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PRACTICE PARAMETER FOR THE ASSESSMENT AND TREATMENT OF CHILDREN AND ADOLESCENTS WITH POSTTRAUMATIC STRESS DISORDER

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ABSTRACT

This practice parameter reviews the evidence from research and clinical experience and highlights significant advances in the assessment and treatment of Posttraumatic Stress Disorder (PTSD) since the previous parameter was published (AACAP, 1998). It highlights the importance of early identification of PTSD, the importance of gathering information from parents as well as children, and the assessment and treatment of comorbid disorders. It presents evidence to support trauma-focused psychotherapy, medications, and a combination of interventions in a multimodal approach. **Key Words:** child, adolescent, posttraumatic stress disorder, treatment, practice parameter.

ATTRIBUTION

AACAP practice parameters are developed by the AACAP Work Group on Quality Issues (WGQI) in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the WGQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP components, the AACAP Assembly of Regional Organizations, and the AACAP Council. Responsibility for parameter content rests with the author(s), the WGQI, the WGQI Consensus Group, and the AACAP Council.

The AACAP develops both patient-oriented and clinician-oriented practice parameters. Patient-oriented parameters provide recommendations to guide clinicians toward best treatment practices. Recommendations are based on empirical evidence (when available) and clinical

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1 consensus (when not), and are graded according to the strength of the empirical and clinical
2 support. Clinician-oriented parameters provide clinicians with the information (stated as
3 principles) needed to develop practice-based skills. Although empirical evidence may be
4 available to support certain principles, principles are primarily based on expert opinion derived
5 from clinical experience. This parameter is a patient-oriented parameter.

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18 groups were as follows: Work Group on Quality Issues (co-chair's name, shepherd's name,
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25 This practice parameter is available on the Internet (www.aacap.org).

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30 **INTRODUCTION**

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1 More than one of four children experiences a significant traumatic event before reaching
2 adulthood (Costello et al., 2002). These traumas may include events such as child abuse;
3 domestic, community or school violence; disasters, vehicular or other accidents, medical
4 traumas, war, terrorism, refugee trauma, the traumatic death of significant others, or other
5 shocking, unexpected or terrifying experiences. While most children are resilient following
6 trauma exposure, some develop significant and potentially long lasting mental health problems.
7 This practice parameter was written to help child and adolescent psychiatrists and other medical
8 and mental health professionals assess and treat one such condition, PTSD. Because the
9 diagnosis of PTSD requires the passage of at least one month following exposure to an index
10 trauma, this practice parameter does not address the immediate psychological needs of children
11 following disasters or other acute traumatic events, i.e. within the first month.

12 These guidelines are applicable to the evaluation and treatment of child and adolescent
13 patients age 17 and younger. This document presumes familiarity with normal child development
14 and the principles of child psychiatric diagnosis and treatment. In this parameter the word
15 “child” refers to both adolescents and younger children unless explicitly noted. Unless otherwise
16 noted, “parents” refers to the child’s primary caretakers, regardless of whether they are the
17 biological or adoptive parents or legal guardians.

18

19 **METHODOLOGY**

20 A literature search was conducted of MEDLINE accessed at www.pubmed.gov using the
21 following MeSH terms: Stress disorders, Posttraumatic AND randomized controlled trials;
22 Limits All child: 0-18 years, only items with abstracts, English, Randomized controlled trials.
23 This resulted in 70 abstracts. A search of PsycINFO was conducted using the following
24 Thesaurus terms: Posttraumatic stress disorder; Limit 1 to “treatment outcome/randomized
25 clinical trial”; Limit 2 to (childhood or adolescence), resulting in 24 abstracts. A search of the
26 PILOTS database was conducted using the terms “clinical trials AND child AND adolescent”,
27 resulting in 20 abstracts. The search covered the period from 1996 to 2006. Only abstracts which
28 included randomized controlled trials (RCTs), instruments measuring childhood PTSD
29 symptoms, and significant results with regard to PTSD symptoms were included. This search
30 was augmented by programs listed on the National Child Traumatic Stress Network website

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1 (www.NCTSN.org), those nominated by expert reviewers, and manuscripts which have recently
2 been accepted for publication in peer-reviewed journals.

