Most individuals who experience life-threatening traumas show some symptoms of post-traumatic stress disorder (PTSD) immediately. Only approximately 30% have vulnerabilities to this disorder, and/or suffer the most chronic and terrifying events that maintain these symptoms as an enduring syndrome a month after the threats are gone. This is true for nearly all ages. Since the revision of PTSD in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised* (DSM-III-R) in 1987, the diagnostic criteria have included special developmental considerations for children and adolescents. This special language was revised with the subsequent version of the DSM. Initially, skeptics doubted whether children could develop PTSD, but this is no longer debatable. More current concerns include whether the PTSD criteria adequately describe the psychopathology of children and adults who have experienced severe trauma. This paper will review the following important issues for assessing children who have experienced traumatic events: (i) the specificity of the PTSD diagnosis; (ii) developmental considerations for preschool and school-age children; and (iii) a variety of assessment challenges that reflect the difficulty and complexity of interviewing children and caregivers about these symptoms. Despite these challenges, PTSD remains the best construct for clinical and research work with trauma survivors. Pediatric PTSD criteria are valuable for identifying children at risk and in need of treatment, and can be even more helpful when developmentally modified in ways that are discussed.

**Keywords:** child; adolescent; post-traumatic stress disorder; DSM-IV-TR; trauma; diagnostic criterion; internalizing disorder; treatment
Despite these diagnostic challenges, many crucial benefits derive from attempting to accurately assess PTSD symptoms in children. This paper addresses the above challenges, and also explores reasons why despite these, clinicians should persist in exploring the possible presence of PTSD symptoms in children who have experienced traumatic life events.

**DSM-IV-TR PTSD diagnostic criteria**

The current diagnostic criteria for PTSD (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (DSM-IV-TR)) require that children have experienced, witnessed, or learned of a traumatic event, defined as one that is terrifying, shocking, and potentially threatening to life, safety, or physical integrity of self or others. Children must also meet at least one re-experiencing criteria, three avoidant/numbing criteria, and two hyperarousal criteria, listed in Table I. Children must meet minimal duration criteria of at least 1 month, and they must show functional impairment in an important area (school, peers, family, etc).

**Challenge 1: specificity of pediatric PTSD diagnostic criteria**

Some overlap exists between diagnostic criteria for PTSD and other childhood internalizing disorders. Four PTSD diagnostic criteria (decreased interest in activities, sleep disturbance, restricted range of affect, and decreased concentration) overlap with those for major depressive disorder (MDD). Three symptoms of PTSD (decreased concentration, irritability, and sleep disturbance) also overlap with symptoms of generalized anxiety disorder (GAD). Despite this overlap, there are pathognomonic symptoms of PTSD that make it distinct. No diagnoses other than acute stress disorder (ASD) include trauma-specific items such as criteria B 1-5 (specific to traumatic reexperiencing symptoms) or C 1-3 (specific to traumatic avoidance and numbing). Thus, 8 out of 17, or nearly half of the PTSD

| A: Person was exposed to a traumatic event in which both were present: |
|---|
| 1) person experienced, witnessed or was confronted with event(s) involving actual or threatened death, serious injury, or threat to physical integrity of self or others |
| 2) person's response involved intense fear, helplessness or horror; in children may be expressed by disorganized or agitated behavior |
| B: Traumatic event is persistently re-experienced in at least one of the following: |
| 1) recurrent and intrusive distressing recollections of the event including images, thought or perceptions; in young children repetitive play in which trauma themes are expressed |
| 2) recurrent distressing dreams of the event; in children frightening dreams with no recognizable content |
| 3) acting or feeling as if the traumatic event were recurring, reliving illusions, hallucinations, dissociative flashbacks; in young children trauma-specific re-enactment |
| 4) intense psychological distress at exposure to reminders of the traumatic event |
| 5) intense physiological distress at exposure to reminders of the traumatic event |
| C: Persistent avoidance of trauma reminders and new numbing of general responsiveness, indicated by at least three of the following: |
| 1) efforts to avoid thoughts, feelings, or conversations about the trauma |
| 2) efforts to avoid activities, places, or people that arouse memories of the trauma |
| 3) inability to recall an important aspect of the trauma |
| 4) markedly diminished interest or participation in significant activities |
| 5) feeling of detachment or estrangement from others |
| 6) restricted range of affect |
| 7) sense of a foreshortened future |
| D: Persistent new symptoms of increased arousal as indicated by at least two of the following: |
| 1) difficulty falling or staying asleep |
| 2) irritability or angry outbursts |
| 3) difficulty concentrating |
| 4) hypervigilance |
| 5) exaggerated startle response |

