DIFFICULT FOR CHILDREN TO:

- remember or enjoy positive memories of the deceased person,
- cope with the many life changes that occur as a result of the death, and
- continue with normal development.

GRIEF vs. TRAUMA

GRIEF:

- Generalized reaction: sadness, anger, guilt, and appreciation
- Accept the reality and permanence of the death
- Pain is the acknowledgement of the loss
- Dreams tend to be of the deceased
- Generally grief reactions stand alone and do not involve trauma reactions
- Adjust to changes in their lives and identity that result from the death
- Develop new relationships or deepen existing relationships with friends and family
- Invest in new relationships and life-affirming activities
- Maintain a continuing, appropriate attachment to the person who died through such activities as reminiscing, remembering, and memorialization; make some meaning of the death that can include coming to an understanding of why the person died
- Continue through the normal developmental stages of childhood and adolescence

TRAUMA:

- Generalized reaction: TERROR
- Pain triggers tremendous terror, sense of powerlessness and loss of safety
- Guilt may focus on: "It was my fault. I could have prevented it. It should/could have been me."
- Dreams are about the self as the potential victim
- Often involves grief reactions (sadness, etc.) in addition to trauma reactions: flashbacks, startle reactions, hyper vigilance, numbing, etc.

(Joseph Benamati, LMSW, April 2005), National Child Traumatic Stress Network

More about Grief

What Do We Mean by Grief?

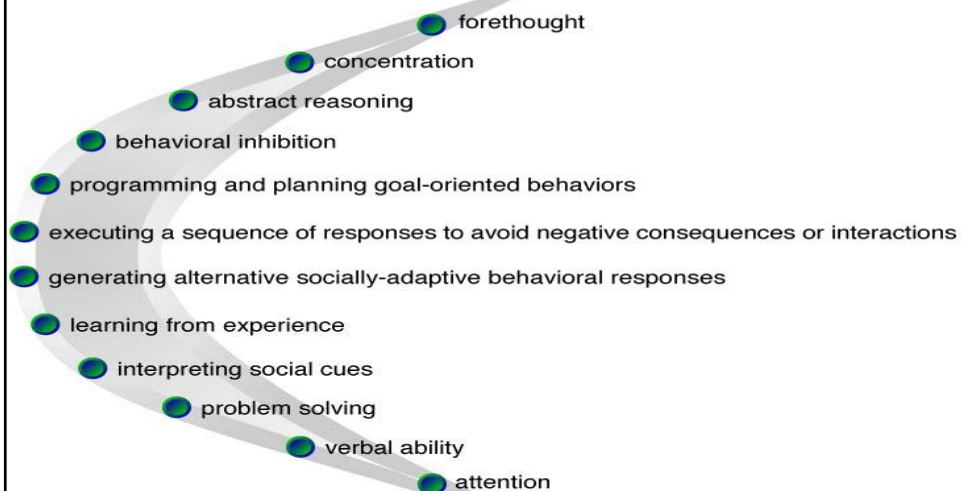
- *Grief* describes the intense emotional distress we have following a death.
- *Bereavement* refers to the state or fact of being bereaved, or having lost a loved one by death.
- *Mourning* refers to the encompassing family, social, and cultural rituals associated with bereavement.
- **Thus, when you are bereaved, you feel grief, and mourn in special ways.**

Types of Traumatic Events

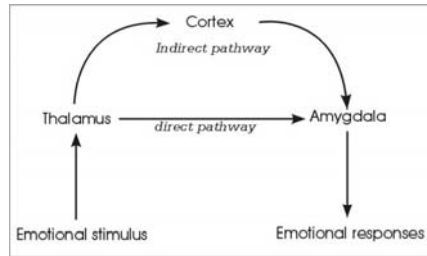
- Sexual Abuse
- Life-threatening injury/illness
- Violence (family, social, predatory)
- Terrorism
- Natural or other disasters (hurricane, earthquake, fire)
- Parental Substance Abuse
- Rape/Assaults
- Murder
- Threaten with a weapon
- War
- Early loss of parent
- Neglect
- Physical Abuse
- Emotional Abuse
- Vicarious/Secondary Trauma
- Natural and man-made disasters
 - Earthquakes
 - Floods, mudslides
 - Hurricanes
 - Tornadoes
 - Volcanic eruptions
 - Major transportation accidents
 - Industrial accidents
 - Technological disasters
- Catastrophes of human origin
 - Armed conflicts/wars
 - Genocide
 - Terrorist attacks

