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Trauma-Focused Cognitive Behavioral Therapy Applied to Childhood Traumatic Grief in the Aftermath of a Motor-Vehicle Accident: A School-Based Case Study

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Abstract

Symptoms of posttraumatic stress, depression, and unresolved grief can appear in children and adolescents following the witnessing or experiencing of a traumatic event and respond with intense fear, helplessness, or horror. Those who lose a loved one in a traumatic manner can develop childhood traumatic grief (CTG), where typical grieving is hindered by trauma symptoms, causing significant impairment in daily functioning, relationships, and academic pursuits. The following is a case study describing a trauma-focused cognitive behavioral approach to treat posttraumatic stress disorder and CTG in a 16-year-old driver of a motor vehicle accident in which his peer was killed. A graduate student clinician provided treatment under supervision within the context of a school mental health program. The results of the intervention were associated with significant reductions in symptoms and impairments in daily living. The implications of these data and recommendations for clinicians treating CTG are provided.

I Theoretical and Research Basis for Treatment

Research indicates that there are high rates of children and adolescents exposed to trauma in the United States (Briggs et al., 2013). A survey of 1,400 children and adolescents found that approximately one in four youth experience a high-magnitude traumatic event before the age of 16 (Costello, Erkanli, Fairbank, & Angold, 2002). However, others estimate that two thirds of adolescents have been exposed to a traumatic event by the age of 16 (Angold, Copeland, Costello, & Keeler, 2007). These traumatic exposures include events such as child abuse, domestic violence, bullying, severe automobile accidents, and death of a loved one (Cohen, Berliner, & Mannarino, 2010). Due to the acute and potential long-term adverse effects that trauma can have on developmental, social, emotional, behavioral, and academic functioning, these high rates of childhood and adolescent trauma are concerning (Briggs et al., 2013).

The present case is distinctive and will enhance the treatment of adolescents who are facing posttraumatic stress, guilt, and traumatic grief, offering a window into applying a module-based protocol in a school-based mental health program context. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) was provided following a motor vehicle accident (MVA) in which the driver's close friend was killed. Empirical support has been garnered for group interventions for treating posttraumatic stress disorder (PTSD) and traumatic loss in school contexts (Rolfesnes & Idsoe, 2011). Furthermore, two case studies have been used to describe the effectiveness of TF-CBT in reducing symptoms and impairment

related to PTSD and childhood traumatic grief (CTG) in a parentally bereaved child (Brown, Pearlman, & Goodman, 2004) and in a family after experiencing several traumatic deaths (Kerig, Sink, Cuellar, Vanderzee, & Elfstrom, 2010). However, what remains unknown is the efficacy of individual TF-CBT embedded in the school setting for concurrent PTSD and CTG symptoms and related impairment in the driver of a fatal MVA.

Significant psychological morbidity has been well documented in adults following involvement in a MVA. Trauma reactions may include persistent symptoms related to re-experiencing the event, flattened affect, avoidance of traumatic event cues, and physiological hyperarousal (American Psychiatric Association [APA], 2000; Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009). PTSD prevalence rates following a MVA range from 11% (Kelley et al., 2009) to 16% (Nickerson, Aderka, Bryant, & Hofmann, 2013) to 18% (Chossegros et al., 2011). Adults report interfering intrusive memories of the MVA, emotional reactivity, and situational and cognitive avoidance (Kazantis et al., 2012). Comorbid depression and other anxiety disorders are frequently present when PTSD is chronic in nature (i.e., at least 1 year in duration; Blanchard et al., 2004). Psychosocial detriment specific to MVAs relate to major role functioning, engagement in recreation activities, relationships with family and friends, and overall quality of life (Gudmundsdottir, Beck, Coffey, Miller, & Palyo, 2004).

Several factors at the time of the MVA have been shown to increase the risk for onset of post-traumatic stress symptoms and/or a diagnosis of PTSD. These include prior history of psychological symptoms, severe physical injury, presence of posttraumatic amnesia, litigation surrounding the MVA, and chronic pain (Chossegros et al., 2011). In addition, adults not responsible for the MVA and individuals who report external causal attributions are more likely to suffer from PTSD, even in individuals driving at the time of the MVA (odds ratio [OR] = 3.42; Nickerson et al., 2013). To wit, individuals' subjective reactions, such as perceived threat of serious injury or death and self-report of chronic physical consequences of the MVA, better predict the presence of trauma symptoms compared with the objective severity of the MVA and scope of physical injuries as rated by a physician (Fujita & Nishida, 2008).

Given the prevalence and intensity of posttraumatic symptoms experienced by adults subsequent to a MVA, it follows that children and adolescents experience analogous negative psychological consequences. Youth who are directly involved in an MVA are significantly more likely to develop impairing posttraumatic stress symptoms compared with those who are indirectly affected or witnesses (Tierens, Bal, Crombez, Loeys, et al., 2012). Within 1 month of being injured in a MVA, trauma symptoms may negatively affect social and emotional functioning and independence in completing daily living activities (Landolt, Vollrath, Gnehm, & Sennhauser, 2009). Prevalence rates of PTSD post-MVA range from 6% to 34%, with female sex, perceived threat to life, elevated level of distress during and immediately following the MVA, increased parental vigilance, and depressive symptoms associated with increased morbidity (Olofsson, Bunketorp, & Andersson, 2009). High-school students who survive a fatal MVA are at increased risk at displaying significant trauma symptoms compared with a crash in which there was no fatality (Tierens, Bal, Crombez, Van de Voorde, et al., 2012). However, there is a lack of understanding the disparities in symptom

presentation and functioning in surviving drivers of a fatal MVA and drivers involved in non-fatal MVAs.

Of importance in highlighting the impact of PTSD on MVA drivers are the cognitive characteristics and coping used subsequent to the trauma. Ehlers and Clark's (2000) cognitive model of PTSD has been used to describe the genesis and maintenance of symptoms, arguing that the traumatic memory fails to be synthesized into the afflicted individual's memory due to the absence of in-the-moment cognitive processing and avoidant cognitive coping post-trauma. Likewise, cognitive appraisals of the event are exceedingly negative, leading to maladaptive coping such as thought suppression and rumination (Ehlers & Clark, 2000). The presence of MVA-specific cognitive patterns and coping styles serve to maintain PTSD symptoms and, as such, are significant predictors of the presence of symptomatology longitudinally (Ehlers, Mayou, & Bryant, 2003). Both children (Ehlers et al., 2003) and adult (Ehring, Ehlers, & Glucksman, 2006) survivors of MVAs who develop subsequent PTSD are more likely to endorse incomplete cognitive processing of the event, negative appraisals of intrusive memories, perceived estrangement from others, and impaired cognitive coping. Furthermore, changes in the way MVA survivors appraise themselves predict significant PTSD symptom reduction (Karl, Rabe, Zöllner, Maercker, & Stopa, 2009).