3

4 **CLINICAL PRESENTATION**

5 PTSD is the one of the few psychiatric diagnoses in DSM-IV-TR that requires the
6 presence of a known etiologic factor, i.e., a traumatic event that precedes the development of the
7 disorder. In order for PTSD to be present, the child must report (or there must be other
8 compelling evidence of) a qualifying index traumatic event as well as specific symptoms in
9 relation to that traumatic experience. Compelling evidence might include sexually transmitted
10 infection in a young child, a reliable eyewitness report (for example, a police report that a child
11 was rescued from the scene of an accident) or a forensic evaluation confirming the likelihood
12 that the child experienced a traumatic event. Childhood adversities such as foster care placement
13 or parental substance abuse do not typically qualify as traumatic stressors to which children
14 develop PTSD. However, specific events may have occurred within these contexts (for example,
15 child abuse or domestic violence) which would qualify as traumatic stressors. An inherent
16 contradiction exists in that avoidance of describing traumatic experiences is a core feature of
17 PTSD as described below; yet diagnosing PTSD requires that the child describe the traumatic
18 event.

19 In the absence of child report or other compelling evidence of a qualifying index trauma,
20 a PTSD diagnosis should not be made. There may be situations where children or adolescents
21 present with symptoms suggestive of PTSD (for example, general anxiety symptoms, nightmares
22 and impairment; or in an older youth, self-injurious behavior such as repeated cutting, substance
23 abuse and indiscriminant sexualized behavior) in the absence of a disclosure of trauma exposure.
24 In this situation the clinician should not presume that trauma has occurred. Therapists are
25 obligated to ask whether traumatic events have occurred in nearly all routine evaluations (e.g.,
26 maltreatment, acute injuries, disasters, and witnessed violence to loved ones). However, if both
27 children and caregivers cannot confirm that a traumatic event has occurred, then therapists ought
28 not to imply that symptomatology is a consequence of forgotten trauma. Conversely some
29 children may be afraid, ashamed, embarrassed or avoidant of disclosing traumatic experiences,
30 particularly upon an initial clinical interview. Avoidance may take the form of denial of trauma
31 exposure and as such may be an indication of the severity of the child's avoidance symptoms

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1 rather than lack of trauma exposure. Parental denial of the child’s exposure to trauma may occur
2 because the parent is unaware of the child’s trauma exposure, because the parent is a perpetrator,
3 or for a variety of other reasons. An error in either direction, i.e., mistakenly attributing
4 symptoms to trauma that did not occur, or disregarding the possibility of a real trauma history,
5 has potential risks. Children should be referred for a forensic evaluation if the clinician has
6 suspicion in this regard. There are many differences between forensic and clinical evaluations;
7 clinicians should not attempt to conduct forensic assessments in the context of a clinical
8 evaluation.

9 The majority of individuals who experience truly life-threatening events manifest
10 posttraumatic symptomatology immediately (e.g., Aaron et al., 1999; Rothbaum et al., 1992).
11 However, only about 30% on average tend to manifest enduring symptomatology beyond the
12 first month (Kessler et al., 1995). Therefore, PTSD is not diagnosed until at least one month has
13 passed since the index traumatic event occurred. Following large scale disasters, vehicular
14 accidents or medical trauma, children may be seen very soon after traumatic exposure by
15 medical personnel, mental health professionals or paraprofessionals. Acute Stress Disorder,
16 Adjustment Disorder or another disorder may be diagnosed within the first month of exposure.
17 Transient moderate psychological distress may be a normative reaction to traumatic exposure.
18 Recent data suggest that panic symptoms in the immediate aftermath of trauma exposure is
19 predictive of later PTSD in children and this may an important symptom to evaluate in this acute
20 period (Sinclair et al., in press; Pfefferbaum et al., 2006). Little is known about the efficacy of
21 early interventions that are typically provided in the immediate aftermath of disasters, and
22 whether they may cause harm to children as they have been found to do in some adult studies
23 (reviewed in Litz and Gray, 2004). One randomized controlled study demonstrated that
24 providing an early mental health intervention, psychological debriefing, was neither better nor
25 worse than a wait list control condition in improving PTSD symptoms for children in road traffic
26 accidents (Stallard et al., 2006 [rct]).

27 Acute PTSD is diagnosed if the symptoms are present after the first month and for less
28 than 3 months of the index trauma; chronic PTSD is diagnosed if the symptoms persist beyond 3
29 months. Debate is ongoing whether or not a condition referred to as “complex PTSD” (also
30 known as Disorders of Extreme Stress Not Otherwise Specified, or DESNOS) exists in severely
31 traumatized children or adolescents (Briere and Spinazzola, 2005). An alternative view with

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1 substantial support is that “complex PTSD” is chronic PTSD occurring in the presence of other
2 comorbid DSM-IV-TR conditions (Kilpatrick, 2005).

3 **PTSD symptom clusters:** In addition to the presence of a known trauma, diagnosing
4 PTSD requires the presence of symptoms in three distinct clusters.