The Thinking Brain (Cortex) Frontal Cortex “computer system”

EXECUTIVE FUNCTIONS



The Doing Brain (Limbic System) “emotional system”



1. Amygdala perceives a threat
2. Brain responds through fight-flight-freeze mechanism
3. Cortex “higher-functioning” gets cut off
4. Behavior becomes impulsive reaction to perceived threat

Doing Brain...functions:

- Senses, emotional, reactions, danger (real or perceived)

How our bodies response to a real or perceived threat or a trigger:

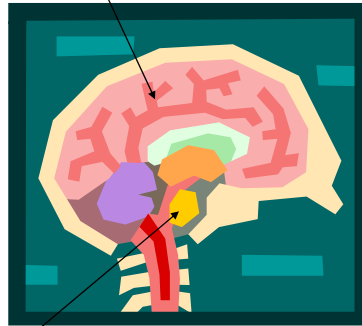
- Sympathetic Nervous System
 - Fight, Flight, Freeze Response
 - Physiological responses
 - » Heart rate, sweat response, energy increases

Triggered Behavior: Fight-Flight-Freeze

Patterns of Reacting & Responding

- **Fight**
 - Hyperarousal
 - Aggression
 - Trouble concentrating
 - Irritability
 - Anger
 - Hyperactive
- **Flight**
 - Withdrawal
 - Avoidance
 - Isolation
 - Running away
- **Freeze**
 - Constriction/shutting down
 - Numbing
 - Spacey, zoning out
 - Daydreaming
 - Overcompliance

Cortex: Thinking Brain



Limbic System: Doing Brain
(Amygdala)

Biochemical changes during and after the traumatic event

- Adrenaline-levels are chronically increased resulting in constant hyperstress and inability to distinguish danger signals (the amygdala becomes over sensitive)
 - Inability to sleep, flashbacks, trouble with concentrating, shuts off the brain (frontal cortex)
- Biochemical changes during and after the traumatic event
 - Damage of the neuroreceptors that control the stress response
 - Increase of receptors for cortisol, with the result that it is easier to be triggered (vicious cycle-less able to switch “off” the stress, which produces more of the stress hormone that damages the neuroreceptors...

How this impacts over time

- At optimum level, the biochemical change allow us to function at a higher capacity during stressful events. However, if the stress continues too long or is too overwhelming, functioning becomes impaired rather than enhanced.
- Stress chemical during the trauma and subsequent triggered periods results in:
 - Biochemical changes during and after the traumatic event
 - A change in memory function during and after the event

Long-term trauma and behavior

- Every exposure to trauma activates the “doing-brain” (complex trauma)
- Continual activation of this system resets the doing brain to a more easily activated setting
- The sensitized doing brain sounds the danger alarm more often, even when there isn’t any real danger
- The sensitization is called a trigger

Impact on children

- Experience can change the mature brain-but experience during the critical periods of childhood
ORGANIZES Brain Systems
(Bruce Perry)



Triggers

- Any stimulus which acts as a reminder of a traumatic experience, and leads to a set of behaviors/actions designed to cope with the original experience
- A trigger may be
 - Internal (emotion, physical sensation)
 - External (facial expressions, crowds, smells, sounds)
 - A combination

Blaustein and Kinniburgh 2004

Triggers

- Key Triggers
 - Lack of power or control
 - Unexpected change
 - Feeling threatened or attacked
 - Feeling vulnerable or frightened
 - Fireworks!
 - Other loud noises

Responses to triggers

To seek safety & avoid danger

Blaustein & Kinniburgh 2004

Impact of Trauma on Child Development

- To understand how trauma affects children, it is important to understand children from a developmental context.
- When a child experiences a traumatic event or a series of traumas, a great amount of emotional and mental energy is expended to process the event and what it means in their world.
- This may reduce the child's capacity to explore and gain mastery over age appropriate developmental tasks.