In addition to posttraumatic stress symptoms, children and adolescents who experience the death of a family member or friend in a traumatic manner may suffer from CTG (Brown et al., 2008). This construct is akin to complicated grief in adults, also referred to as "prolonged grief disorder," and is named "persistent complex bereavement disorder" with a "traumatic bereavement" specified under the conditions for further study in *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013). CTG is distinct from PTSD, other anxiety disorders, and depression, although is moderately correlated (Brown et al., 2008; Spuij et al., 2012). Impairment in daily functioning is present, as academic functioning, school attendance, and completing routine daily tasks may all be negatively affected (Cohen & Mannarino, 2011). Evidence suggests that children and adolescents are at increased risk for experiencing CTG when they perceive a threat to their lives during the traumatic event and experience a high level of sadness and modeling of maladaptive coping by caregivers in the home (Brown et al., 2008).

It appears that the loss of a loved one can lead to a constellation of posttraumatic and CTG symptomatology that have a synergistic effect on one another. Chronically bereaved children and adolescents exhibit increased PTSD symptoms regardless of the nature of the significant other's death (i.e., expected or unexpected; McClatchey, Vonk, & Palardy, 2009). The PTSD cognitive symptoms, emotional numbing, and avoidance arrest the grieving process (Boelen & Spuij, 2013). Memories of the deceased are confined to the terrorizing manner in which they died and thus are avoided due to the presence of posttraumatic stress symptoms. Specifically, the maladaptive cognitive patterns and coping styles that develop in the wake of PTSD lead to the inability to affectively and emotionally process through the loss of a loved one (Cohen, Mannarino, & Deblinger, 2006).

TF-CBT was developed initially to treat child victims of sexual abuse (Cohen,

Mannarino, & Deblinger, 2006; refer to www.musc.edu/tfcbt for additional description). The treatment has been applied to treat victims of other types of traumas (i.e., interpersonal violence, repeated exposure to traumas; Cohen, Mannarino, & Iyengar, 2011; Cohen, Mannarino, & Murray, 2011). TF-CBT is a modular treatment that includes components to address symptoms of PTSD and CTG, allowing symptoms related to fear, hypervigilance, social withdrawal, and uncontrollable trauma memories to abate, permitting typical mourning to resume. Cohen, Mannarino, and Deblinger (2006) summarized the trauma-focused components in nine steps that correspond with the acronym "PRACTICE." These nine steps include sessions addressing psychoeducation, parenting skills, relaxation skills, affective modulation, cognitive coping skills, trauma narrative and processing, in vivo mastery of trauma reminders, conjoint-child-parent sessions, and enhancing safety and future development. The grief-focused components of the TF-CBT model include grief psychoeducation; grieving the loss and resolving ambivalent feelings about the deceased; preserving positive memories; and redefining the relationship with the deceased and committing to present relationships (see www.musc.edu/ctg; Cohen, Mannarino, & Deblinger 2006).

TF-CBT has shown to be efficacious in decreasing symptoms of PTSD in children who have experienced sexual abuse (Murray, Cohen, & Mannarino, 2013) and CTG symptomatology in parentally bereaved children (Cohen & Mannarino, 2011). Posttraumatic stress and CTG symptomatology appear to decrease in children and adolescents who have experienced traumatic loss after participating in TF-CBT with at least one parent (Cohen, Mannarino, & Staron, 2006). TF-CBT has also been shown to be effective compared with non-CBT approaches in treating trauma ($d = .50$) and depressive ($d = .29$) symptoms in children and adolescents exposed to violence, natural disasters, physical abuse or neglect, and MVAs (Silverman et al., 2008). Furthermore, a recent systematic review of TF-CBT interventions provided further support for the treatment paradigm, as evidenced by significant reductions in symptoms of PTSD, depression, and behavior problems (Cary, & McMillen, 2012).

Finding meaning in traumatic loss and redefining the relationship with the deceased is the final grief-focused component within TF-CBT. Adhering to the beliefs that the deceased is at peace and the existence of an afterlife, and using religion as a source of strength (i.e., participating in rituals) may facilitate improved coping after a loss (i.e., enhanced cognitive processing; Becker et al., 2007). Religion and spirituality have been studied in the context of trauma recovery and grief, especially in adults. To wit, trauma survivors may use already-held beliefs to aid them in finding and committing to a mission in life (i.e., to help other victims) and making meaning from the horrific event. Similarly, individuals who find spiritual or religious beliefs helpful during the grieving process report increased optimism about the future. For example, 62% of adolescents who had experienced the death of a sibling indicated that religion had played a significant role in their coping (Becker et al., 2007).

2 Case Introduction

At initial assessment, "Drew," a 16-year-old Latino male, was a junior in high school. Drew self-referred for individual therapy with the strong encouragement of his

parents, pediatrician, and school counselor to a school mental health (SMH) program for students. During the previous summer, Drew had been the driver in a single-car MVA in which one of the passengers was killed. The accident was reported by local news outlets throughout the region due to the tragic nature of the crash, and thus had a considerable impact on students, teachers, and staff at the high school and on the community residents. Highway patrolmen determined that Drew had overcorrected his steering after driving off the side of the road, causing the vehicle to strike a ditch and overturn several times ejecting those riding in the bed of the truck. Alcohol and excessive speed were determined not to be the factors in the crash by law enforcement officers. The deceased passenger was Drew's close friend, as they had been schoolmates beginning in preschool. According to Drew and his mother, he and his parents attended an initial assessment with a therapist in the community a few weeks after the accident who concluded that Drew was "stable" and "well-parented" and that no further treatment was indicated. However, once school began in the fall, it became apparent to Drew and his parents that he was experiencing significant impairments that needed to be addressed.