5 Reexperiencing of the trauma must be present as evidenced by at least one of the
6 following symptoms: recurrent, intrusive recollections, memories, nightmares, or other senses of
7 reliving the traumatic experience. In young children this can take the form of repetitive play in
8 which aspects or themes of the trauma are expressed, or trauma-specific reenactment may occur.
9 Frightening dreams without trauma-specific content may also occur. Trauma reminders (people,
10 places, situations or other stimuli that remind the child of the original traumatic event) may lead
11 to intense psychological or physiological distress.

12 Persistent avoidance of trauma reminders and emotional numbing must be present as
13 evidenced by at least three of the following symptoms: efforts to avoid trauma reminders
14 including talking about the traumatic event or other trauma reminders; inability to recall an
15 important aspect of the trauma; decreased interest or participation in previously enjoyed
16 activities; detachment or estrangement from others; restricted affect; and sense of a foreshortened
17 future.

18 Persistent symptoms of hyperarousal must also be present as evidenced by at least two of
19 the following symptoms: difficulty falling or staying asleep; irritability or angry outbursts;
20 difficulty concentrating; hypervigilance; and increased startle reaction. In young children
21 hyperarousal may also be evidenced by the onset of new fears which were not present prior to
22 the onset of the traumatic event (Scheeringa et al., 2001).

23 There is ongoing debate about the validity of the DSM-IV-TR diagnostic criteria for
24 children, particularly the requirement of three avoidance/numbing symptoms in younger
25 children, since these symptoms require children to report on complex internal states which are
26 difficult for young children to comprehend and for parents to observe. Empirical studies have
27 also raised serious questions about the appropriateness of this threshold for prepubertal children
28 (Bryant et al, 2004; Scheeringa et al., 2006).

29 Childhood PTSD confers increased risk for a number of problems in later childhood,
30 adolescence and adulthood. PTSD related to child abuse or domestic violence is associated with
31 smaller cerebral volume and smaller corpus colossi (DeBellis et al., 1999), with the severity of

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1 these changes being proportional to the duration of the children’s trauma exposure. Some studies
2 have shown that childhood PTSD is associated with lower academic achievement compared to
3 children who have been exposed to trauma but have not developed PTSD (Saigh et al., 1997),
4 whereas a more recent study found that only reexperiencing symptoms were associated with
5 cognitive impairment in adults with child maltreatment-related PTSD (Diamond et al., 2001).
6 Certain types of traumatic events seem to be particularly associated with poor outcomes, whether
7 or not children develop full-blown PTSD. For example, childhood sexual abuse alone is a strong
8 predictor of a number of adverse outcomes in adolescence and adulthood, including substance
9 abuse, conduct disorder and depression (Fergusson et al., 1996). The relationship of child sexual
10 abuse with suicidality is particularly serious, with up to 20% of all adolescent suicide attempts
11 being attributable to this trauma and childhood sexual abuse victims being eight times more
12 likely than their non-sexually abused counterparts to attempt suicide repeatedly during
13 adolescence (Brent et al, 2002; Brown et al., 1999; Fergusson et al., 1996). Adolescents with
14 sexual abuse-related PTSD also have high risk sexual behaviors (Stiffman et al., 1992). Adults
15 with PTSD related to childhood trauma have been found to have significantly higher rates of
16 depression, suicide attempts, substance abuse, psychiatric hospitalizations and relationship
17 difficulties compared to anxiety disordered adults who either have a trauma history without
18 PTSD or no trauma history (Warshaw et al., 1993).

19

20 **EPIDEMIOLOGY**

21 One sample of adolescents and young adults indicated that the overall lifetime prevalence
22 of PTSD in the general youth population was 9.2% (Breslau et al., 1991). A recent national
23 sample of adolescents (12-17 year olds) indicated that 3.7% of males and 6.3% of females met
24 full diagnostic criteria for PTSD (Kilpatrick et al., 2003). A survey of 1,035 German adolescents
25 found a lifetime prevalence rate of 1.6% (Essau et al., 2000). Many more trauma exposed
26 children develop clinically significant PTSD symptoms without meeting full diagnostic criteria;
27 research indicates that these children have comparable functional impairments to those with a
28 diagnosis of PTSD (Carrion et al., 2002). The few studies that examined the natural course of
29 PTSD in children have sometimes concurred with the general trend of adult studies that PTSD
30 rates per sample decrease, albeit gradually, with time (Bryant et al., 2004; Koplewicz et al.,
31 2002; Kuterovac-Jagodic, 2003; LaGreca et al., 1996; Vila et al., 1999). Despite these group

