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Post-traumatic Stress in Children and Adolescents Exposed to Family Violence: I. Overview and Issues

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Abstract

Exposure to child physical abuse and parents' domestic violence can subject youth to pervasive traumatic stress and lead to Post-traumatic Stress Disorder (PTSD). The often repeating and ongoing nature of family violence exposure may result in youth exhibiting problems in multiple domains of functioning and meeting criteria for multiple disorders in addition to PTSD. These characteristics as well as unique factors related to children's developmental level and symptom presentation complicate a PTSD diagnosis. This paper describes evolving conceptualizations in the burgeoning field of trauma related to family violence exposure, and reviews considerations that inform assessment and treatment planning for this population.

Keywords

Post-traumatic stress disorder (PTSD); child physical abuse; domestic violence; complex trauma; Developmental Trauma Disorder (DTD)

Children's interpersonal violence exposure is now recognized as a potential precursor to post-traumatic stress disorder (PTSD) in youth with the acknowledgement that extraordinarily stressful events can occur as part of children's customary experiences. Early examples of children's PTSD focused on sudden, out-of-the-ordinary catastrophic events such as sniper attack and natural disaster (Pynoos, et al., 1987); however, recent definitions of trauma stressors have expanded to include events within the range of normal experience that are capable of causing death, injury, or threaten the physical integrity of the child or a loved one (American Academy of Child and Adolescent Psychiatry [AACAP], 1998; American Psychological Association [APA], 1994). Yet, children's violence exposure poses challenges to current understanding of PTSD: What if the violence exposure is life-long and there is not a discrete precipitating event? Does violence that is not "life-threatening" still qualify as a traumatic event? This paper addresses children's exposure to violence in the home, specifically domestic violence and child physical abuse, as potential precursors to PTSD in children, and provides a foundational framework of knowledge essential to working with youth traumatized by family violence. For a review of treatments with this population, please see Vickerman and Margolin, this issue. Child sexual abuse and community violence, other examples of youth violence exposure, have somewhat different mechanisms of impact and have received attention

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elsewhere (Deblinger, & Heflin, 1996; Deblinger, Lippmann, & Steer, 1996; Finkelhor & Browne, 1985; Lynch, 2003), and thus are not the focus here.

Scope of the Problem

Youth's exposure to violence in the home occurs at high rates and often is noted as one of the most common and severe adverse events during childhood (Margolin & Gordis, 2000). Recent data from a nationally representative sample show that, each year, domestic violence occurs in the homes of approximately 30% of youth living with two parents (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Lifetime prevalence of exposure to interparental aggression is likely to be substantially higher, particularly with the inclusion of youth whose parents have separated or divorced. Somewhere between 5–10% of children are directly victimized by severe physical abuse each year, whereas over 50% experience corporal punishment (Straus & Gelles, 1986; Straus, Hamby, Finkelhor, Moore & Runyan, 1998). Many youth who experience domestic violence and child physical abuse are "invisible" victims because the violence exposure is not known to anyone outside the family (Fantuzzo, Mohr, & Noone, 2000; Margolin, 1998). Failure to recognize violence as a precipitating distress in these youth can lead to misdiagnoses and misguided treatment plans.

As with all traumatic events, only a portion of the children who experience violence exposure in their homes will develop PTSD. Summarizing several studies, Rossman and colleagues (Rossman, Hughes, & Rosenberg, 2000) report that 13–50% of youth exposed to interparental violence qualify for diagnosis of PTSD. In a sample of community children exposed to partner aggression, only 13% of the children met diagnostic criteria for PTSD; however, over 50% met the symptom criterion for intrusive thoughts regarding the events, one-fifth of the sample exhibited avoidance of trauma-related stimuli, and two-fifths of the sample experienced over-arousal symptoms related to the traumatic events (Graham-Bermann & Levendosky, 1998). In a clinic setting, 26% of physically abused children qualified for PTSD diagnoses; the percentage was higher for girls (50%) than for boys (18%) (Ackerman, Newton, McPherson, Jones, & Dykman, 1998). Based on a study of youth in foster care, 42% of those who were physically abused experienced PTSD (Lubit, 2006). PTSD diagnoses related to child abuse also are seen in samples not receiving clinical services. Random-digit dialing interviews with over 4000 adolescents showed lifetime PTSD rates of 15.2% for boys and 27.4% for girls who experienced either physically abusive punishment or physical assault (albeit not limited to the family); comparable rates for those with no physically abusive punishment or physical assault was 3.1 for boys and 6.0 for girls (Kilpatrick, Saunders, & Smith, 2003).