Table I. DSM-IV-TR PTSD diagnostic criteria.
diagnostic criteria, are unique to PTSD or partly shared by ASD. It is literally impossible to be diagnosed with PTSD without trauma-specific criterion B symptoms. In this regard, a study conducted by Keane et al. demonstrated that clinicians could readily distinguish PTSD from MDD or GAD despite several overlapping criteria, due to the presence of a number of discriminating items and dimensions that differentiate these respective disorders. Nevertheless, in a debate that so far has been largely confined to the adult literature, the specificity of PTSD has been challenged because of concerns that persons who do not really have the disorder may be diagnosed (too many false-positives). For example, in one study of patients enrolling in treatment studies for depression, the group with true trauma events and the group with “minor traumas” both had nearly 80% rates of PTSD from structured interviews. That is, the “minor trauma” subjects endorse enough criteria B, C, and D symptoms from their events to qualify for the diagnosis. However, the authors paid only glancing attention to the issue that this was a highly selective help-seeking depressed sample, suggesting that they had greater vulnerability to react to minor trauma and develop symptoms. Furthermore, no attempt was made to comparatively grade the severity of PTSD within each of those groups to explore the possibility that the “minor trauma” group may have had relatively less severe PTSD than the trauma group, which would not be a surprising finding if symptom severity follows from the severity of perceived life threat. Speculating from these types of concerns, Spitzer and colleagues proposed modified diagnostic criteria for PTSD in an effort to restrict who can receive the diagnosis. The main suggestion was to eliminate five symptoms that overlapped with other disorders. In addition, the requirements for three out of seven symptoms from criterion C plus two out of five symptoms from criterion D were replaced with a single criterion (criteria C and D collapsed) with seven possible symptoms, of which four symptoms were required. Unfortunately, these changes were proposed in the absence of empirical data. Elhai and colleagues reviewed the data of 5692 participants in the National Comorbidity Survey Replication, and found that these recommendations made an insignificant impact. The recommendations lowered the rate of PTSD only from 6.81% to 6.42%. These authors concluded that “little difference was found between the criteria sets in diagnostic comorbidity and disability, structural validity, and internal consistency” (p597).

In contrast, concern about specificity has not been prominent in the child literature because historically the issue “in the trenches” clinically is that children have been under-recognized as having internalizing symptoms, rather than being overdiagnosed. In other words, the concern has been lack of sensitivity rather than lack of specificity. For example, one vocal group of child researchers argues that too many children who have been chronically and repeatedly traumatized, abused, and/or neglected are not being diagnosed with anything because they believe that their symptoms do not fit PTSD. In addition, when they are diagnosed with PTSD plus the inevitable comorbid disorder(s), this purportedly misleads clinicians to treat comorbid conditions rather than the trauma syndrome and “may run the risk of applying treatment approaches that are not helpful.” A new syndrome has been proposed, similarly to Spitzer et al, based on speculation in the absence of empirical data, but does not have operationalized symptoms and has far to go in achieving face validity. It is yet to be empirically documented that chronically and repeatedly traumatized youngsters are not adequately represented by PTSD, or that neglect (as opposed to trauma) leads to a novel syndrome.