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1 averages that show overall “natural recovery” (i.e., remission without treatment), within these
2 samples are always those who experience chronic PTSD over the course of many years. In other
3 words, cohorts of children exposed to sexual abuse, natural disasters, war, accidents and school
4 violence have been documented to have decreases in rates of PTSD over the course of time, but
5 significant proportions of these cohorts continued to meet criteria for chronic PTSD as well
6 (reviewed in AACAP, 1998). More ominous are two prospective studies that showed no group
7 average decrease in PTSD symptomatology. McFarlane showed that Australian school-age
8 children (mean age 8.2 years) did not decrease their PTSD symptomatology over 18 months
9 following a bushfire (McFarlane, 1987). Scheeringa et al. (2005) showed that preschool-age
10 children did not decrease PTSD symptomatology over two years. An important question is
11 whether younger children are more vulnerable to permanent effects of trauma. Another important
12 question is whether earlier treatment would result in better outcomes than delayed or no
13 treatment, even if rates for of PTSD diagnosis decline over time for all three groups. A new
14 study indicates that this is the case for adults (Shalev et al., 2006).

15

16 RISK AND PROTECTIVE FACTORS

17 Female gender, past trauma exposure, greater exposure to the index trauma, the presence
18 of a pre-existing psychiatric disorder (particularly an anxiety disorder), parental psychopathology
19 and lack of social support are all risk factors for developing child PTSD following trauma
20 exposure (reviewed in Pine and Cohen, 2002). Conversely, parental support, lower levels of
21 parental PTSD and resolution of other parental trauma-related symptoms have been found to
22 predict lower levels of PTSD symptoms in children (Cohen and Mannarino, 1996b; Laor et al.,
23 1997). In the context of a disaster, increased television viewing of disaster-related events,
24 delayed evacuation, extreme panic symptoms, or having felt that one’s own or one’s family
25 member’s life was in danger have each been found to be independently and significantly
26 associated with developing PTSD symptoms in children (Hoven et al., 2005; Pfefferbaum et al.,
27 1999; Thienkrua et al., 2006). Recent research suggests that children’s psychological reactions to
28 trauma exposure are to some degree influenced by genetic factors (Caspi et al., 2002).

29

30 EVIDENCE BASE FOR PRACTICE PARAMETERS

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1 In this parameter, recommendations for best treatment practices are stated in accordance
2 with the strength of the underlying empirical and/or clinical support, as follows:

- 3 • Minimal Standard [MS] is applied to recommendations that are based on rigorous
4 empirical evidence (e.g., randomized, controlled trials) and/or overwhelming clinical
5 consensus. Minimal standards apply more than 95% of the time (i.e., in almost all
6 cases).
- 7 • Clinical Guideline [CG] is applied to recommendations that are based on strong
8 empirical evidence (e.g., non-randomized controlled trials) and/or strong clinical
9 consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases).
- 10 • Option [OP] is applied to recommendations that are acceptable based on emerging
11 empirical evidence (e.g., uncontrolled trials or case series/reports) or clinical opinion, but
12 lack strong empirical evidence and/or strong clinical consensus.
- 13 • Not Endorsed [NE] is applied to practices that are known to be ineffective or
14 contraindicated.

15
16 The strength of the empirical evidence is rated in descending order as follows:

- 17 • [rct] Randomized, controlled trial is applied to studies in which subjects are randomly
18 assigned to two or more treatment conditions
- 19 • [ct] Controlled trial is applied to studies in which subjects are non-randomly assigned to
20 two or more treatment conditions
- 21 • [ut] Uncontrolled trial is applied to studies in which subjects are assigned to one
22 treatment condition
- 23 • [cs] Case series/report is applied to a case series or a case report

24 25 SCREENING

26 **Recommendation 1.** *The psychiatric assessment of children and adolescents should*
27 *routinely include questions about traumatic experiences and PTSD symptoms [MS].*

28 Given the high rate of trauma exposure in children and the potentially long lasting course
29 of PTSD, it is important to detect this condition early. Routine screening for PTSD during the
30 initial mental health assessment is therefore recommended. Even if trauma is not the reason for
31 referral, clinicians should routinely ask children about exposure to commonly experienced

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1 traumatic events (for example, child abuse, domestic or community violence or serious
2 accidents) and if such exposure is endorsed, the child should be screened for the presence of
3 PTSD symptoms. Screening questions should use developmentally appropriate language and be
4 based on DSM-IV-TR criteria. Obtaining information about PTSD symptoms from multiple
5 informants including children and parents or other caretakers is essential because the addition of
6 caretaker information significantly improves diagnostic accuracy (Scheeringa et al., 2006).

7 In order to screen for PTSD symptoms, clinicians must first determine whether children
8 have been exposed to qualifying traumatic experiences. One of the best tools in this regard is the
9 Juvenile Victimization Questionnaire (JVQ), which has been validated for ethnically diverse
10 samples of children ages 2-17 years of age, relying on caretaker report for children under 10
11 years of age (Finkelhor et al., 2005). For children 7 years and older, self-report measures for
12 PTSD such as the UCLA PTSD Index (Steinberg et al., 2004) or the Child PTSD Symptom Scale
13 (CPSS) (Foa et al., 2001) can assist with screening and monitoring response to treatment. An
14 abbreviated version of the UCLA PTSD Reaction Index is included below.