Children's exposure to multiple types of violence is an important consideration in the likelihood that they will experience PTSD. The co-occurrence rate between child abuse and domestic violence is estimated to be about 40% in clinical samples referred for one of these problems, although only 6% for non-referred community samples (Appel & Holden, 1998). In some instances, this coincidence of domestic violence and injuries to children is by happenstance rather than intent, for example, as young children cling to a parent out of fear or as adolescents attempt to intervene and stop their parents' battles (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Laumakis, Margolin & John, 1998). Beyond co-occurrence between child abuse and domestic violence, there also is considerable overlap in children's exposure to family violence and community violence (Margolin & Gordis, 2000), and adverse life circumstances more generally (Anda et al., 1999). Emotional abuse is another potential precipitant or exacerbating factor of child trauma that is often overlooked, but is co-occurring with many forms of violence exposure and may account for detrimental outcomes (Toth & Cichetti, 2006). Because children generally enter the health or mental health care system due to one specific type of violence exposure, assessment for exposure to other types of violence and other traumatic events should be standard procedure.

Violence in the Home as a Traumatic Event

In light of the wide variety of events that comprise child abuse and domestic violence, it is not surprising that there is confusion about whether violence in the home qualifies as a traumatic event. Events that fall in the realm of family violence can include physical or emotional aggression, and involve at least one family member as a victim and another as a perpetrator. The actions vary widely in severity, from minor aggression (e.g., pushing, shoving, slapping) to death of a family member. Moreover, the physical and psychological impact of specific aggressive acts varies not only by severity but also by size and developmental status of the recipient. Shaking, for example, can be fatal to a young infant but is unlikely to injure an adolescent. Impact also takes into account disruption to the family system, including family dissolution. For some children, violence in the home leads to one parent leaving, an out-of-home placement for the youth, or temporary relocation with their mother and siblings to a domestic violence shelter. For other children, normal everyday activities are not even disrupted by family violence.

Rossman and Ho (2000) describe children's experience with serious forms of domestic violence as "... a type of war zone. Sometimes they feel they can predict the "attacks" and sometimes the aggression is unexpected. This leaves them with a sense of danger and uncertainty" (p. 85). Children's experiences of intense physical child abuse and domestic violence are quite similar in their overwhelmingly intense affective and physiological reactions. What is less clear is whether the so-called minor or typical forms of child abuse or domestic violence also elicit intense reactions, or perhaps elicit such reactions only in some children. It is tempting to think that aggressive acts should reach a criterion level of violence, either in frequency or severity, before qualifying as a traumatic event. However, there is little basis by which to set such a criterion. Severity of violence exposure is one factor affecting the development of PTSD but other factors, such as accumulation of multiple stressors, functioning of the non-offending caregiver, and the child's perception of the stressor also are significant variables (AACAP, 1998; Pynoos, Steinberg, & Piacentini, 1999).