Comorbidity is an issue that seems to drive concerns about lack of specificity for adults and lack of sensitivity for children. Implicit in the arguments of Spitzer et al is that comorbidity is clouding the picture; specifically, that non-PTSD symptoms are being misidentified as part of PTSD because they overlap. In both adult and child populations, 80% to 90% of the time PTSD occurs with at least one other disorder. In adults, the common comorbid conditions are depression, anxiety, and substance abuse. However, viewing comorbid disorders simply as overlap with PTSD has been rejected generally when examined empirically in adults. In McMillen et al’s study of 162 adult flood survivors, those with the overlap symptoms that developed after the flood did not have MDD or GAD. They had PTSD, indicating that the symptoms are part and parcel of the PTSD syndrome.

Furthermore, the temporal relations between comorbid disorders have simply not been asked about in most prior studies. It appears that this lack of data has led some observers to assume that the non-PTSD disorders developed after traumas in the absence of PTSD. But when the onsets were tracked, the relationships were clear. McMillen et al tracked the onsets of all disorders, and
found that all of the survivors diagnosed with a new non-PTSD disorder also had the PTSD diagnosis or substantial PTSD symptoms that did not meet the diagnostic algorithm. This finding was replicated with preschool children and their caregivers following Hurricane Katrina. This suggests that all post-trauma disorders have an underlying connection to PTSD. The issue of comorbidity takes a developmental twist with younger children, but the fundamental conclusion about the validity of PTSD is the same as in adults.

In preschool children, the most common comorbid disorders are oppositional defiant disorder (ODD) and separation anxiety disorder (SAD). The issue in older children and adolescents is less well-documented. Since the comorbid conditions seen with childhood PTSD are more observable than the situationally triggered or highly internalized symptoms of PTSD, the concern is that these conditions may be erroneously targeted for treatment without full appreciation of the concurrent PTSD symptomatology.

It is worth noting that if confusion exists from the presence of comorbidity, it is not inherently a flaw of the taxonomy system in general or PTSD specifically. Good history-taking about the timing of symptom onset, and knowledge of the research that PTSD is the underlying basis of new disorders after trauma exposure should contribute substantially to accurate diagnosis and treatment planning.

It is also worth noting that not all comorbidity codevelops with PTSD following trauma. Findings from studies that examined subjects prospectively prior to exposure to traumatic events showed that a proportion of the comorbid conditions predate (and perhaps serve as vulnerability factors for) the development of PTSD. For example, when studied prior to traumatic events, 100% of adults who had PTSD in the last year at age 26 had met criteria for another mental disorder between the ages of 11 to 21 years.

Overall, we see contrasting trends between developmental periods. The adult field has focused relatively more on PTSD, leading to too many false-positives (lack of specificity) because, in part, a faction views the overlap of symptoms as illogical and want a more restrictive syndrome. In contrast, a faction in the child field has focused on PTSD as insufficient, because it purportedly does not adequately diagnose those with chronic and repeated trauma and/or neglect, and they are opting for a broader, more inclusive new syndrome. In fact, the data show PTSD to be one of the most well-studied and validated disorders in longitudinal, neurobiological, and treatment response studies. Some clinicians, scholars, and other observers may be dissatisfied with the complexity and messiness of post-traumatic responses, but the data do not support a wholesale deconstruction of PTSD based on false-negatives or false-positives.

**Strategies for addressing this challenge**

Overlap of a portion of PTSD symptoms with other disorders is neither a dense conundrum nor careless taxonomy. Clinicians should be careful to assess children based on the criteria provided, and not assume that children have stress-related disorders based on the presence of general negative affectivity symptoms (eg, hyperarousal symptoms, detachment, decreased interest or participation in activities). Clinicians should attend to the high proportion of children who have PTSD symptoms along with other comorbid conditions, while at the same time not mistakenly misdiagnosing children who have general negative affectivity.

**Challenge 2: symptomatic and impaired, but not diagnosed**

One function of diagnostic criteria is to differentiate groups of individuals according to clinically meaningful levels of severity or impairment. That is, people who have a diagnosis should differ significantly from people without that diagnosis in terms of how functionally impaired they are. There is growing evidence that the current PTSD diagnostic criteria actually underestimate the number of children and adults with symptom-related functional impairment. One study found that children who met PTSD diagnostic criteria in two but not three diagnostic clusters had the same level of functional impairment as children who had full PTSD diagnoses. One problem with the current criteria is that they do not give adequate consideration to the intensity of symptoms, despite the fact that clinical impairment is often more closely associated with the intensity of symptoms rather than with the number or frequency of symptoms. In a prospective longitudinal study of preschool children, 47 children were followed 1 year after their first assessment, and significantly more were impaired in at least one domain (48.9%) than had the full diagnosis of PTSD (23.4%). For the 35 children that were followed after
2 years, the gap was even greater, with 74.3% impaired compared with 22.9% with the full diagnosis. The following two cases illustrate this discrepancy.