15

16 Figure 1: Abbreviated UCLA PTSD Reaction Index

17

18 Screening tools for young children can only be administered to caregivers since young
19 children do not yet possess the developmental capacities for accurate self-report of psychiatric
20 symptomatology. The PTSD-PAC (PTSD symptoms in preschool children) is an 18-item
21 checklist that covers most of the PTSD items plus several items appropriate for young children
22 (Levendosky et al., 2002). A subset of 15-items in the Child Behavior Checklist has shown
23 promising sensitivity and specificity compared to a gold-standard interview for PTSD (Dehon
24 and Scheeringa, 2005). The Trauma Symptom Checklist for Children (TSCC) (Briere, 1996) is a
25 checklist for a wide range of trauma-related difficulties such as PTSD, depressive, anxiety,
26 dissociative and anger symptoms. The companion instrument for younger children, the Trauma
27 Symptom Checklist for Young Children (TSC-YC) has also been found to have good
28 psychometric properties and its PTSD subscale correlated well with PTSD scores on the UCLA
29 PTSD Index in young children (Gilbert, 2003).

30

31 **EVALUATION**

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1 **Recommendation 2.** *If screening indicates significant PTSD symptoms the clinician*
2 *should conduct a formal evaluation to determine whether PTSD is present, the severity of*
3 *those symptoms, and the degree of functional impairment. Parents or other caregivers should*
4 *be included in this evaluation wherever possible [MS].*

5 The proper assessment of PTSD requires relatively more diligence and educational
6 interviewing than perhaps for any other disorder. Most PTSD symptoms are highly internalized
7 and conceptually abstract, and are not obvious by observation, as in, for example depression or
8 ADHD. Eighty-eight percent of PTSD symptomatology were not observable from clinical
9 examination of young children (Scheeringa et al., 2001). The reexperiencing and avoidance
10 items in particular require an individual to recognize that their emotions and behaviors are yoked
11 to memories of past events that, almost by the definition of PTSD, they are trying to avoid
12 remembering. In particular, it is insufficient to ask about reexperiencing and avoidance items
13 generically, such as, “Do you have distress at reminders of your past event?” Interviewers must
14 tailor these probes to the individualized experiences of each patient with specific examples, such
15 as, “When you went past the house where the event occurred, did you get upset?” Many
16 individuals will respond in the negative to the generic question, but in the affirmative to the
17 specific probe once they have been properly educated on what the interviewer is asking about.

18 The clinician should ask the child and parent about symptom severity and functional
19 impairment along with the presence of PTSD symptoms during the assessment. The CPSS
20 includes a rating of functional impairment which can be followed during the course of treatment
21 to monitor improvement. Younger children may use more developmentally appropriate visual
22 analogues such as gradated depictions of fearful to happy faces or a “fear thermometer” to rate
23 symptom severity and interference with functioning.

24 Although formal psychological testing or questionnaires are not required to diagnose
25 PTSD, several instruments may be helpful in supplementing the clinical interview in youth 4-17
26 years old. Clinicians may find the Clinician’s Assessment of PTSD Symptoms-Child and
27 Adolescent Version (CAPS-CA) (Nader et al., 1998) or the Schedule for Affective Disorders and
28 Schizophrenia for School Aged Children-Present and Lifetime Version (K-SADS-PL) PTSD
29 Section (Kaufman et al, 1996) helpful in this regard. Both of these entail child and parent
30 consensus ratings of PTSD symptoms which are rated in relation to an index trauma selected at
31 the beginning of the interview. For preschool children, the Posttraumatic Stress Disorder Semi-

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1 Structured Interview and Observational Record for Infants and Young Children (PTSD-SSI) is
2 an interview for caregivers that contains appropriate developmental modifications (Scheeringa et
3 al., 2003).

