Brief Summary

TITLE:

Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder.

SOURCE(S):

Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. J Am Acad Child Adolesc Psychiatry 1998 Oct;37(10 Suppl):4S-26S. [99 references]

ADAPTATION:

Not applicable: The guideline was not adapted from another source.

RELEASE DATE:

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MAJOR RECOMMENDATIONS:

I. Diagnostic assessment.

A. Interview with parent or primary caregiver (Note: If a parent is the alleged perpetrator of child abuse or domestic violence that is the identified traumatic event, the nonoffending parent or other primary caretaker should be interviewed. Interview of the alleged perpetrator is not required to diagnose and treat PTSD in the child.)

1. Obtain report of the traumatic event(s) and determine whether it qualifies as an "extreme" stressor.
    a. Note the nature of the event, when it occurred, the parents' perception of the child's degree of exposure to the event.
2. Obtain report of any preceding, concurrent, or more recent stressors in the child's life.
    a. Child abuse or neglect.
    b. Significant conflict, separation, or divorce.
    c. Frequent moves, school changes, or other significant disruptions.
    d. Family deaths, illnesses, disabilities, or substance abuse.
    e. Exposure to domestic or community violence.
    f. Serious traumatic events in the parents' lives of which the child has knowledge.
3. Obtain report of *DSM-IV* PTSD symptomatology in the child, with

particular attention to developmental variations in clinical presentation.

   a. Reexperiencing symptoms.
   b. Avoidant and numbing symptoms.
   c. Increased arousal symptoms.

4. Obtain report of any other significant current symptomatology, with particular attention to disorders with high comorbidity with PTSD.
   a. Depressive symptoms including self-injurious behavior.
   b. Non-PTSD anxiety symptoms, including panic attacks.
   c. ADHD and conduct symptoms.
   d. Substance abuse.
5. Obtain report of whether the symptoms began prior to or following the identified traumatic event(s). (Note: This determination may be difficult if the stressor has been longstanding or ongoing; e.g., physical abuse).
6. Obtain report of the parents' and other significant others' emotional reaction to the traumatic event.
   a. Ascertain whether the parent or primary caregiver was directly exposed to the trauma (e.g., driving when a motor vehicle accident occurred) or experienced only vicarious exposure (e.g., child disclosed sexual abuse by a stranger).
   b. Obtain report of the presence of parental PTSD symptoms following the traumatic event.
   c. Obtain perception of how much support has been available to the child since the event.
7. Obtain report of child's past psychiatric history.
   a. Outpatient psychotherapy.
   b. Partial or inpatient hospitalization.
   c. Psychotropic medications.
   d. Symptom course.
8. Obtain medical history.
   a. Significant current or past medical problems, somatic complaints, surgery, significant injuries.
   b. Current or past medications.
   c. Current primary medical care provider.
9. Obtain report of child's developmental history, with particular

emphasis on reactions to normal stressors (e.g., birth of sibling, beginning school) and child's level of functioning prior to the traumatic stressor.

10. Obtain report of school history, with particular emphasis on changes in school behavior, concentration, activity level, and performance since the traumatic stressor.
11. Obtain report of family history and family members' medical/psychiatric history.
    a. PTSD symptoms or diagnosis.
    b. Mood disorders.
    c. Anxiety disorders.
    d. Family medical conditions including any that may present as anxiety or mood disorders (e.g., thyroid disease).

B. Interview with the child, including mental status exam.

1. Obtain child's report of the reason for referral.
2. Encourage child to describe his or her memories of the traumatic event. (Note: There is no consensus regarding the optimal degree of detail, or whether certain kinds of leading questions are helpful or harmful. Clinical consensus clearly indicates that requesting some description of the stressor from the child is desirable but that the use of highly suggestive questioning is not recommended.)
3. Obtain the child's report of trauma-related attributions and perceptions.
    a. Who or what the child believes was responsible for the traumatic event.
    b. Whether the child believes he or she had any responsibility for causing or perpetuating the traumatic event.
    c. Whether the child believes he or she should have behaved differently in response to the event.
    d. Whether the child feels ostracized, damaged, or negatively judged by others as a result of being exposed to the stressor.
    e. The child's perception of how emotionally distressed and supportive parents and significant others have been since the traumatic event.
    f. In cases where the stressor was not public knowledge,

child's perception of whether adults believed his or her disclosure of exposure to the traumatic event.

g. The child's perception of how "normal" his or her current symptoms are in reaction to the stressor.

4. Obtain child's report of present symptomatology, with particular emphasis on developmentally appropriate questioning regarding *DSM-IV* PTSD criteria symptoms. (Note: Although it is important for the evaluator to explore with the child the link between the traumatic event and PTSD symptomatology, many children may not make this connection. This should not deter the evaluator from diagnosing PTSD if the temporal relationship between the event and symptom formation as reported by child or parent supports this diagnosis.)

5. Obtain child's report of symptomatology frequently associated with PTSD.

   a. Depressive symptoms, including suicidal ideation.

   b. Substance abuse or self-injurious behavior (in older children and adolescents).

   c. Dissociative symptoms, including fugue states, periods of amnesia, depersonalization or derealization (in older children and adolescents).

   d. Panic attacks and other non-PTSD anxiety symptoms.

6. Observe the child for the elements of the mental status exam and for behaviors that are found with PTSD.

   a. Increased startle reaction or vigilance.

   b. Traumatic reenactment (in younger children).

   c. Observable changes in affect or attention that may be indicative of reexperiencing phenomena.

C. Obtain information from school with appropriate release of information, if clinically indicated. (Note: Although school reports may be helpful with regard to confirming certain symptoms or post-traumatic changes, in many cases, school reports are not necessary to diagnose or treat PTSD in children.)