Child A experienced a rape at school 6 weeks ago. She has severe, recurrent, intrusive horrifying memories of the rape. She is afraid to go to sleep because she believes the rapist will break into the house when she is sleeping. She is extremely distressed psychologically and physically when she thinks of the event, demonstrated by the fact that she vomits several times a day and has lost 9 kg. She refuses to say the name of the rapist and is too afraid to return to school (avoidance of people, places, thoughts, conversations). She denies decreased interest, difficulty remembering important details about the rape, restricted range of affect, or foreshortened future. She endorses extreme difficulty sleeping and cannot sleep for more than an hour at a time. She jumps when she hears the slightest sound. She checks to make sure the door is locked at least 10 times a day. She is impaired in every aspect of her life. She has 8 PTSD symptoms but does not meet the criteria for PTSD (due to only meeting two avoidance criteria).

Child B experienced a car accident 6 weeks ago. She has scary dreams about the accident once or twice a week and gets a headache or becomes sad when reminded of the accident. She does not like to talk about the accident, forgets many details about it, and no longer wants to go to dance lessons, since she was on her way to dance when the accident occurred. She does not mind driving in the car otherwise. She continues to go to school and play with her friends. She has become irritable and is having some trouble falling asleep most nights because she is afraid of bad dreams. She also has 8 PTSD symptoms. She meets the criteria for PTSD.

It seems clear that Child A has more functional impairment than Child B, despite not meeting diagnostic criteria for PTSD, and that despite having the same number of PTSD symptoms, the severity of symptoms needs to be factored into the diagnostic criteria in a more comprehensive manner. Further research is needed to determine whether the current diagnostic criteria validly differentiate children from those who fail to meet diagnostic criteria in clinically meaningful ways.

**Strategies for addressing this challenge**

Current practice parameters recommend that children with clinically significant impairing levels of PTSD symptoms, regardless of diagnostic status, should be provided with evidence-supported treatment options. An alternative appropriate diagnosis (eg, adjustment disorder; anxiety disorder not otherwise specified [NOS], etc) should be used if PTSD diagnostic criteria are not met. This issue may be reflected in the future DSM-V since it has been suggested for adults to lower the threshold for cluster C from three to two symptoms, and for young children from three symptoms to one.

**Challenge 3: developmental considerations in the diagnosis of pediatric PTSD**

Growing research demonstrates that the current diagnostic criteria are not sensitive enough for preschool children and perhaps also not sensitive enough for prepubescent children. Ten studies have examined the validity of the diagnostic criteria for PTSD in preschool children. The consistent findings are that PTSD can be reliably detected in young children, they manifest most (but not all) of the items, and, most importantly, an alternative criteria algorithm appears more developmentally sensitive and valid than the DSM-IV algorithm.

The alternative algorithm for PTSD in young children (PTSD-AA) includes modifications in wording for several items to make them more developmentally sensitive to young children. For example, the DSM-IV item for irritability and outbursts of anger was modified to include extreme temper tantrums. However, the major change is a modification to lower the requirement for the C criterion (numbing and avoidance items) from three out of seven items to just one out of seven items because many of the C criterion items are highly internalized phenomena that appear to be either developmentally impossible in young children (eg, sense of a foreshortened future) or extremely difficult to detect even if they were present (eg, avoidance of thoughts or feelings related to the traumatic event, and inability to recall an important aspect of the event).