4

5 **Recommendation 3.** *The psychiatric assessment should consider differential diagnoses*
6 *of other psychiatric disorders and physical conditions that may mimic PTSD [MS].*

7 Psychiatric conditions may present with symptoms similar to those seen in PTSD.
8 Avoidance and reexperiencing symptoms of PTSD such as restless, hyperactive, disorganized
9 and/or agitated activity or play can be confused with attention deficit hyperactivity disorder
10 (ADHD). Hyperarousal symptoms in children such as difficulty sleeping, poor concentration,
11 and hypervigilant motor activity, also overlap significantly with typical ADHD symptoms, and
12 unless a careful history of trauma exposure is taken in relation to the timing of the onset or
13 worsening of symptoms, these conditions may be difficult to distinguish. PTSD may also present
14 with features more characteristic of oppositional defiant disorder (ODD) due to a predominance
15 of angry outbursts and irritability; this may be particularly true if the child is being exposed to
16 ongoing trauma reminders (such as the presence of the perpetrator of violence). PTSD may
17 mimic panic disorder if the child has striking anxiety and psychological and physiological
18 distress upon exposure to trauma reminders and avoidance of talking about the trauma. PTSD
19 may be misdiagnosed as another anxiety disorders including social anxiety disorder (SAD),
20 obsessive compulsive disorder (OCD), general anxiety disorder (GAD) or phobia due to
21 avoidance of feared stimuli, physiological and psychological hyperarousal upon exposure to
22 feared stimuli, sleep problems, hypervigilance and increased startle reaction. PTSD may also
23 mimic major depressive disorder (MDD) due to the presence of self-injurious behaviors as
24 avoidant coping with trauma reminders; social withdrawal, affective numbing and/or sleep
25 difficulties. PTSD may be misdiagnosed as a primary substance use disorder since drugs and/or
26 alcohol may be used to numb or avoid trauma reminders. Conversely it is important to remember
27 that there are many youth with a history of trauma who have primary substance use disorders
28 with few trauma symptoms; these youth will typically benefit more from receiving treatment for
29 substance use than for PTSD. PTSD should also be differentiated from psychotic disorders,
30 which it may mimic due to the presence of hypervigilance, flashbacks, sleep disturbance,

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1 numbing, and/or social withdrawal. PTSD should also be differentiated from milder adjustment
2 disorders.

3 Physical conditions that may present with PTSD-like symptoms include hyperthyroidism,
4 caffeinism, migraine, asthma, seizure disorder, and catecholamine or serotonin secreting tumors.
5 Prescription drugs with side effects that may mimic aspects of PTSD include antiasthmatics,
6 sympathomimetics, steroids, selective serotonin reuptake inhibitors (SSRIs), antipsychotics
7 (akathisia), and atypical antipsychotics. Nonprescription drugs with side effects that may mimic
8 PTSD include diet pills, antihistamines and cold medicines.

9 PTSD is often associated with somatic symptoms such as headaches and abdominal
10 complaints. The mental health assessment should be considered early in the medical evaluation
11 of youth with somatic complaints, particularly those with a known history of trauma exposure.
12 There is some preliminary evidence to suggest that trauma exposure adversely impacts
13 immunologic functioning in children (DeBellis et al., 1996)

14

15 TREATMENT

16 **Recommendation 4.** *Treatment planning should consider a comprehensive treatment*
17 *approach which includes consideration of the severity and degree of impairment of the child's*
18 *PTSD symptoms [MS].*

19 Treatment of children with PTSD symptoms should include education of the child and
20 parents about PTSD, consultation with school personnel and primary care physicians once
21 informed consent/assent has been obtained, and trauma-focused psychotherapy including
22 cognitive-behavioral therapy, psychodynamic psychotherapy, and/or family therapy.
23 Pharmacotherapy may also be considered in the multimodal approach to children with PTSD.
24 School-based screening and treatments should be considered following community level
25 traumatic events since this is an efficient way of identifying and treating affected children.
26 Selection of the specific treatment modalities for an individual child and family in clinical
27 practice involves consideration of psychosocial stressors, risk factors, severity and impairment of
28 PTSD, age and developmental functioning of the child and family functioning. In addition, child
29 and family factors such as attitudes or acceptance of a particular intervention and provider-
30 practitioner factors such as training, access to and attitudes about evidence based interventions,
31 and affordability of such interventions need to be considered.

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1 Children with significant PTSD symptoms who do not meet full criteria for a PTSD
2 diagnosis often have comparable functional impairment to those with a PTSD diagnosis (Carrion
3 et al., 2002; Scheeringa et al., 2005). Treatment decisions for children should take into account
4 symptom severity and functional impairment, regardless of whether or not they have an actual
5 PTSD diagnosis. Until evidence from comparative studies can inform clinical practice, treatment
6 of mild PTSD should begin with psychotherapy. Valid reasons for combining medication and
7 psychotherapy include the following: need for acute symptom reduction in a child with severe
8 PTSD, a comorbid disorder that requires concurrent treatment, or unsatisfactory or partial
9 response to psychotherapy and potential for improved outcome with combined treatment (March,
10 2002).

