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 [http://medicaidmentalhealth.org/](http://medicaidmentalhealth.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, may consider TF-CBT (4 months) or Child Parent Psychotherapy (CPP) (6 months) as first line treatment.

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

Level 3
Re-evaluate and reassess for new or ongoing safety concerns. Refer to Principles of Practice on page 6 for under age 6 and page 9 for 6–17 years old.

- There no empirical evidence to support the use of psychotropic 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 5 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.

Not Recommended:
- SSRIs because of several negative trials
- 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. Limited evidence of efficacy for agents listed in Level 3.

For a full list of references, visit http://medicaidmentalhealth.org/.