1. Academic functioning with particular attention to changes since the traumatic event.

2. Interactions with peers and involvement in non-academic activities, with particular attention to changes since the traumatic event.

3. Temporal appearance of ADHD symptoms (i.e., present prior to or only after the traumatic event).

D. Determine the need for additional evaluations (IQ testing, speech and language evaluation, pediatric evaluation).

E. Consider the usefulness of standardized interviews and rating scales. Although semistructured interviews and parent- and child-rating scales of PTSD symptomatology may be helpful in following clinical course of children with PTSD, the diagnosis of PTSD is based primarily upon the clinical interview. The use of standardized interviews and scales is not necessary to make this diagnosis.

1. Semistructured interviews. The following semistructured interviews include PTSD sections; none has established psychometric properties for measuring *DSM-IV* PTSD symptoms in children.

a. K-SADS-PL.

b. Diagnostic Interview Schedule.

c. Structured Clinical Interview for *DSM-III-R*.

d. Clinician-Administered PTSD Scale for Children and Adolescents.

2. Child- and parent-rating forms that may be clinically useful for following the course of PTSD symptoms in children.

a. PTSD Reaction Index.

b. Trauma Symptom Checklist for Children.

c. Checklist of Child Distress Symptoms Child and Parent Report Versions.

d. Children's Impact of Traumatic Events Scale.

e. Child PTSD Symptom Scale.

f. Impact of Events Scale (Revised version for adolescents).

II. Differential diagnosis. Psychiatric disorders that may be comorbid with or misdiagnosed as PTSD, or which PTSD may be misdiagnosed as.

A. Acute stress disorder.

B. Adjustment disorders.

C. Panic disorder.

D. Generalized anxiety disorder.

E. MDD.

F. ADHD.

G. Substance use disorders.

H. Dissociative disorders.

I. Conduct disorder.

J. Borderline or other personality disorder.

K. Schizophrenia or other psychotic disorder.

L. Malingering.

M. Factitious disorder.

III. Establish the subtype of PTSD present.

A. Acute.

B. Chronic.

C. With delayed onset.

IV. Treatment.

Formulate the treatment plan based on the clinical presentation of the child and to address both PTSD symptoms and other behavioral and emotional problems the child is experiencing. The course of PTSD and its particular symptom pattern in different children is extremely variable. Short-term, long-term, or intermittent treatment may be required. Different levels of care (outpatient, partial or inpatient hospitalization) and modalities (individual, family, group, psychopharmacologic therapy) may be required for different children or for a given child at different points in the course of the disorder. Comprehensive treatment for PTSD is generally multimodal and may include any or all of the following components.

A. Psychoeducation. Education of the child, parents, teachers, and/or significant others regarding the symptoms, clinical course, treatment options, and prognosis of childhood PTSD.

B. Individual therapy.

1. Trauma-focused therapy.

a. Exploration and open discussion of the traumatic event; relaxation, desensitization/exposure techniques may be useful.

b. Examination and correction of cognitive distortions in attributions about the traumatic event.

c. Behavioral interventions to address inappropriate traumatic reenactment (e.g., sexually inappropriate behaviors following sexual abuse; self-injurious, aggressive, and other behavioral difficulties).

d. Cognitive-behavioral techniques to help child gain control over intrusive reexperiencing symptoms.

2. Insight-oriented, interpersonal, and psychodynamic/psychoanalytic therapeutic interventions may be appropriate for treating PTSD in some children.

3. Therapy to address non-PTSD behavioral and emotional difficulties, in conjunction with trauma-focused interventions.

C. Family Therapy.

1. Trauma-focused parental therapy.

a. Exploration and resolution of the emotional impact of the traumatic event on the parent.

b. Identification and correction of inaccurate parental attributions regarding the traumatic event (e.g., self-blame, blaming the child).

c. Identification and implementation of appropriate supportive parenting behaviors and parental reinforcement of therapeutic interventions (e.g., teaching parents to help the child use progressive relaxation techniques).

d. Parent training on management of inappropriate child behaviors.

2. Traditional family therapy with all immediate family members for families with high conflict, harsh discipline, and/or when PTSD symptoms are present in several family members. However, family therapy generally should occur only after the child has received individual intervention to optimize comfortable disclosure of traumatic experiences and trauma-related symptoms. No empirical or clinical consensus is currently available regarding the use of family therapy for children with PTSD.

D. Group Therapy.

1. Trauma-focused groups for children of similar developmental levels who have experienced similar traumatic exposure may be beneficial in encouraging open discussion of and appropriate attributions regarding the event.

2. School-based group crisis intervention may be particularly useful in disaster situations.

3. Adult psychoeducational groups may be helpful in addressing parental and/or teacher concerns following exposure of groups of children to disaster or community violence situations.

E. Psychopharmacology.

1. Antidepressants (SSRIs, tricyclic antidepressants) may be useful for children exhibiting concurrent major depressive or panic

disorder symptoms.

2. Psychostimulants or alpha-adrenergic agonists (e.g., clonidine) may be useful for children exhibiting concurrent ADHD symptoms.
3. Antianxiety medications (benzodiazepines, propranolol) generally have not been used to treat children with PTSD. There is no current clinical consensus that use of these medications is effective for this population.

CLINICAL ALGORITHM(S):
None provided

DEVELOPER(S):
American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

COMMITTEE:
Work Group on Quality Issues

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ENDORSER(S):
Not stated

GUIDELINE STATUS:
This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY:
Electronic copies: Available (to members only) from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site.

Print copies: Available from AACAP, Communications Dept., 3615 Wisconsin Ave, NW, Washington, DC 20016. Additional information can be obtained through the AACAP Publication Catalog for Parameters.

COMPANION DOCUMENTS:
None available

PATIENT RESOURCES:
None available

NGC STATUS:
This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998.