3 Presenting Complaints

Although Drew presented for treatment at the SMH program 3 months after the traumatic event, it appeared that his symptom onset was almost immediately following MVA according to Drew's report. Drew had not disclosed the intensity of his distress to his parents, as he spent most of his time with peers outside of home. From Drew's point of view, as the driver of the vehicle, he had taken a respected, compassionate high achiever from his parents and the community at large. Drew and his parents agreed that symptoms of depression, extreme moodiness, anger, and feelings of guilt were impairing Drew's ability to function in the community, at home, and in school. Although Drew had attended his friend's memorial service, he had not been able to engage in typical activities of grieving (i.e., adapting to life without the deceased, making meaning of his death) in the 3 months since his passing away. Moreover, Drew could not remember all the events during the MVA, felt detached and different from his peers, and appeared emotionally numb at times. Drew also described symptoms of hyper-arousal in which he experienced difficulty concentrating and periods of feeling overly alert and "on edge."

At initial assessment, Drew was quiet and withdrawn, but was willing to explain the present manifestation of his distress. He reported lying in bed approximately 2 hr before falling asleep, and once sleeping, he experienced nightmares several times a week, although he had no memory of such dreams once he awakened. He attributed this insomnia to recurrent and intrusive distressing memories of the MVA, rumination on the absence of his friend, and the negative self-view he held since the MVA. Drew admitted to having intense anger outbursts in which he exhibited vocalized anger toward his mother and engaged in damaging objects in his bedroom. He also described periods of time during which he would cry uncontrollably. In addition, he explained that he was intensely worried about being charged with vehicular manslaughter. Drew explained that he experienced thoughts of suicide in the weeks following the MVA, especially while driving. Specifically, he reported thinking about intentionally crashing his car

approximately two times per week. Drew had never executed his plan and had never crashed his car on purpose. At the start of treatment, his most recent suicidal ideation had been 1 month prior.

4 History

Drew is the second of three children and lives with both biological parents and younger sister, as his older brother attends college and is home during breaks. Drew reported that he has good relationships with his siblings and parents. Since the MVA, he and his mother reported a deterioration in their relationship. He stated that he is most comfortable seeking out support and advice from his father. According to Drew's mother and grade-level counselor, he typically earned As and Bs throughout his academic career. At the beginning of treatment, Drew was earning a C and a D in his chemistry and math classes, respectively. Drew and his deceased friend had begun preschool in the same class, grew up together in a small tight-knit rural community, and shared interests in outdoor activities. The boys were loyal friends to one another and participated in service-oriented activities together, as they shared an in-depth bond that had helped them remain close friends for the majority of their lives. Both Drew and his mother agreed that Drew had been a "happy-go-lucky" teenager and child prior to the MVA. His mother asserted that he was a typical teenager who enjoyed spending time with friends, attending school events, and spending time with his parents at home and in the community. He also had played on various organized sports teams throughout his life and was a member of the golf team when treatment commenced. Drew had gotten his driver's license a few months prior to the MVA, and his mother reported she had generally felt comfortable with his driving.

5 Assessment

Preceding the start of individual sessions, Drew and his mother each completed baseline assessments designed to measure behavioral, emotional, and psychological aspects of his complaints. Drew's mother completed the Behavioral Assessment System for Children—Second Edition

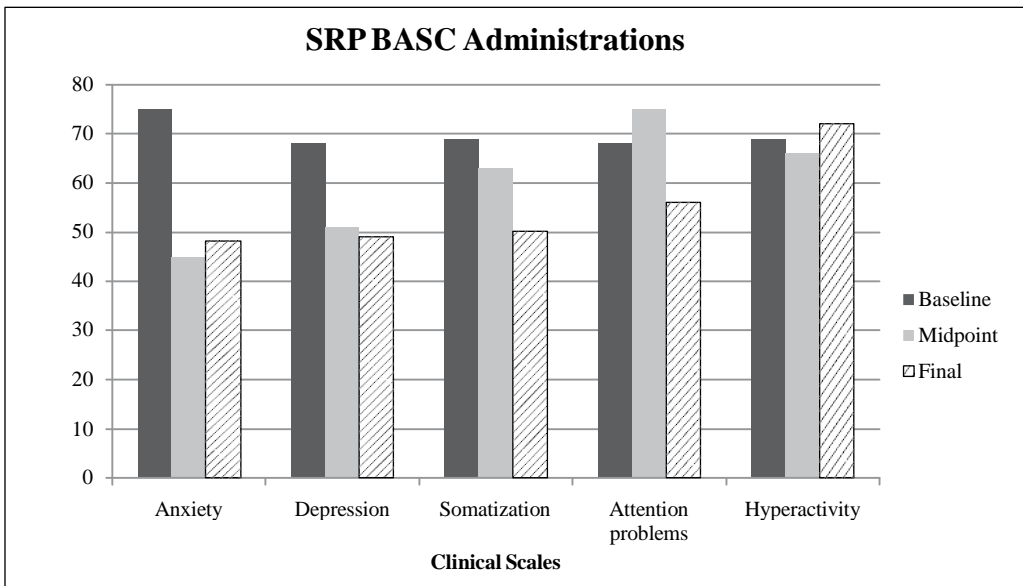


Figure 1. Self-reported BASC-2 Clinical Scale *T*-scores at baseline, mid-point, and final assessments.

Note. BASC = Behavioral Assessment System for Children.

Parent Rating Scale (BASC-2 PRS; Reynolds & Kamphaus, 2004), and Drew completed the BASC-2 Self-Report Form (SRP). The BASC-2 is a multi-informant questionnaire that yields broadband subscales (i.e., Externalizing, Internalizing, Adaptive Skills) and narrow-band sub-scales (i.e., Anxiety, Depression, Somatization, Conduct problems). Respondents indicate the frequency the client engages in the behavior, displays the emotion, or holds the particular attitude by choosing “never,” “sometimes,” “often,” or “almost always.” The BASC-2 SRP includes a true/false section in which the client responds dichotomously to each statement.

Based on Drew and his mother’s initial BASC scores (see Figures 1, 2, and 3), Drew was experiencing at risk levels ($T \geq 60$ for clinical scales) of both Internalizing and Externalizing Symptoms. For example, Drew endorsed symptoms of Depression ($T = 68$), Somatization ($T = 69$), Hyperactivity ($T = 69$), and Attention problems ($T = 68$). Of note, Drew’s highest elevation was on the Anxiety subscale ($T = 75$), indicating he was suffering from clinically significant levels of hypervigilance, avoidance, and cognitive and physiological symptoms of anxiety. Drew indicated that his Relations with parents ($T = 51$) and Interpersonal relationships ($T = 55$) were comparable to those of the majority of his peers. His Self-esteem ($T = 42$) and Self-reliance ($T = 41$) scores were in the average range, although on the less adaptive end of the spectrum.