When the DSM-IV criteria are applied to samples and compared head-to-head to the PTSD-AA criteria, significantly higher rates of PTSD were consistently found with the PTSD-AA criteria. The rate of DSM-IV PTSD in nonclinical samples (non-help-seeking) from a gas explosion in Japan was 0%, and from a variety of traumatic events (mainly auto accidents and witnessing domestic violence) was 0%, whereas the rates of PTSD
using the PTSD-AA criteria in those studies were 25% and 26% respectively. The rates of DSM-IV PTSD in clinic-referred children who witnessed domestic violence was 2%26 and from a variety of traumas in two small clinic studies were 13%29 and 20%,30 but the rates by the PTSD-AA criteria were approximately over 40%, 69%, and 60% respectively. These rates of PTSD found in young children with developmentally sensitive measures and criteria are consistent with rates found in older populations.

Because PTSD has been recognized formally in preschool children only relatively recently, it is noteworthy to mention the common comorbid disorders that codevelop with PTSD at this age. As noted earlier, the most common codeveloping comorbid disorders are ODD and SAD. In one study, the comorbid rates with PTSD were 75% ODD and 63% SAD.15 In another study, the comorbid rates were 61% ODD and 21% SAD.14

Prospective longitudinal data are among the strongest data for construct validity of syndromes. These data in youth have indicated that PTSD is a stable diagnosis, and that children do not simply “grow out of it” as if it were a normative reaction or a minor developmental perturbation. Meiser-Stedman et al.28 in a prospective design, showed that 69% of those children diagnosed with PTSD-AA at 2 to 4 weeks post-trauma retained the diagnosis 6 months later. Scheeringa and colleagues20 studied 62 children with mixed traumatic experiences 4 months (Time 1) after the trauma, and again at 16 months (Time 2) and 28 months (Time 3) after the trauma. They found significant stability of symptoms over the 2 years. At 4 months post-trauma, the group that had been diagnosed with PTSD-AA at visit 1 had an estimated mean of 6.1 PTSD symptoms. This number of symptoms did not diminish by even as much as one symptom over 2 years. Furthermore, PTSD diagnosis at Time 1 significantly predicted degree of functional impairment 1 and 2 years later.

**Strategies for addressing this challenge**

First, professionals must be aware that preschool children can develop PTSD. Only then can appropriate screening and referrals for assessment be triggered. Second, when conducting assessments, developmentally appropriate measures and criteria must be used so as not to miss the diagnosis. Third, because of the traditional under-recognition of PTSD, which may be overshadowed by the more behaviorally observable comorbid symptoms of ODD and SAD, professionals must be on alert when children present with sudden onset of new symptoms to evaluate for past traumatic events and do a thorough PTSD assessment.

**Challenge 4: assessment challenges**

The accurate assessment of PTSD is perhaps more time-consuming, difficult, and emotional than for any other disorder. Details of a proper assessment are beyond the scope of this paper, but this section highlights three particular challenges.

**Interviewing burden and complexity for multiple traumatic events**

While the DSM-IV criteria do not restrict making the diagnosis to a single traumatic event, diagnostic interviews and self-report instruments that assess PTSD often ask respondents to select “the worst” traumatic event that he or she experienced and to rate all PTSD symptoms in relation to that specific event. Many children have experienced multiple traumatic events. One recent study indicates that 68% of all children in the US have experienced at least one potentially traumatic event (PTE), and half of these children have experienced multiple PTEs.32 It is often difficult for children, particularly young children, to select only one traumatic event as “the worst” they have experienced. It is common for children who have experienced multiple PTEs to describe that they are experiencing some PTSD symptoms related to one trauma and other symptoms related to another trauma. No known study has specifically examined (i) children’s PTSD symptoms related to any traumatic event; versus (ii) children’s PTSD symptoms only related to the “worst” traumatic event they had experienced. A reasonable hypothesis is that significantly more symptoms would be reported in (i) than (ii).

Suppose such a child reported domestic violence, traumatic death of a brother, and sexual abuse exposure. This child reports one re-experiencing, one avoidance, and one hyperarousal symptom related to domestic violence; two re-experiencing, two avoidance, and two hyperarousal symptoms related to the traumatic death; and one re-experiencing, two avoidance, and one hyper-
arousal symptom related to sexual abuse. None of these alone are enough to qualify the child for a “full-blown” PTSD diagnosis, but taken together (four re-experiencing, five avoidance, four hyperarousal) symptoms, the child definitely qualifies.