As a trauma-eliciting event, violence in the home has certain unique characteristics, some of which challenge assumptions about the conceptualization and diagnosis of PTSD. The chronic nature of family violence is one such characteristic that complicates the diagnosis of PTSD. With violence in the home, there may not be an identifiable pre-trauma state of the child's functioning, there may not be one specific traumatic event that stands out, and violent episodes may not present life-threatening circumstances. These factors can obfuscate a DSM-IV (APA, 1994) PTSD diagnosis, which requires exposure to an extremely threatening precipitating event resulting in symptoms that reflect a change from a baseline state. Paradoxically, however, the chronic nature of family violence with the constant threat of additional episodes makes it particularly salient as a trauma-eliciting stimulus. Even if the violence occurs sporadically or only one time, the child's trauma reactions may generalize to other, less serious demonstrations of anger and conflict, and even to verbal aggression, which has a high likelihood of occurrence among family members. Thus, children who live with family violence cannot rely on home as a safe base when threats of repeating violence are real, and there is no escape from the physical or emotional reminders of previous scary incidents.

Parents' compromised emotional availability is another unique characteristic of family violence as a traumatic stressor (Margolin, 1998; van der Kolk, 2005). PTSD symptoms are more likely when a person, not an act of nature, causes the traumatic event, when that person is a trusted individual, and when the victim is a loved one (Green et al., 2000). Thus, fear and helplessness may be particularly overwhelming when the threatened or actual injury is caused by one parent and is directed to the child, the other parent, or a sibling. With traumatic events such as natural disasters or accidents, parents' support for the child has proven to be an

important buffer to help minimize PTSD symptoms (AACAP, 1998). From an attachment perspective, the child is in an irresolvable situation and is likely to respond with disorganized attachment when the parent simultaneously is the source of safety and the source of danger (Hesse & Main, 2006; Lieberman & Van Horn, 2005). Moreover, the non-offending parent may not be able to offer security if she herself is threatened or victimized (Dutton, 2000). Mothers who have PTSD tend to be quicker and more impulsive in their actions toward their children and also to underestimate their children's distress (Chemtob & Carlson, 2004). For all of these reasons, family violence has the unfortunate consequence of undermining parents as protectors and sources of support.

In addition, the potential toll on youth's perceptions of self-worthiness and self-esteem can be especially poignant when the parents are the source of the traumatic stress (Silvern, Karyl, & Landis, 1995). Being the recipient of parents' aggressive words and actions can damage children's perceptions of themselves as deserving, lovable individuals. It is not unusual for children to attribute the abuse they receive to self-identified faults, misdeeds, and negative traits (Briere, 1992). Even interparental violence can inadvertently communicate a message of disregard for the child and can leave the child wondering: How can you care about me if you hurt my mom and destroy our family? Relatedly, children's diminished self-worth may stem from their perceptions that they should have tried to protect the victim or to stop the violence, but failed to do so (Silvern et al., 1995).

Child abuse and exposure to domestic violence fall into the category of complex traumas (Cook et al., 2005; van der Kolk, 2005), a relatively recent conceptualization of long-standing, repeating, traumatic events. Complex trauma refers to "the experience of multiple, chronic, and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early life onset" (van der Kolk, 2005, pg. 401). Six domains of potential impairment related to complex trauma exposure have been delineated: (a) affect regulation, including difficulty with modulation of anger and being self-destructive; (b) information processing, including attention, concentration, learning difficulties, and consciousness, e.g., amnesias and dissociation; (c) self-concept, including guilt and shame, (d) behavioral control, including aggression and substance abuse, (e) interpersonal relationships, including trust and intimacy, and (e) biological processes, including somatization and delayed sensorimotor development (Cook et al., 2005; Spinazzola et al., 2005; van der Kolk, 2005). Van der Kolk (2002) additionally includes alterations in the systems of meaning and loss of sustaining beliefs. Because of the overwhelming dysregulation experienced by these youth, even minor stressors can lead to serious distress.