11 There is evidence that including parents in treatment is helpful for resolution of
12 children’s trauma-related symptoms. Deblinger, et al. (1996 [rct]) provided trauma-focused CBT
13 to parents alone, children alone or to parents and children and compared these three conditions to
14 community treatment as usual. Parental inclusion in treatment resulted in significantly greater
15 improvement in child reported depression and parent reported behavior problems. Studies have
16 demonstrated that lower levels of parental emotional distress (Cohen and Mannarino, 1996b
17 [rct], 1998b [rct]) and stronger parental support (Cohen and Mannarino, 2000 [rct]) predict more
18 positive treatment response, including in PTSD symptoms, during children’s participation in
19 trauma-focused CBT treatment.

20

21 **Recommendation 5. *Treatment planning should incorporate appropriate interventions***
22 ***for comorbid psychiatric disorders [MS].***

23 Children with PTSD often have comorbid psychiatric conditions. Appropriate diagnosis
24 and treatment should be provided in a timely manner, following established treatment guidelines
25 for the comorbid condition. PTSD commonly occurs in the presence of depressive disorders
26 (Dixon et al., 2005), attention deficit hyperactivity disorder (ADHD) (Ford et al., 2000),
27 substance abuse (Lipschiz et al., 2003) and other anxiety disorders (Dixon et al., 2005). Ideally
28 treatment of comorbid conditions should be provided in an integrated fashion. One evidence-
29 supported model for treating adolescents with PTSD and comorbid substance abuse has been
30 described (Najavits, 2002; Najavits et al., 2006). This model, “Seeking Safety” integrates

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1 evidence –based interventions for PTSD and substance use disorders, as well as a focus on
2 assuring safety in the present moment.

3

4 **Recommendation 6. *Trauma-focused psychotherapies should be considered first line***
5 ***treatments for children and adolescents with PTSD [MS].***

6 Amongst the psychotherapies there is convincing evidence that trauma-focused
7 therapies, that is, those that specifically address the child’s traumatic experiences, are superior to
8 non-specific or non-directive therapies in resolving PTSD symptoms. This has been true across
9 the developmental spectrum from preschooler to adolescents, and encompassing diverse
10 theoretical therapies such as psychoanalytic, attachment and cognitive-behavioral treatment
11 models (Cohen et al., 2004 [rct]; Lieberman et al., 2005 [rct]; Trowell et al., 2002 [rct]). The
12 importance of directly addressing the child’s traumatic experiences in therapy makes sense when
13 considering PTSD symptoms: avoidance of talking about trauma-related topics would be an
14 expected occurrence when children are given a choice of focus during treatment, as is the case in
15 non-directive treatment models. This outcome was observed in a study comparing child centered
16 therapy sessions compared to trauma-focused treatment, i.e., children in child centered therapy
17 rarely spontaneously mentioned their personal traumatic experiences (Cohen et al., 2004 [rct]).

18 Amongst the trauma-focused psychotherapies, trauma-focused CBT (TF-CBT) has
19 received the most empirical support for the treatment of childhood PTSD. TF-CBT and a similar
20 group format, Cognitive Behavioral Intervention for Trauma in Schools (CBITS) have been
21 supported by numerous randomized controlled trials for children with PTSD comparing these
22 treatments to either wait list control conditions or to active alternative treatments. Child-Parent
23 Psychotherapy combines elements of TF-CBT with attachment theory and has been tested in one
24 randomized controlled trial. A trauma-focused psychoanalytic model for sexually abused
25 children has been tested in one randomized study. Many other models are in development and at
26 various stages of testing.

27 Based on the evidence presented below, there is growing support for the use of trauma-
28 focused psychotherapies which a) directly address children’s traumatic experiences; b) include
29 parents in treatment in some manner as important agents of change; and c) focus not only on
30 symptom improvement but also on enhancing functioning, resiliency and/or developmental
31 trajectory.

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COGNITIVE BEHAVIORAL THERAPIES

In trauma-focused CBTs the clinician typically provides stress management skills in preparation for the exposure-based interventions which are aimed at providing mastery over trauma reminders. Cohen et al. (2006) describe commonly provided trauma-focused CBT components using the PRACTICE acronym: *Psychoeducation* (e.g., educating children and parents about the type of traumatic event the child experienced, for example, how many children this happens to, what causes it to happen, etc; common trauma reactions including PTSD and about the trauma-focused CBT treatment approach); *Parenting skills* (the use of effective parenting interventions such as praise, positive attention, selective attention, time out and contingency reinforcement procedures); *Relaxation skills* (focused breathing, progressive muscle relaxation and other personalized relaxation activities to reverse the physiological manifestations of traumatic stress); *Affective modulation skills* (feeling identification; use of positive self-talk, thought interruption and positive imagery; enhancing safety, problem solving and social skills; recognizing and self-regulating negative affective states); *Cognitive Coping and Processing* (recognizing relationships between thoughts, feelings and behaviors; changing inaccurate and unhelpful thoughts for affective regulation); *Trauma Narrative* (creating a narrative of the child’s traumatic experiences, correcting cognitive distortions about these experiences and placing these experiences in the context of the child’s whole life); *In vivo mastery of trauma reminders* (graduated exposure to feared stimuli); *Conjoint child-parent sessions* (joint sessions in which the child shares the trauma narrative with parents and other family issues are addressed); *Enhancing future safety and development* (addressing safety concerns related to prevention of future trauma, return to normal developmental trajectory). Different forms of trauma-focused CBT interventions use varying combinations and dosages of these PRACTICE components, depending on their target populations and types of trauma.