Drew's mother endorsed at-risk levels for the Adaptive Scales Adaptability ($T = 33$) and Activities of daily living ($T = 35$), suggesting Drew was having difficulty solving problems and completing daily living tasks. She also rated Drew as having an at-risk level of Conduct problems ($T = 62$), asserting at times that Drew did not follow rules at home.

In addition to the BASC-2, Drew completed the Youth Outcome Questionnaire-30 (YOQ; Burlingame et al., 2004), a 30-item scale designed to measure the severity of psychological symptoms over the previous 7 days. Respondents answer on a 5-point Likert scale, with higher scores indicating more severe distress and clinical elevations designated as 29 and above. Drew's initial YOQ total score (42; see Figure 4) further corroborated his clinical levels of symptomatology and impairment related to PTSD and traumatic grief, as the instrument includes items

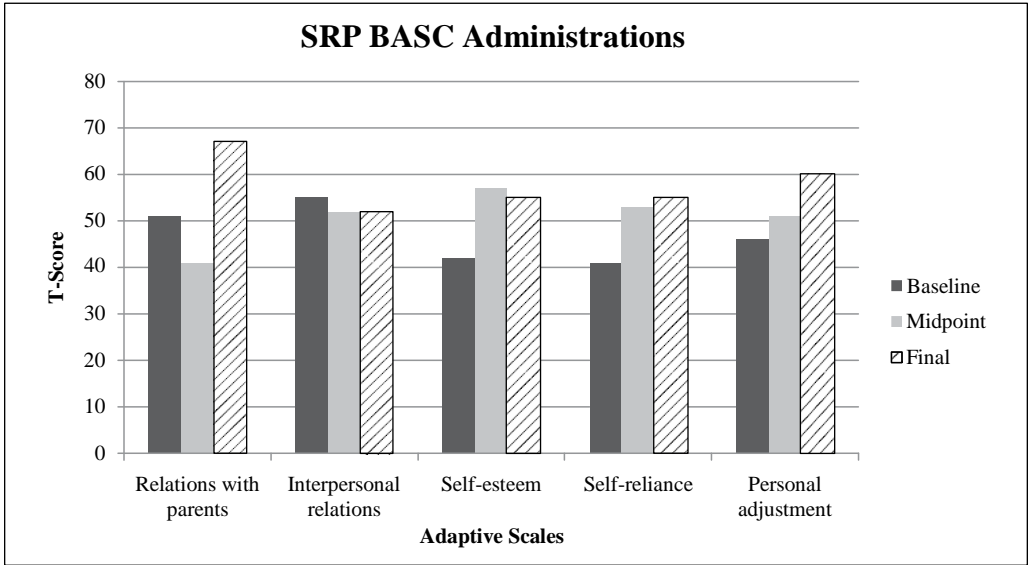


Figure 2. Self-reported BASC-2 Adaptive Scale *T*-scores at baseline, mid-point, and final assessments. *Note.* BASC = Behavioral Assessment System for Children.

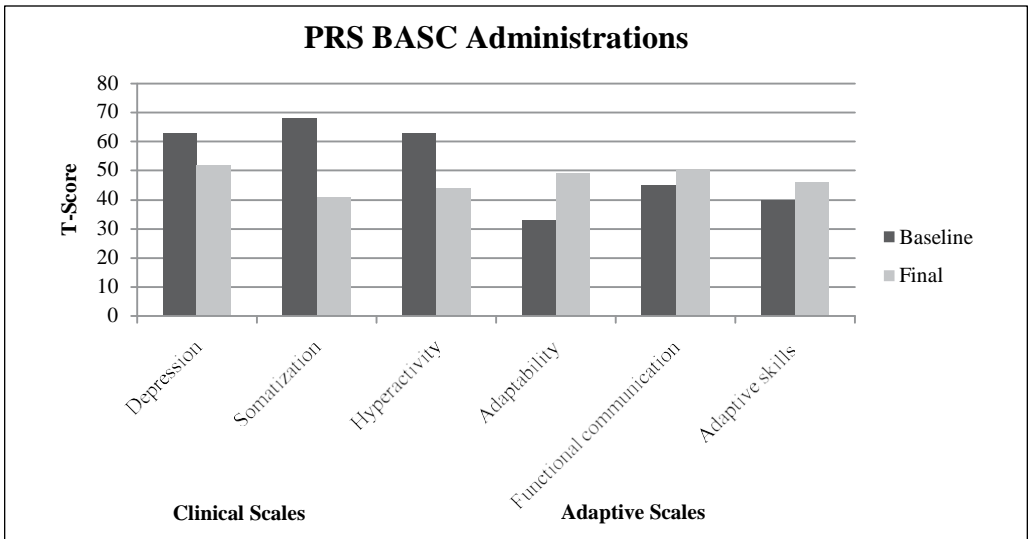


Figure 3. Parent -reported BASC-2 *T*-scores at baseline and mid-point assessments. *Note.* BASC = Behavioral Assessment System for Children.

designed to assess intrusive thoughts, sleep disturbances, connection with peers, hyperarousal, and mood dysregulation. The YOQ was administered prior to each subsequent session. While the BASC and YOQ were used to aid in diagnostic considerations, they were also used as outcome tracking instruments.

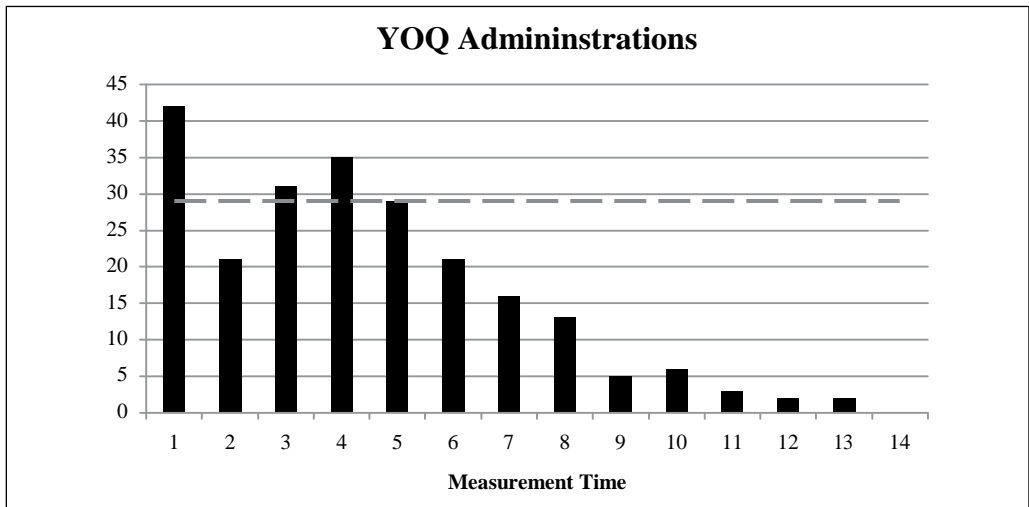


Figure 4. YOQ total scores.
Note. YOQ = Youth Outcome Questionnaire.

