Post-Traumatic Stress Disorder (PTSD) in Children and Adolescents

Level 0

Comprehensive assessment includes:

- Use of standardized measures:
  - Juvenile Victimization Questionnaire (JVQ)
  - Trauma History component of the University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-PTSD RI)
- For specific PTSD symptoms, clinicians may use self-report and parent report measures:
  - University of California at Los Angeles Posttraumatic Stress Disorder Reaction index for DSM-5.
  - Child PTSD Symptom Scale for DSM-5

  Note: The UCLA-PTSD RI is not available in the public domain. The JVQ is available with permission.

  Links to the measures are available at ***https://floridabhcenter.org/***.
- Assessment of ongoing trauma in the context of the environment including history of abuse (physical, sexual, neglect), traumatic life events, domestic violence, economic instability, court involvement, etc.
- Address all safety concerns (i.e., child abuse), report to the appropriate agencies and/or make any mandated reports based on history.
- A comprehensive assessment of psychiatric symptoms and co-morbidities, as well as impairment from these symptoms and disorders.
- Thorough assessment of developmental, medical history, family structure, and parent-child relationship.
- An assessment of family psychiatric history, including: past and current history of parental psychiatric illnesses, substance abuse and treatment history of parents, parental figures (e.g., step parent), siblings, and other relatives.

Level 1

The greatest level of evidence supports exposure-based therapies, of which Trauma-Focused CBT (TF-CBT) has the most data and is the most widely used.

In children under 6 years old, may consider TF-CBT (4 months) or Child Parent Psychotherapy (CPP) (6 months) as first line treatment.

Consider Medical University of South Carolina (MUSC) online TF-CBT training if TF-CBT trained therapists are not available: ***https://tfcbt2.musc.edu/***.

Note: The TF-CBT course through Medical University of South Carolina requires a cost per person.

Treat comorbid conditions optimally.

Level 2

Where TF-CBT is not readily available or after inadequate response to TF-CBT (or CPP in younger children), other psychosocial interventions include:

- Prolonged Exposure therapy
- Cognitive behavioral therapy for PTSD
- Eye Movement Desensitization and Reprocessing (EMDR) therapy
- KIDNET (A child friendly version of Narrative Exposure Therapy or NET)
- Trauma and Grief Components Therapy for Adolescents
- Child and Family Traumatic Stress Intervention (Brief PTSD prevention therapy for recent trauma exposure)

When oppositional behavior (in younger children) or emotional dysregulation and/or self-harm and suicidal behavior (in adolescents) are prominent and debilitating, consider the following prior to or in conjunction with trauma specific therapies:

- Young children - Parent Child Interaction Therapy (PCIT)
- Adolescents - Dialectical Behavior Therapy (DBT)

Level 3

Re-evaluate and reassess for new or ongoing safety concerns.
Refer to *Principles of Practice* on page 3 for under age 6 years old and page 6 for 6-17 years old.

- There is no empirical evidence to support the use of psychotherapeutic medications in children 6 years or younger.
- For PTSD symptoms that impair sleep (e.g., nightmares, night-time hyperarousal), may consider psychotherapy augmentation at night with prazosin. Start prazosin at 1 mg nightly and titrate by 1 mg every week until target symptoms improve or intolerable side effects emerge, up to a maximum dose of 10 mg nightly.
- For persistent intrusive symptoms or increased arousal/reactivity, may consider psychotherapy augmentation with clonidine or guanfacine.
- Re-assess diagnosis and refer to specialist if not already done for persistent trauma exposure.
- Assess that family has received supportive treatment.

Level 4

Fluoxetine and sertraline may be considered for treatment of depression, anxiety and mood dysregulation symptoms associated with PTSD. These medications do NOT have as robust evidence for treatment of core PTSD symptoms in children as compared to adults.

Not Recommended:

- Benzodiazepines
- Second generation (i.e., atypical) antipsychotics (SGAs)
- Two or more agents that reduce sympathetic arousal concurrently (prazosin, guanfacine, clonidine)
- Use of medications to prevent PTSD in children, due to lack of evidence

Notes:

1. Not every trauma results in PTSD.
2. No FDA approved medications listed in Level 3.
3. Limited evidence of efficacy for agents listed in Levels 3 and 4.

For a full list of references, visit ***https://floridabhcenter.org/***.