Manifestations of PTSD in Violence-Exposed Youth

A developmental psychopathology conceptualization of youth violence exposure incorporates multi-faceted and interacting variables that contribute to adaptive or maladaptive trajectories. The child's vulnerability versus resilience to traumatic events relates to a complex system of variables, including associated and secondary stresses (e.g., other losses or changes), reminders of the trauma (external and internal cues), and the child's appraisals of ongoing danger, which all occur in the context of intrinsic child characteristics (e.g., temperament, developmental competencies, physiological reactivity), and family and social environment of the child (Pynoos et al., 1999). Building on a developmental psychopathology framework, the Complex Trauma Taskforce of the National Child Traumatic Stress Network emphasizes that multiple traumas are likely to result in complex disturbances in multiple domains, potentially leading to wide-ranging developmental delays and/or fluctuating presentations of symptoms (van der Kolk, 2005). Post-traumatic reactions typically comprise the interplay of dysregulation in emotional, cognitive, behavioral and psychobiological domains, with symptoms in each domain potentially triggering symptoms in other domains. These symptoms can disrupt typical

maturation and derail the child from normal developmental tasks and activities (Cicchetti & Toth, 1995; Silvern, et al., 1995; van der Kolk, 2005).

A hallmark reaction to trauma events is the flooding of negative affect, both in reaction to the actual trauma and to recurrent intrusive thoughts about the event. Over time, emotional reactions fluctuate between anxious, hyperactivated emotional responses and restricted, flat affect. Consequences of affect dysregulation, both the detachment and excessive reactivity, include difficulty containing emotions, displays of inappropriate affect, and withdrawal from affect arousing situations, all of which increase the risk of poor impulse control and relationship problems (Cicchetti & Toth, 1995; van der Kolk, 2005).

Cognitive symptoms in youth exposed to violence include over estimations about danger, preoccupied worry, and intrusive thoughts about the safety of oneself and other family members (Briere, 1992). Attempts to modulate these cognitive symptoms can result in efforts to minimize the impact of new information (i.e., slower processing of incoming information) or alternatively, to maximize new information (i.e., maintaining a state of preparedness and vigilance) or in alternating between minimizing and maximizing (Rossman & Ho, 2000). If these cognitive reactions lead to difficulties in concentration and decision-making, they can have serious consequences for the youth's ability to function in school (Rossman et al., 2000). Cognitive distortions due to either minimizing or maximizing information, coupled with high emotional arousal, also provide an explanation for violence-exposed youth's increased risk of engaging in aggressive behaviors. That is, the youth may rely on past aggressive understandings of interpersonal situations and not attend to the nuances of the current situation. Or the youth may over-interpret ambiguous cues as aggression and respond in kind. In both situations, the youth may exhibit "preemptive" aggressive responding due to her or his faulty processing of social information (Crick & Dodge, 1994; Dodge, Petit, & Bates, 1994; Rossman & Ho, 2000).

Sensory experiences associated with trauma events are closely intertwined with physiological reactions and, over time, with alterations in biological stress systems (De Bellis et al., 1999; van der Kolk, 1996). Repeated neural activation due to trauma exposure can alter the quantity and quality of neuro-transmitter release (Mohr & Fantuzzo, 2000). Prolonged stress due to family violence exposure and/or sexual abuse has been linked to chemical changes, such as higher levels of norepinephrine, dopamine, epinephrine and cortisol (De Bellis et al. 1999). Elevations in adrenalin and noradrenalin prepare the body for quick action, through increased heart rate and blood flow, but also increase agitation and perhaps decrease attention (Rossman et al., 2000). Over prolonged exposure, the body regulates arousal by decreasing the number of receptors for arousal. Also, high levels of glucocorticoids are associated with damage in the hippocampus, which can negatively impact memory. Perhaps most alarmingly, because children's brains are still developing, they are particularly vulnerable to negative effects of periods of overactivation or underactivation in their neurodevelopment (Schwartz & Perry, 1994).