6 Case Conceptualization

The conceptualization was primarily based on a TF-CBT model (Cohen, Mannarino, & Deblinger, 2006), as Drew was experiencing traumatic grief, a conglomeration of symptoms that included unresolved grief, PTSD symptoms, and symptoms of depression. Drew displayed affective, behavioral, and cognitive symptoms that were clearly the result of the traumatic event he experienced, which made him an appropriate candidate to participate in TF-CBT. The treatment is based on core values that emphasize flexible and adaptable components that build on one another, family involvement, respect of community and cultural values, centrality of the therapeutic alliance, and enhancing self-efficacy. The protocol is firmly grounded in theory, taking into account developmental considerations in providing optimal treatment to the traumatized young person.

Subsequent to the MVA, Drew began to re-experience the event mainly when at home through experiencing uncontrollable thoughts and images from the event. Because his memory of the event was not completely intact, he continuously replayed the accident in his head visualizing various permutations of how the car crashed. When Drew thought about his deceased companion, he only thought about the horrific nature of his death and the blame he ascribed to himself. The psychological sequelae he experienced did not permit him to adequately resolve his grief. In an effort to avoid the distress that was associated with thoughts of the MVA and of his friend, Drew began to spend most of his time at his peers' homes, even spending the night several times a week. This was an effort to avoid an environment he associated with anxiety-provoking stimuli. Drew was also confronted with trauma reminders outside of his home, as memorial fundraisers were held at school, and community members approached him to inquire about the accident. He was determined to avoid these cues by leaving school without permission, planning to graduate early, and even attempting to gain permission from his parents to move several hundred miles away to live with his grandparents.

Triggers at home activated a fear schema (see Foa, Chrestman, & Gilboa-Schechtman, 2009) that he had incorporated into how he viewed the world and himself since the MVA. Because the trauma occurred during the summer when school was out of session and the need to physically recover from his injuries, Drew spent a substantial amount of time at home immediately following the accident. He associated his home environment with feelings of acute anxiety he experienced in the immediate

aftermath of the MVA. Being at home with his family activated a memory structure that was characterized by cognitions related to loss of any control over his life, including persistent fear of detrimental events occurring and belief that he could not cope with his feelings of intense sadness and grief. By avoiding home and the activation of his fear schema, Drew was not accessing information that would invalidate some of his irrational beliefs and allow him to habituate to the fear and anxiety.

In addition, Drew felt detached and different from everyone else—even surviving passengers of the MVA—due to being the one who lost control of the vehicle. Drew isolated himself, spending the time he was at home in his room, continuing to ruminate on the events of the MVA, causing the feelings of guilt and despair to persist. Bursts of emotion overwhelmed him, negatively affecting his sleep, appetite, and even the strong bond he had previously felt with his family members. Commensurate to symptoms of PTSD, he experienced significant levels of depression, as he felt worthless and despondent due to the death of his close friend and the role he played in his death. Indeed, Drew's symptoms of PTSD were hindering his ability to adequately grieve the loss of his close friend. Specifically, Drew's thoughts of his friend automatically led to thoughts about the horrifying way in which he died, making it nearly impossible to hold onto positive memories of his friend.

7 Course of Treatment and Assessment of Progress

Drew participated in active treatment for 15 individual therapy sessions over a 7-month period. During the first 10 sessions, treatment was provided weekly; however, school holidays and two appointments missed due to physical illness led to increased time between sessions. After treatment gains were made and the majority of the manual components were covered, meetings were tapered during the final phase of treatment. Concurrent to the TF-CBT-based treatment, Drew took 10 mg of Prozac daily, as prescribed by his pediatrician. He expressed thoughts of harming himself during the initial meeting that warranted focusing on establishing a strong therapeutic alliance, aiding in identifying feelings prior to thoughts of suicide, bolstering protective factors, and collaboratively creating a safety plan/contract with his mother and father. Due to the readily accessible and lethal nature of Drew's plan to end his life by crashing his car, a thorough risk assessment was completed, including the development of a safety plan with Drew and his parents that delineated safety measures that were enacted for the following 2 weeks. If Drew experienced suicidal thoughts while driving, he agreed to safely drive to the side of the road or into the nearest business parking lot and call his father to tell him he was thinking of harming himself. His father agreed to then drive to pick Drew up and bring him home. Drew also agreed to text his father just prior to driving somewhere (i.e., from school to golf practice) and again when he arrived to his destination as a plan for increased monitoring.

After the initial assessment and once his suicidality had abated, psychoeducation, the first TF-CBT treatment component was introduced to both Drew and his mother individually. As the manual states, psychoeducation was provided prior to any other treatment component, although it continued throughout the treatment process. Information about experiencing traumatic events and common reactions to such events were provided. Drew maintained that he was relieved that the symptoms he had been experiencing since the MVA were characteristic of others diagnosed with PTSD and that there were effective treatment strategies available. Drew and the clinician discussed how his posttraumatic stress symptoms were hindering his ability to grieve the loss of a close comrade. Thus, applicable trauma and grief components of the TF-CBT model were over-viewed. In addition, the TF-CBT model of treatment was explained, and Drew grew more hopeful that a reduction of symptoms was possible. Finally, sleep hygiene strategies were introduced to Drew to begin managing his most

distressing symptoms (i.e., lying in bed for several hours before falling asleep, having nightmares).

In conjunction with psycho-education, the parenting skills component was introduced, due to Drew's mother's uncertainty on appropriate parenting techniques given both his recent isolative and antagonistic behavior. Drew's mother voiced her struggle with continuing to hold Drew accountable for his actions and felt as though her rules at home were adding to Drew's emotional pain. The clinician met with Drew's mother two times to review positive praise, self-care, expectations at home, and contingency-reinforcement strategies. For example, Drew's mother consulted with the clinician about appropriate loss of privileges after Drew left school without notifying his parents or teachers during a particularly anxiety-provoking day. Throughout the remainder of the Drew's treatment, the clinician had bi-monthly telephone consultations that mainly consisted of building Drew's mother's self-efficacy in implementing the parenting strategies discussed during the face-to-face meetings.