NCTSN The National Child Traumatic Stress Network

Impact of Trauma on Child Development

- As trauma goes untreated, children tend to stray further and further away from appropriate developmental paths. The consequences of chronic exposure to maltreatment can include social inadequacy and increasingly disruptive behavior, resulting in interventions becoming more punitive in nature.
- Refugee children often don't have access to the details of what happened

NCTSN The National Child Traumatic Stress



Complex Trauma Attachment

- Uncertainty about the reliability and predictability of the world
- Problems with boundaries
- Distrust and suspiciousness
- Social isolation
- Difficulty relating to others
- Difficulty empathizing

* Source: Complex Trauma White Paper published by the NCTSN

NCTSN The National Child Traumatic Stress Network

Complex Trauma Biology

- Hypersensitivity to physical contact
- Problems with coordination, balance, body tone
- Delayed sensory and motor development
- Somatic complaints and increased medical problems (e.g. asthma, skin problems, autoimmune disorders)

NCTSN The National Child Traumatic Stress Network

Complex Trauma Affect Regulation

- Difficulty with emotional self-regulation
- Difficulty describing feelings and internal experience
- Problems knowing and describing internal states
- Difficulty communicating wishes and desires

NCTSN The National Child Traumatic Stress Network

Complex Trauma Dissociation

- Withdrawing attention from the outside world
- A detached feeling as if one is “observing” something happen or as if it is unreal
- When “fleeing or fighting” is not physically possible, a child may “psychologically flee”
- Amnesia

NCTSN The National Child Traumatic Stress Network

Complex Trauma Behavioral Control

- Poor impulse control
- Aggression against self or others
- Pathological self-soothing behaviors
- Disturbances in sleeping or eating
- Substance abuse
- Excessive compliance or oppositional behavior
- Difficulty understanding and complying with rules
- Communicating past trauma by reenactment in behavior or play (sexual, aggressive, etc.)

NCTSN The National Child Traumatic Stress Network

Complex Trauma Cognition

- Lack of sustained curiosity
- Problems focusing on and completing tasks
- Difficulty planning and anticipating
- Problems understanding own contribution to what happens to them
- Learning difficulties
- Problems with language development

NCTSN The National Child Traumatic Stress Network

Complex Trauma Self-Concept

- Lack of continuous, predictable sense of self
- Poor sense of separateness
- Disturbances of body image
- Low self-esteem
- Shame and guilt

NCTSN The National Child Traumatic Stress Network

Common Long-Term Problems

- Sleep disturbance
- Guilty and shameful sense of self
- Acting younger
- Fear
- “Watchfulness”
- Anxiety/excessive worry
- Withdrawal
- Hyperactivity
- Focus on power and control within relationships and in situations which are perceived as stressful
- School deficits

Why Do Some Develop Traumatization While Others Don't?

Factors Influencing the Impact of Trauma

- Nature & extent of trauma
- Coping skills
- Previous experiences
- Current stress levels
- Support system
- Family & social environment
- Biology / brain
- The stability of life before becoming a refugee
- Personality structure
- Levels of trauma experienced
- Skills possessed
- Amount and quality of support available after arrival

Refugee experiences that may be predictive of later mental health concerns:

- Lack of preventative services or early intervention
- Amount/type of pre-trauma experiences and psychological stability. Many refugees experience tremendous trauma but are able to process it - much as post-war veterans have. Studies suggest that 10-15% of refugees have significant mental health symptoms.
- Those repeatedly traumatized (COMPLEX TRAUMA)
- Victims of torture



Survey of National Refugee Working Group sites, 2004

- Throughout this survey, the term *refugee* is used to refer to immigrants who have been exposed to war and/or forced displacement, regardless of their immigration status. Therefore, unless otherwise specified, the following information references this population.
- Most notably, over 50% of sites report measuring child depression, child PTSD, and child's exposure to traumatic events. The next symptoms most likely measured in 46% of sites include child school functioning and disruptive child behavior. Child peer relations, self-esteem, coping, and risk behaviors are also measured in 31% of sites.

Outcomes	N	Sites Measured	% Sites Measured
Child Depression	13	8	62 %
Child PTSD	13	8	62 %
Child Exposure to Traumatic Events	13	8	62 %
Child School Functioning	13	6	46 %
Disruptive Child Behavior	13	6	46 %
Other Child Mental Health symptoms	13	5	39 %
Child Peer/Social Relations	13	4	31 %
Child Self-Esteem	13	4	31 %
Child Coping	13	4	31 %
Child Risk Behaviors	13	4	31 %
Child Acculturation Issues	13	3	23 %
Child Physical Health	13	1	8 %

Nation Child Traumatic Stress Network

Cultural Practices that May Look Like Abuse or Neglect

- Cao Gio (coin rubbing)
- Scarification
- Foot binding
- Cliterodectomy
- Bundling
- Forced fasting
- Child crying self to sleep
- Child sleeping in parents' room
- Smoking/drinking while pregnant

Dr. Dennis Hunt 2002

Helping Refugees Deal with Trauma

Create a Safe/Supportive Place

- Develop relationships that soften traumatic experiences.
- Do not pressure to tell too much too early.
- Medication to combat symptoms, such as for sleep.
- Generate some hope through stabilization with medication.
- Link with social service agencies to deal with war issues, such as housing, employment, and food.
- Relaxation exercises to deal with anxiety.

