Psychological and Pharmacologic Treatment of Youth with Posttraumatic Stress Disorder

An Evidence-based Review

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KEYWORDS

- Posttraumatic stress disorder
- Trauma-focused cognitive behavior therapy (TF-CBT)
- Selective serotonin reuptake inhibitor (SSRI, SRI) • Trauma • Prevention

KEY POINTS

- Posttraumatic stress disorder (PTSD), in children and adolescents, is a constellation of symptoms that likely represent multiple pathophysiologic responses to stress.
- Psychotherapy is the mainstay of treatment of pediatric PTSD, with the greatest evidence supporting the use of trauma-focused psychotherapies.
- Pharmacotherapy should be used in conjunction with ongoing psychotherapy when prolonged and severe symptoms (including comorbid conditions such as depression and anxiety disorders) warrant additional intervention.

EVIDENCE FOR PSYCHOTHERAPEUTIC TREATMENT OF YOUTH WITH PTSD

Children exposed to violence and abuse experience a wide range of psychological sequelae, including attention disorders, mood disorders, and anxiety disorders.[1] Many children, especially those who are exposed to child abuse and neglect, as

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Acronyms	
CAPS	Clinician-Administered PTSD Scale
CBITS	Cognitive Behavioral Interventions for Trauma in Schools
CFTSI	Child and Family Traumatic Stress Intervention
CGI	Clinical global impression scale
CPP	Child Parent Psychotherapy
DSM-5	Diagnostic Statistical Manual of Mental Disorders
EMDR	Eye Movement Desensitization and Reprocessing
PE-A	Prolonged Exposure for Adolescents
SRI	Serotonin reuptake inhibitor
SSRI	Selective serotonin reuptake inhibitor
TGCT	Trauma and grief component therapy
TSCC	Traumatic Symptom Checklist for Children

well as a variety of disasters and noninterpersonal forms of trauma, may experience stress disorders, including posttraumatic stress disorder (PTSD).[1] In the recently released *Diagnostic Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5),[2] the criteria for PTSD has been revised and new, developmentally sensitive criteria for children who experience trauma before the age of 6 years is available to guide clinicians in diagnosis of both young and older children. The revision of these criteria from the *Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) criteria includes the separation of avoidance and negative alterations in mood into separate categories, as well as the categorization of dissociative experiences as a qualifier. Because PTSD has various neuroendocrine and neuroanatomic correlates that predict specific phenomenologic characteristics (reviewed by De Bellis elsewhere in this issue), it is likely that this new classification will help clinicians design treatment strategies based on specific impairing symptoms rather than on the broad, often heterogenous symptoms of PTSD.

Psychotherapeutic interventions are the mainstay of treatment of traumatized children with symptoms of traumatic stress, including those with PTSD, regardless of the cause. Although there are many permutations of these psychotherapeutic interventions, including adaptation to specific target populations (eg, individual, dyadic, group) and foundational theory (eg, cognitive behavioral, psychodynamic, and so forth), there are several core unifying concepts that characterize most evidence-based psychotherapies for traumatized youth. These include: (1) ensuring safety from continued trauma; (2) providing psychoeducation regarding the potential effects from, and responses to, trauma; (3) providing effective coping/behavior management strategies; (4) assisting children in mastering trauma avoidance, typically through trauma narration and/or exposure activities; and (5) engaging parents or other caregivers in treatment and enhancing the parent-child relationship. These concepts crosscut psychotherapeutic modalities with an emphasis on different components often depending on the specific therapy model and the child's most debilitating symptoms.[3] For example, increased focus on self-calming coping strategies are key in an adolescent with extreme hyperarrousal, whereas the parent-child relationship and behavior management are areas of focus in a young child who is reexperiencing symptoms that are born out through aggressive and assaultive play. This article reviews the primary components, target populations, and effectiveness of the most studied and commonly available evidence-based trauma treatments for children.