In addition, it became apparent that Drew's mother's own anxiety was intensifying his worry. Drew reported his mother "nagged" him to talk with her about the accident and his friend's death, attempting to get him to confront his painful memories, thus creating a rift between mother and son. At the encouragement of the clinician, Drew's mother sought individual therapy to aid her in coping with the traumatic event and to provide parenting consultation. Accordingly, Drew and the clinician endeavored to decrease the hostility between him and his mother through practicing strategies to use during their interactions. Drew learned to communicate more directly with his mother, as he admitted that his explosive reactions negatively contributed to the relationship.

The third component, relaxation, was initiated during the second meeting with Drew to give him tools to reduce the heightened physiological arousal that he experienced. Because Drew experienced intense distress and anxiety throughout the day, it became essential to regain control over the physical sensations that were occurring. The clinician taught Drew about how the body reacts in response to stress and gave him a menu of relaxation options to try and begin practicing at home. Strategies to help Drew cope with his increased startle response, restlessness, and irritability were brainstormed and implemented. For example, the clinician introduced breathing retraining as a general stress management technique and a strategy when he recognized physical signs of anxiety and/or noticed himself becoming hypervigilant. Other strategies focused on Drew's strengths: going to the driving range, talking to his father, briefly walking away to calm down, and positive self-talk.

As outlined in the TF-CBT treatment manual, the affective expression and regulation component was introduced to Drew. Affect regulation was emphasized in preparation for the exposure-based components of treatment. Drew learned to identify his thoughts, physiological sensations, and behavioral reactions for each of the intense emotions he was experiencing (i.e., sadness, anxiety, nervousness, guilt, anger). He learned how to monitor his feelings by labeling them and assigning a number between 1 and 10 to designate intensity of the feeling. Drew reported experiencing emotional numbing in stark contrast to the sometimes formidable anger and sadness that would manifest in him. This treatment component became not only an avenue for Drew to better regulate his emotions but also an opportunity for him to allow himself to fully express and experience the emotions he had not felt comfortable doing so with his peers or at home with his family.

Trauma Component 5 is the first of two cognitive coping and processing units, and is designed to introduce children and adolescents to the cognitive triangle and apply techniques to modify irrational or unhelpful thinking patterns. Gaining access to his internal dialogue was particularly challenging for Drew, so neutral and positively-remembered events were used to aid Drew in capturing his automatic thoughts, as is suggested in the manual. He learned how to identify his automatic thoughts and how they were related to his behaviors and feelings through the use of thought records completed initially in the session and then on his own. This helped Drew understand

that his emotions did not change “out of the blue,” but were mostly related to the intrusive thoughts he was having about the accident. With practice, Drew improved and additional columns were added to the thought record so he could record the cognitive distortion and implement alternative, more realistic thinking. As he implemented both cognitive and behavioral strategies, Drew reported feeling a greater sense of control of his unwanted thoughts.

Beginning mid-treatment, the modules that focused on the trauma narrative (also conceptualized as gradual exposure), cognitive coping and processing of the traumatic event, and in vivo mastery of trauma reminders were intertwined based on the clinician’s judgment in flexibly but reliably implementing TF-CBT. Drew and the clinician discussed and implemented gradual exposure as an approach to incrementally increase his ability to cope with the multitude of trauma reminders that activated his fear schema while at home. From the outset, it became apparent that Drew was avoiding thoughts about the MVA by not spending time at home. He explained, “It was all [he] ever thought about,” when at home. It was discovered that Drew had spent almost all of his time at home in the days following the accident. He described vividly remembering the atmosphere as both extremely somber and anxiety-provoking, as many friends and family members visited, and his mother displayed high levels of intense anxiety and depression.

As shown in Figure 4, Drew’s symptoms intensified in Sessions 3, 4, and 5 consistent with using imaginal exposure during these meetings. Drew had grown more comfortable talking about the MVA and his emotions associated with it and agreed to begin changing his behavior to confront his triggers. Drew planned to remain outside of his bedroom unless he was working on homework or sleeping to expose himself to interacting with his family, especially his mother with the aim to engage in positive interactions with his family instead of solely negative ones. This plan was communicated to Drew’s parents with the goal of using exposure to aid in modifying his fear structure that was activated most often while at home. This allowed for more adaptive responses to be reinforced, invalidation of erroneous meanings associated with the stimuli, and avoidance or escape to be deterred.

Imaginal exposure was used with Drew in sessions to help him reduce his anxiety about spending time at home, allowing him to imagine what it would be like if he attempted one of the strategies to gain further confidence in his ability to confront his fears. In rehearsing for the in vivo experiences, the clinician implemented the second cognitive coping and processing component to challenge Drew to restructure his trauma-related cognitive errors. Referring to the cognitive restructuring learned earlier in treatment, the clinician worked collaboratively with Drew to correct inaccurate or unhelpful thoughts. For instance, he challenged the thought, “My family and friends will think of me as weak if I cry in front of them,” with “My family and friends want to support me when I’m sad,” “It’s okay to let others see me cry,” and “Crying does not mean I’m weak.” These and other cognitions related to how he viewed himself since the MVA were reprocessed, as this was fundamental to recovery from PTSD given Ehlers and Clark’s (2000) cognitive model of the disorder.

The clinician and Drew discussed the activities he had enjoyed prior to the accident while at home and decided to engage in one of them per day (i.e., family dinner, watching television, playing in the yard). As mentioned above, Drew was also reminded of the trauma while in school due to the absence of his friend, his peers asking him about the accident, or being confronted with events memorializing his deceased friend. One of the advantages of applying TF-CBT in a school setting is availability of using in vivo exposure to increase mastery of trauma reminders. The clinician role-played with Drew what to say and what to do to increase his comfort and confidence in handling those situations without avoiding environments in which he would encounter such stimuli. For example, Drew rehearsed what he would say to a peer when asked about the MVA instead of avoiding interacting with his peers just prior

to the bell ringing to switch classes, signaling being confronted with reminders while navigating the hallway. In addition, including the School Resource Officer (SRO) on the treatment team allowed him to reinforce Drew's effective use of coping strategies when he observed him in the school building hallways.