Judith Herman



Helping the Refugee/Migrant and Family Members

Assess

Current emotional, physical, and spiritual needs.

Provide

Non-judgmental emotional support.

Help

Clarify the problem(s).

Offer Choices

Identify action to relieve present stress.

Instill

Hope.



Helping the Refugee/Migrant and Family Members

Create

Awareness of environmental stressors.

Facilitate

Expression of feelings regarding the trauma.

Identify Fears

Of all family members.

Refer

When necessary.

Give

Accurate information regarding available services and possible support systems.



How is childhood trauma treated?:

Fortunately, children experiencing childhood traumatic grief recover with appropriate help. Consultation with a qualified mental health professional is encouraged. Ideally, this professional should have experience working with children and adolescents and specifically with issues of grief and trauma. Treatment itself should address both the trauma and grief symptoms.

In learning how to manage the trauma-related reactions, a child becomes better able to reminisce productively about the person.

Several treatment manuals have been developed by the NCTSN Childhood Traumatic Grief Task Force for treating this condition at different developmental stages. In general, all of these treatments incorporate components of evidence based treatments for trauma symptoms. These include affective regulation, stress management, and cognitive reprocessing skills, as well as encouraging the child to tolerate increasingly more detailed memories of the traumatic event that led to the death through the creation of a trauma narrative.

These interventions also include grief-focused treatment components, such as acknowledging what has been lost in the relationship, exploring "unfinished business" with the deceased, memorializing the person who has died, and committing to other relationships in the present. Treatments for children and younger adolescents include parents in treatment, while adolescent treatment is often provided in a group format. It is important for the caregiver to process and work on personal trauma and grief issues in order to best help a child.

More information about these treatment models is available at NCTSNnet.org. Further information about these topics, additional fact sheets, resources, and assistance in locating appropriate treatment is available from the National Child Traumatic Stress Network (NCTSN) at (310) 235- 2633 and (919) 682-1552 and at the National Child Traumatic Stress Network Web site, www.NCTSN.org.

Recommendations for Clinicians Working with Refugee Populations

- 1. Address social needs early, as these may motivate initial contact with health and services agencies. These may be financial, occupational, educational, legal, residential, or spiritual.
- 2. Learn about culturally familiar people and supports available within the community, and facilitate their availability to refugee patients.
- 3. To facilitate communication, use counselors, trained in basic therapeutic techniques, from within the culture. They serve as cultural brokers, enticing patients to come, and representing the agency or clinic to the community .Otherwise, use interpreters trained to work in mental health settings.
- 4. Account for developmental vulnerabilities when determining the nature and pace of psychotherapeutic interventions for refugees of any age, especially children and adolescents.
- 5. Capitalize upon the positive regard generally afforded to physicians, and be aware of the stigma associated with seeking mental health services.

Review of Child & Adolescent Mental Health, National Center for Child Traumatic Health

Recommendations for working with Refugee populations cont.

- 6. When appropriate, refer refugees to other medical practitioners for assessment of medical problems that may augment psychiatric symptoms.
- 7. Take into account the role of somatization as a common presentation of underlying psychopathology.
- 8. Explore with refugees which coping strategies and sources of personal strength they have used in the past in overcoming tremendous adversity, and identify those that are healthy and adaptive for the future. 9. Encourage alternative means of expression besides "talk therapy," such as testimonials, drama, dance, music, and art.
- 10. Remember that talking about painful events may not be experienced as valuable or therapeutic by refugees from societies in which psychological models are not hegemonic; explore how they would experience a therapeutic encounter.
- 11. Take into account the role of ongoing traumatic triggers
- 12. Appropriate interpreters for communication

Review of Child & Adolescent Mental Health, National Center for Child Traumatic Health

The Goal...Collaborative efforts to...

mend lives



& rekindle hope.

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- www.childtrauma.org – Child Trauma
- www.ncptsd.va.gov – National Center for Post Traumatic Stress Disorder