Challenges with the Diagnosis of PTSD in Youth

Ever since PTSD was recognized as a valid condition in youth, there has been considerable re-evaluation and refinement about appropriate diagnostic criteria. Based on understanding PTSD in adults, children currently must exhibit at least one re-experiencing, three avoidance and numbing, and two arousal criteria for a DSM-IV PTSD diagnosis (APA, 1994). The DSM-IV criteria recognize that PTSD is likely to be exhibited differently in children than adults, for example, with children re-experiencing the traumatic event through repetitive or reenacting play, or frightening dreams. Scheeringa and colleagues (Scheeringa, Zeanah, Drell, & Larrieu, 1995) have introduced developmentally sensitive criteria for preschool age children that are

less dependent on verbalizations and abstract thought, and included new symptoms such as aggression, new fears, and loss of previously acquired developmental skills, e.g., language regression.

Although children are more likely to manifest adult-type PTSD symptoms as they mature (AACAP, 1998), school-age children and adolescents still have their own age-specific ways of registering post-traumatic distress. Kerig and colleagues (Kerig, Fedorowicz, Brown, & Warren, 2000) differentiate PTSD symptoms for adolescents, school-age children, and preschool children. For adolescents, their list of arousal symptoms includes insomnia or withdrawal into heavy sleep, angry or aggressive behavior, and academic difficulties in addition to the standard symptoms of hypervigilance and exaggerated startle response. In contrast, arousal symptoms listed for school-age children are difficulty falling asleep, oppositional acting out behavior, and obsession with trauma details. Problems also have been noted with the distinctions between symptom clusters in youth. Rossman and Ho (2000) argue that arousal and avoidance symptoms actually represent one factor, which they explain as youths' efforts to cope with physiological arousal by withdrawing physically and psychologically from the aversive situation.

To capture youth's complicated and multidimensional reactions to severe and prolonged interpersonal violence, the Complex Trauma Taskforce of the National Child Traumatic Stress Network (e.g., van der Kolk, 2005) has re-conceptualized the diagnostic criteria for PTSD in complex cases and propose a new diagnostic category, Developmental Trauma Disorder (DTD). The criteria for DTD include: (a) repeated exposure to developmentally adverse interpersonal trauma; (b) triggered pattern of repeated dysregulation in response to trauma cues, including dysregulation in multiple domains; (c) persistently altered attributions and expectancies about self, relationships, and others; and (d) evidence of functional impairment (van der Kolk, 2005). This new diagnostic category, which is being considered for possible inclusion in the American Psychiatric Association's DSM-V (DeAngelis, 2007), directs attention to the wide-ranging symptoms exhibited by youth exposed to interpersonal traumas. The goal of introducing this new diagnosis is to better identify children who have experienced complex trauma so that they can receive trauma-related interventions.

Co-Morbid and Secondary Problems Associated with PTSD

The wide-ranging constellation of problems associated with trauma means that violence exposed youth often meet criteria for multiple diagnoses, one of which may be PTSD. In addition to co-morbidity with depression and a variety of anxiety disorders including separation anxiety, PTSD also often is co-morbid with attention-deficit hyperactivity disorder (ADHD), conduct disorders, and aggression (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Buka, Stichick, Birdthistle, & Earls, 2001; Famularo, Fenton, Kinscherff, & Augustyn, 1996; Lubit, 2006). In some instances, PTSD symptoms may be a mediator between violence exposure and other outcomes (Lisak & Miller, 2003; Wolfe, Wekerle, Scott, Straatman, & Grasley, 2004). The distress associated with the PTSD symptoms can overwhelm the youth, interfere with coping responses to other stresses, and thereby lead to more symptoms of maladjustment.

A concern when diagnosing violence exposed youth is that PTSD will be misdiagnosed as another childhood condition, particularly when the assessment is made without knowledge about violence exposure in the home. In some situations, misdiagnosis can have problematic outcomes. For example, a misdiagnosis of ADHD that results in treatment with Ritalin may actually increase symptoms of intrusion for some youth (Rossman & Ho, 2000). Moreover, despite empirically supported treatments for childhood problems such as depression or anxiety,

we lack information on the effectiveness of these treatments when the problems are etiologically related to violence exposure.