Part of Drew's plan to help others included sharing his story with others in the context of his church's youth group—a course of action that was wholly initiated by him. He decided to share a version of the trauma narrative he had written prior to beginning therapy. Drew gave a presentation in front of his church's youth group about the accident in great detail and to the entire congregation during a service written and performed by the youth. Drew used pictures taken after the MVA of his damaged vehicle to augment his presentations, allowing himself to fully confront the previously evaded emotions connected with the event. Although Drew wrote his trauma narrative in preparation for speaking to members of his church outside of sessions, the clinician assisted him in cognitively processing the most traumatic of memories (i.e., the moment he found out his friend was deceased). Often, thinking about how his deceased friend would react to Drew's distorted thinking patterns facilitated more rational and realistic thinking. These public speaking events allowed Drew to expose himself to the horrendous details of the accident, thereby teaching himself that his anxiety would dissipate and the memories would be more easily contained. The process of creating and then sharing his trauma narrative publicly allowed Drew to begin integrating the event into the rest of his experiences, not permitting it to define him.

Complementing the trauma-focused components were grief-focused aspects that were aimed at aiding Drew in mourning the loss of this friend. As is the case frequently, Drew's progression in therapy was non-linear and focusing on his grief was interspersed throughout treatment. As Drew felt more comfortable with the clinician and his symptoms of PTSD subsided, he discussed his bereavement related to the loss of his friend. To help facilitate this dialogue, the Mourner's Bill of Rights (Wolfelt, 2007), a tool aimed at encouraging the development of the individual's unique grief experience, was provided, as the clinician integrated grief psycho-education, the first of the grief-specific modules. Drew expressed what he missed about not having his friend in his life since the accident and future events he would not experience with him (i.e., attending prom, high school graduation). The clinician also gave Drew opportunities to verbalize any ambivalent feelings toward his friend, especially regarding the anger Drew felt toward him for initiating the late night drive. Drew expressed relief when he reached a point in treatment in which reminders of his friend cued positive memories they shared together, instead of the tragic manner in which he died. This allowed him to wholly engage in the preserving positive memories unit.

In processing through his grief, he described feeling somewhat more comfortable due to the development of his religious beliefs since the MVA, engaging in the grief element, making meaning of the traumatic loss. To wit, Drew decided that he would honor the deceased through his relationship with God and by helping other teenagers avoid what happened to him. He expressed that although he could not modify the events that occurred the night of the MVA to bring his friend back, he chose to engage in charitable activities to gain a sense of control over his life and to exhibit how he had become stronger as a result of his traumatic experience.

As Cohen, Mannarino, and Deblinger (2006) explain, “. . . once the child has begun to accept the death and begins to turn back to the task of living, an important aspect of healing is that of reconnecting with other important individuals in his/her life” (p. 193). In doing so, Drew began a romantic relationship and modified his peer group to avoid substance use while still in active treatment, actions that moved him toward committing to present relationships (the final TF-CBT grief component). He chose to invest time in explicitly developing and strengthening different parts of his identity (i.e., spirituality, familial relationships, planning for his academic future), as he further

incorporated his trauma into a renewed sense of the self.

Drew participated in weekly YOQ administrations throughout the main components of treatment. By the beginning of the sixth session and through the remainder of the school year, Drew's YOQ scores consistently remained at subclinical levels (see Figure 4), indicating a significant reduction in PTSD symptoms and related impairment. In addition, Drew participated in a mid-point BASC-2 SRP assessment to gather quantitative data after the completion of eight sessions (see Figures 2 and 3). He indicated a clinically significant level of Attention problems ($T = 75$), and at-risk levels of Hyperactivity ($T = 66$) and Somatization ($T = 63$). However, Drew endorsed subclinical levels of Anxiety ($T = 45$) and Depression ($T = 51$) and average levels of Self-esteem ($T = 57$) and Self-reliance ($T = 53$), suggesting significant reductions in symptoms and impairment.

Drew and his mother (see Figure 4) completed final BASC-2 assessments to further gauge Drew's functioning at the end of the school year. Drew's rating of symptoms of Anxiety ($T = 48$) and Depression ($T = 49$) remained at subclinical levels and his report of Somatic ($T = 50$) and Inattentive ($T = 56$) symptoms had significantly decreased since mid-point measurement. Although Drew's initial self-rating on the adaptive scales revealed no clinically significant difficulties, his ratings at final assessment showed substantial improvement (denoted as an *increase* in T -score): Relations with parents ($T = 67$), Self-esteem ($T = 55$), Self-reliance ($T = 55$), and Personal adjustment ($T = 60$). Drew's mother rated Drew as having subclinical levels of Depression ($T = 52$), Somatization ($T = 41$), Hyperactivity ($T = 44$), Adaptability ($T = 49$) and Functional communication ($T = 50$), and overall Adaptive skills ($T = 46$), corroborating Drew's own report of his symptom abatement.

Drew's level of anxiety dissipated in large part due to his ability to confront those fearful environments by providing corrective experiences, reinforcing effective coping strategies, and reducing safety behaviors (i.e., remaining in his bedroom). He was also relieved when the SRO informed him mid-way through treatment that no legal charges would be filed against him. Drew developed confidence in withstanding salient trauma reminders and began to develop other aspects of his identity resulting in focusing on more of his positive characteristics. While some level of guilt over the death of his friend remained present, the majority of thoughts of his friend triggered pleasant recollections.

The PTSD module of The Mini-International Neuropsychiatric Interview (MINI; Sheehan, Lecrubier, & Sheehan, 1998), a brief structured interview designed to assess Axis I disorders described in the *DSM-IV* and the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10), was administered to determine whether Drew met diagnostic criteria for PTSD in the latter stage of treatment. Drew endorsed continuing to be affected by the following symptoms: avoiding thinking or talking about the event, having trouble recalling important parts of the event, and emotional numbing. After further inquiry, it appeared that these symptoms were occurring at subclinical levels and not causing significant distress in Drew's life. As such, he did not meet diagnostic criteria for PTSD. Drew continued to be interested in his athletic and social outlets, felt more connected to friends and family, and was looking forward to his future, as he has plans to attend college after graduating high school. Drew also reported increased quality of sleep and no instances of nightmares within the past few months. Furthermore, he appeared to be exhibiting developmentally appropriate levels of irritability and antagonism that are associated with being an adolescent. Finally, he reported no instances of hypervigilance or being easily startled and has had infrequent intrusive thoughts about the accident.