**Accuracy from information sources**

Several issues make it difficult to obtain accurate information from respondents. First, asking about PTSD symptoms is relatively more abstract than other, more observable disorders. Children with PTSD may not appear symptomatic to most observers. This leads to a public health challenge because professionals and caregivers do not recognize PTSD or provide appropriate treatment. Complicating this issue is that PTSD is not in the normal lexicon of observable phenomenon for most people. Everyone knows what depression and hyperactivity look like. But most people in their ordinary experiences do not know what it is like to have overgeneralized fear responses to nonthreatening stimuli, or a constant state of hyperarousal in the absence of a present stressor. This illustrates one source of false-negatives in assessment. Another source of false-negatives arises from caregivers who minimize, deny, or are simply unaware of their children’s symptoms, perhaps because of their own avoidance symptomatology. In order to minimize both false-positives and false-negatives, one must conduct a comprehensive, standardized, and rigorous interview of caregivers and, if old enough, the children. This means systematically enquiring about all 17 signs of PTSD. Specifically, one must ask from a menu of probes, ask for examples, and include onsets, durations, and frequencies. This type of educational interviewing gives respondents a frame of reference for the internalized and abstract items comprising signs of PTSD. This is in contrast to other types of symptomatology, such as hyperactivity or depression, which are readily observable and intuitively obvious to most people.

Second, children and parental agreement about symptoms is notoriously poor. Each provides different information. Three known studies have concurrently assessed the rates at which children and their parents report PTSD symptoms. All three studies sampled children who experienced motor vehicle accidents and other acute injuries from emergency departments. In a sample of 24 12- to 18-year-old adolescents, 8.3% met the threshold for the diagnosis by child report, 4.2% by parent report, and 37.5% by combined report. In a sample of 51 10- to 16-year-old children, 11.9% met the diagnosis by child report, and 13.0% by parent report (combined child-parent rates were not reported). In a sample of 51 7- to 10-year-old children, 17.8% met the PTSD-AA diagnosis by child report and 18.8% by parent report, and 40.0% by combined report.

**Contradiction in asking children to report avoidance symptoms**

Inherent in the current diagnostic criteria for PTSD is the requirement that respondents report (either to a clinician or on self-report instruments) avoidance symptoms. However the very nature of successful avoidance is that it prevents children from acknowledging its presence, thus presenting a challenge to clinicians in distinguishing avoidance from normal functioning. When asked to describe something about a traumatic event, many children will say, “I don’t want to talk about it” or “I don’t think about it.” What is a clinician to make of this response? Does this mean the child has resolved any psychic pain about the potentially traumatic event; that the child is oppositional to your request; that the child is highly avoidant; or none of the above? A child who says he “never thinks about” his father murdering his mother, despite the fact that he witnessed his father killing his mother, may raise questions in the minds of most clinicians about the possibility of avoidance. In contrast, children who report that they “never think about” a serious car accident, being bullied, or a natural disaster, may easily be seen by clinicians as resilient children who are coping well with their traumatic experiences, and no more questions are asked. Yet, if a clinician were to ask further questions it may become clear that any of these children may be actively avoidant, and may have significant PTSD symptoms. In these types of cases, caregivers may provide more accurate information about avoidance, and expecting children to readily report avoidant symptoms is unrealistic.

**Strategies for addressing this challenge**

Assessments need to comprehensively cover all 17 symptoms with educational interviewing, and ideally, include both children and parent respondents. Clinicians should use clinical judgment in conducting assessments of children’s PTSD symptoms regarding the need for
treatment as in the above scenarios. In settings where children are completing self-report instruments, asking children to yoke PTSD symptoms to “the worst trauma” may significantly underestimate the prevalence of child PTSD symptoms. (Alternatively, it is possible, or perhaps even likely, that some children ignore the instructions and rate the symptoms they are experiencing related to several traumatic events). For children who endorse several traumatic events but report few symptoms on self-report instruments, it is advisable for a mental health clinician to follow this up with a clinical interview to review PTSD symptoms related to any traumatic event. Clinical judgment can then be used to determine treatment needs.