Adolescents show somewhat unique types of co-morbidity, with increased risks for co-occurrence between PTSD and risk-taking activities such as alcohol and drug abuse, suicide risk, eating disorders, delinquency, school truancy and suspension, and violence in dating relationships (Cohen, Mannarino, Zhitova, & Capone, 2003; Flannery, Singer, & Wester, 2001; Kilpatrick, Ruggiero, Acierno, Saunders, Resnick, & Best, 2003; Lipschitz, Winegar, Hartnick, Foote, & Southwick, 1999; Wolfe, Scott, Wekerle, & Pittman, 2001). Adolescents' PTSD and their acting-out and risk-taking behaviors create spiraling patterns of problematic behavior. Youth may engage in risky behaviors such as substance abuse, risky sexual practices, or delinquent acts as ways to cope with PTSD, that is, to self-medicate, reduce their sense of isolation, or improve their esteem (Widom & Hiller-Sturmhofel, 2001). Those behaviors, however, put them at risk for aggression, violence, and social rejection, all of which can further contribute to posttraumatic stress. Mutually reinforcing patterns of PTSD and efforts to cope with the distress associated with PTSD can put adolescents on trajectories with destructive consequences for their schooling, employment, and social relations.

The lack of consensus about PTSD symptoms and about the nature of the relationship between PTSD and co-morbid problems poses important questions with significant implications for assessment and treatment. Are other psychological problems manifestations of syndromes that are distinct from PTSD, or are they actually part of the trauma-related phenomena, as suggested by proponents of complex trauma theories and DTD diagnoses (van der Kolk, 2002)? Does PTSD precipitate other types of problems or make youth vulnerable to other problems? If so, does treatment directed toward lessening the PTSD symptoms interrupt or prevent other psychological conditions? Answers to these questions inform decisions about whether to administer trauma-focused treatment versus treatments directed at other childhood disorders and thus are fundamental to treatment planning for traumatized youth.

Assessment Considerations

Assessment of children with family violence exposure should cover all salient domains of the child's life, be developmentally informed with sensitivity to varying types of symptoms for children, and include information about the family and cultural context. Information should be gathered from relevant adults, including parents, significant care-givers, and perhaps teachers.

Important considerations for informed treatment planning are the nature and type of distress that the child experiences, and the extent to which she or he is hampered in everyday activities. Meeting criteria for a PTSD diagnosis is not the predominant issue, particularly in light of the evolving definitions of PTSD. Children with sub-threshold symptoms for PTSD may demonstrate substantial distress and functional impairment (Carrion, Weems, Ray, & Reiss, 2002; Pelcovitz, Kaplan, Godenberg, Mandel, Lehane, & Guarrera, 1994). Even youth who appear asymptomatic may experience subtle problems, such as difficulties concentrating.

When questioning a child about aggression and violence in the home, the clinician needs to be mindful of the implications for the child of revealing information, particularly information that has not been previously shared. Frequently children do not make connections between their own symptoms and precipitating events. Or, the child may choose not to speak of family violence, either to protect their parents or in response to a direct instruction to remain silent. In assessing violence exposure, questions should refer to specific types of aggressive acts (hitting, slapping) rather than rely on general terms such as abuse or violence, and assess for experiences of emotional abuse and neglect, e.g., calling child stupid or threatening to send the child away. In addition, when obtaining information about actual abuse experiences, clinicians should maximize the use of open-ended, not leading questions, to obtain an uncontaminated

report of the child's abuse experience, even when interviewing children as young as age 4 or 5 (Lamb et al., 2003).

The home environment and the parents are the most salient contextual variables to assess, with a detailed focus on the nature of the child's relationship with his or her parents, and other important family members (e.g., siblings, grandparents). Parents' overall stress and emotional health are important, particularly because of the impact of domestic violence on women, and the impact of mothers' depressed mood and trauma symptoms on youths' distress (Levendosky & Graham-Bermann, 1998, 2000; McClosky, Figueredo, & Koss, 1995). Although there is evidence that abused women can experience high parenting stress (Holden, Stein, Ritchie, Harris, & Jouriles, 1998), mothers' level of abuse does not necessarily impact their parenting behaviors (Sullivan, Nguyen, Allen, Bybee, & Juras, 2000). Assessment with parents also can identify potential obstacles to treatment, e.g., transportation, babysitting needs, etc. (Kolko & Swenson, 2002) as well as alternative potential support networks, e.g., school, counselor, social worker, extended family, community members, etc. (Spinazzola et al., 2005).