8 Complicating Factors

Perhaps the most noteworthy complication in Drew's treatment was conducting

sessions in the school setting by a supervised graduate student trainee. Although there are many advantages to providing therapy in a school setting, Drew initially had difficulty allowing himself to fully express and experience negative emotions due to not wanting to show feelings while at school—a place he associated with positive emotions and focusing on academic pursuits. Creativity and planning were used when conducting sessions that were especially emotionally intense, as the clinician and Drew walked outside on school grounds. Drew welcomed the increased comfort and safety this brought while processing through the event with the clinician. This also gave Drew time to regain his composure outside the confines of the school building before returning to class. In addition, Drew communicated serious self-harm ideation and related plan on initial meeting with the clinician, necessitating a breach of confidentiality. This fact complicated the therapeutic alliance, although Drew participated willingly in the safety planning and agreed to subsequent treatment with the clinician.

Most CBT-based treatment models emphasize using cognitive restructuring to help clients decrease feelings of excessive guilt about some aspects of their trauma. However, in Drew's case, he experienced a level of increased guilt that was to be expected due to being the driver of the vehicle. Although, not legally culpable, Drew had been at the helm of the vehicle and felt completely responsible for an entire community's heartache. In a perspective-taking exercise, the clinician used the responsibility pie technique with Drew, allowing him to draw a pie chart and assign pieces of various sizes to different factors based on the amount of responsibility that contributed to the MVA (www.tfcbt.musc.edu). After completing the exercise, Drew reported feeling less responsible, as he took into account the other factors (i.e., road conditions) that had a role in the MVA. Cognitive restructuring aided Drew in reprocessing his role and subsequent guilt he felt in the aftermath of the traumatic event. Learning to accept that he played a role in his friend's death was an ongoing challenge for Drew throughout treatment and continues to be salient, albeit less so currently. Part of his recovery from this traumatic experience included his faith in God. Drew and the clinician discussed the role of forgiveness in this religious context, building on his developing worldview.

Another factor that complicated treatment was Drew's poor memory of the MVA. Posttraumatic amnesia for important aspects of the event is one of the diagnostic criteria for PTSD and was not unexpected. However, the memory loss was profuse and particularly distressing for Drew and he grew frustrated with himself when he could not retrieve the memories when other passengers in the vehicle could do so. As such, it was vital to educate Drew about memory loss related to traumatic events. Drew used the news article that chronicled the MVA in his vague description of the event. The more detailed trauma narrative began with the events immediately following his arrival to the hospital the night of the MVA, going to the police station, and the moment he learned of his friend's death the next morning.

9 Access and Barriers to Care

Drew received treatment in the school setting through a SMH program that uses graduate-level trainees under supervision wherein services are provided at no cost to families. Accordingly, Drew and his family were not held to the constraints that insurance plans typically require when implementing TF-CBT. The general effectiveness of such paradigms has been documented in the literature (e.g., Albright et al., 2013), but not necessarily for CTG and PTSD in particular. Nonetheless, providing treatment to adolescents in the context of SMH programs has important implications for reducing barriers to receiving evidence-based mental health services for youth overall (Owens, Watabe, & Michael, 2011).

10 Follow-Up

The final stage of treatment consisted of brief check-ins, reviewing progress toward goals, and prevention of relapse of severe symptoms, especially in anticipation of the 1-year anniversary of the MVA. At the end of therapy, Drew continued to participate in medication management with his pediatrician, as he still took 10 mg of Prozac daily. Drew and his mother plan on checking in with the SMH program at the start of school year to determine whether booster sessions or other support at school is warranted.

I I Treatment Implications of the Case

If symptoms of PTSD go unchecked, the adolescent who experiences one or more traumatic events is likely to face significant distress and long-term impairment. Assessment data obtained from Drew throughout treatment indicate support for a TF-CBT approach in addressing symptoms of unresolved traumatic grief, posttraumatic stress, and depression. Drew benefited from strategies that involved psychoeducation, relaxation, affect regulation, imaginal exposure, cognitive processing, redefining his relationship with his deceased friend, and focusing on current relationships. Treatment was enhanced by Drew's family and peer support, as he learned to use family members and close friends as cheerleaders during treatment. Given that Drew felt connected to his school prior to the MVA, creating and using a support system that centered on those in the building was pivotal to his recovery. Together with the clinician, Drew identified particular teachers, peers, and other adults (i.e., school social worker, SRO, baseball coach) who bolstered the skills and emotional processing he gained from TF-CBT. This is consistent with the extant literature that has shown social support moderates both short and long-term psychological outcomes in children and adolescents who have been exposed to traumatic events (Pine & Cohen, 2002) and the death of a peer during adolescence (Balk, Zaengle, & Corr, 2011). Whereas lack of social support and isolation from others may increase risk for developing prolonged grief, depression, and posttraumatic stress, bereaved individuals benefit from social supports who are available, are perceived to be helpful, show affection, and display respect and honor for the deceased (Kristensen, Weisæth, & Heir, 2012). This case further demonstrates the importance of aiding adolescents in increasing engagement with social supports after experiencing a traumatic loss.

I 2 Recommendations to Clinicians and Students

Several recommendations are offered for those who treat adolescents suffering from symptoms of PTSD in light of characteristics of Drew's case. Although Drew's treatment was based on a treatment manual, various components were chosen according to the appropriate timing and Drew's comfort level. Treating adolescents requires flexibility, creativity, and adaptability in helping them face uncomfortable avoided triggers. Furthermore, establishing and developing a strong therapeutic alliance will increase the likelihood of treatment adherence and increased symptom management. In children and adolescents, a robust working alliance may account for a modest portion of the variability in treatment outcomes, and has been associated with ameliorated internalizing and externalizing symptoms, increased youth self-esteem, improved family functioning, and increased perceived social support (Hawley & Garland, 2008; Karver, Handelsman, Fields, & Bickman, 2006). Moreover, a meta-analysis revealed a significant and consistent relationship between the therapeutic alliance and individual therapy outcome, regardless of developmental stage or treatment setting ($r = .20$; Shirk & Karver, 2003). Especially in the school setting, it is vital from the outset of treatment to establish an alliance that will aid in facilitating alleviation of symptoms and improved functioning in daily life (Zirkelback & Reese, 2010).

As in Drew's case, adolescents suffering from posttraumatic stress may experience suicidal thoughts. It is vital to use clinical judgment in addressing safety

concerns prior to beginning to process through the traumatic event. Engaging family members from the outset will allow for additional support outside of therapy sessions and increased compliance with homework assignments. Finally, building on the client's own worldview in adapting the TF-CBT model may encourage the youth to develop coping strategies that are aligned with his or her beliefs, enhancing recovery. Intrinsic religious coping and making meaning using spiritual beliefs after violent and unexpected deaths have been found to protect against severe posttraumatic stress reactions (Kristensen et al., 2012).

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