Clinicians must probe further than asking “do you try to avoid thoughts about what happened?” or “tell me about what happened.” The child’s response to such questions can mean almost anything. Clinical skill (and in most cases, several more follow-up inquiries) are required in order to understand whether or not the child has avoidant symptoms. This is also true for self-report instruments. Some children who have significant PTSD avoidant symptoms may have very low scores on PTSD self-report instruments at the beginning of treatment (but parents or clinical interview reveals reason for concern). After they have received some initial therapeutic interventions their scores markedly increase. This does not indicate that therapy is making them worse, but rather that therapy has begun to address their avoidant strategies to the point that they can start to acknowledge the severity of these symptoms.

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Conclusion

The above discussion highlights challenges and strengths of using the present DSM-IV-TR diagnostic criteria for PTSD in children. Unlike the controversy about pediatric bipolar disorder, there has not been a challenge that too many false-positives of child PTSD are being made. Concern about false-positives (lack of specificity) has been raised in the adult literature, but these concerns and speculations have been forcefully rebutted with empirical data and do not appear to be widely held. In contrast, for child PTSD, the concern has been the opposite: that too few traumatized children are diagnosed whether due to insensitive criteria or due to the need for a novel syndrome. However, again, these are speculations that ignore the data that PTSD is the most common and underlying syndrome that develops after all types of life-threatening trauma, and has shown validity across all ages, good predictive validity, and concurrence with preliminary neurobiological measures.

In summary, PTSD remains a well-validated disorder, and is the most useful construct of child and adolescent post-trauma psychopathology for research and clinical purposes. The current PTSD diagnostic criteria should be revised to reflect current research about developmental manifestations of this disorder.

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El diagnóstico de trastorno por estrés postraumático en niños: desafíos y promesas

Los niños y adolescentes presentan una alta frecuencia de experiencias potencialmente traumáticas. Con posterioridad a éstas muchos niños desarrollan problemas de salud mental que incluyen síntomas del trastorno por estrés postraumático (TEPT). La precisión del diagnóstico de TEPT en los niños constituye un desafío. Este artículo revisa los siguientes temas importantes: 1) la especificidad del diagnóstico de TEPT, 2) los niños que están sintomáticos y afectados, pero que no tienen síntomas suficientes para el diagnóstico de TEPT, 3) aspectos del desarrollo para niños en edad pre-escolar y escolar y 4) una variedad de desafíos de evaluación que refleja la dificultad y complejidad de la entrevista de niños y de sus cuidadores respecto a estos síntomas. A pesar de estos desafíos, el TEPT sigue siendo el mejor constructo para el trabajo clínico y de investigación con sobrevivientes de traumas.

Diagnostic du trouble post-traumatique chez l’enfant : défis et promesses

Un taux élevé d’expériences potentiellement traumatiques peut être retrouvé chez les enfants et les adolescents. Beaucoup développent en retour des problèmes de santé mentale y compris des symptômes de stress post-traumatique (SPT). Établir un diagnostic précis de SPT chez l’enfant est difficile. Cet article propose une revue des questions importantes suivantes : (i) la spécificité du diagnostic du SPT ; (ii) la prise en charge des enfants symptomatiques et touchés mais sans assez de symptômes pour le diagnostic de SPT ; (iii) le problème du développement au cours de l’âge scolaire et préscolaire ; (iv) les objectifs de nombreuses tentatives d’évaluation qui montrent la difficulté et la complexité de l’interrogatoire des enfants et de leurs responsables au sujet de ces symptômes. En dépit de ces obstacles, le SPT reste la meilleure construction pour le travail clinique et de recherche avec les survivants d’un traumatisme. Les critères de syndrome de stress post-traumatique en pédiatrie sont fiables pour identifier les enfants à risque, nécessitant un traitement, et pourraient être encore plus utiles s’ils étaient orientés vers certaines voies discutées dans cette revue.

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