Beyond family context, cultural and community context can influence how a child and the family perceive, respond to, and cope with family violence. PTSD occurs across cultures, but cultural factors may affect the way symptoms are manifested and understood by the family and community (AACAP, 1998). In addition to cultural norms and values about the violence and associated symptoms, culture plays a role in family roles, child rearing, and attitudes about the extent to which extended family and non-family can play a role in ensuring that the child's needs are met (Cohen, Deblinger, Mannarino, & de Arellano, 2001). Culture also is likely to influence the family's receptivity to treatment and even specific types of interventions (Graham-Bermann & Hughes, 2003).

Our recommendations for the assessment of family violence and youth symptoms include the following. First, when violence in the family has been identified, even if the child is not manifesting overt problems, there should be an assessment for subtle signs of impairment and for establishing a baseline measure of the child's adjustment. Second, in light of the number of families where violence is occurring but is unknown to anyone outside of the family, exposure to family violence should be briefly assessed even if it not part of the presenting picture when children are referred for emotional and behavioral problems. Third, any assessment of children exposed to domestic violence should include an assessment of PTSD. Fourth, PTSD should be considered as a potential mediating variable between family violence and other child problems. We make these suggestions neither to implicate family conflict and violence in every child's symptoms, nor to imply that all family aggression and violence is traumatic. Rather, these suggestions are to identify those youth whose experiences with traumatic violence exposure have not been identified but influence their current adjustment. If family violence is not known or if PTSD symptoms are not assessed, these children are likely to receive standard treatment for specific psychological problems when they might benefit more from trauma-based therapy.

Conclusions and Future Directions

Exposure to family violence, including marital aggression and physical child abuse, is increasingly recognized as a possible precursor to PTSD in children and adolescents. However, unique aspects of violence in the family and variations due to a child's developmental level may complicate the diagnosis of PTSD, particularly if treatment professionals are unaware of the child's victimization. In addition, at least one of the child's primary caregivers is also the perpetrator of violence and family violence by nature is often chronic or repeated, both of which may exacerbate youth's symptomatology and lead to maladaptive functioning in multiple domains (i.e., affective, cognitive, behavioral, physiological, and social). Clinicians should be

aware of the potential for possible co-morbid diagnoses and problems for traumatized youth. Assessment of these youth should recognize the family and cultural context, the developmental stage of the youth, and the nature and degree of stress the child has experienced, and should evaluate all domains of the child's life that may impact their well-being or ability to function successfully.

Conceptualizations of PTSD in youth are still evolving. Are PTSD symptoms normal reactions to abnormal circumstances, or abnormal reactions to abnormal circumstances (McNally, Bryant, & Ehlers, 2003)? Further investigation of PTSD in youth is needed to understand the anticipated, yet highly disturbing and disorienting nature of PTSD symptoms from a developmental perspective. Also, information is needed on the progression of PTSD (Pynoos et al., 1999) and on who develops PTSD (Ozer & Weiss, 2004). Despite many explanations about how and why youth develop PTSD, far less is known about factors that contribute to youth's spontaneous recovery from PTSD without intervention, or about resilience to the development of PTSD despite extreme and repeated violence exposure. Information on the natural course of PTSD in youth exposed to family violence with a focus on various sources of healing and with attention to youth of different socio-cultural backgrounds can provide valuable information for improving intervention efforts. For an examination of intervention components and treatment outcome evaluations, see Vickerman and Margolin, this issue. Research on the development and progression of PTSD will improve the extant clinical literature and the limited treatment outcome research on intervening with youth traumatized by family violence.

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