The most widely used and best researched manual based CBT protocol for PTSD is Trauma-Focused CBT (“TF-CBT”) (Cohen et al., 2006; Deblinger and Heflin, 1996). TF-CBT has been designated “supported and efficacious” based on standards of empirical support (Saunders et al., 2004). TF-CBT was designed for children with PTSD as well depression, anxiety and other trauma-related difficulties such as shame and self-blame. TF-CBT is typically delivered individually to children and their non-perpetrator parents although it has also been

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1 provided in group formats. TF-CBT has been tested in several randomized controlled trials
2 involving more than 500 children and showed clinically significant improvement compared to
3 usual community treatment (Deblinger et al., 1996 [rct]), non-directive supportive therapy
4 (Cohen and Mannarino, 1996 [rct], 1998 [rct]), child centered therapy (Cohen et al., 2004 [rct]),
5 and wait list control (King et al., 2000 [rct]) conditions for children between the ages of 3 and 17
6 years old. Treatment gains were maintained at one year follow-up in several of these studies
7 (Cohen and Mannarino, 1997; Cohen et al., 2005; Deblinger et al., 1999, 2006). TF-CBT has
8 been adapted for Hispanic youth (DeArellano, et al., 2005) and Native American families
9 (Bigfoot, 2003). TF-CBT was provided in Spanish and English following the terrorist attacks of
10 September 11, 2001 and superior to treatment as usual in producing reliable decrease in PTSD
11 symptoms (Hoagwood et al., 2006 [ct]). TF-CBT has also been adapted for Childhood Traumatic
12 Grief (CTG), an emerging condition in which children lose loved ones in traumatic
13 circumstances. Two trials of this adapted treatment model have shown significant improvement
14 in PTSD and CTG symptoms (Cohen et al., 2004 [ut], 2006 [ut]).

15 The best researched group CBT protocol for childhood PTSD is Cognitive Behavior
16 Interventions for Trauma in Schools (CBITS). CBITS includes all of the PRACTICE
17 components described above, with the exception of the parental component, which is limited and
18 optional in the CBITS model. CBITS additionally provides a teacher component to educate
19 teachers about the potential impact of trauma on students' classroom behavior and learning.
20 CBITS is provided in a group format in the school setting (i.e., group therapy sessions are held in
21 school, but not within children's regular classroom periods). The trauma narrative component is
22 typically conducted during individual "breakout" sessions during which each child meets one on
23 one with their usual group therapist. CBITS has been tested in two studies of children exposed to
24 community violence. Stein et al. (2003 [rct]) documented that CBITS was superior to a wait list
25 condition in improving PTSD and depression. Kataoka et al. (2003 [ct]) also found that children
26 assigned to CBITS improved more than children assigned to a wait list control; this study cohort
27 consisted of immigrant Latino children.

28 Seeking Safety (Najavits, 2002) is a manualized individual or group CBT protocol for
29 PTSD and comorbid substance use disorders which includes sequential interventions for
30 affective modulation, substance abuse risk reduction and trauma-specific cognitive processing.

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1 Seeking Safety was superior to treatment as usual in a small randomized controlled pilot group
2 study for adolescent girls with PTSD and substance abuse disorder (Najavits et al., 2006 [rct]).

3 Several other manualized CBT protocols for child and adolescent PTSD are currently
4 being used and/or evaluated. The UCLA Trauma/Grief Program for Adolescents is an individual
5 or group CBT-based model that aims to alleviate PTSD, traumatic grief and associated
6 symptoms. It was found to improve PTSD, traumatic grief and depressive symptoms in a study
7 of Bosnian adolescents (Layne et al., 2001 [ct]). In a second study using this model, adolescents
8 exposed to community violence experienced improvement in PTSD symptoms (Saltzman et al.,
9 2001 [ut]). This model was also found to be effective for reducing children’s PTSD symptoms
10 related to terrorism (Hoagwood et al., 2006 [ct]). Individual child trauma-focused CBT has
11 shown superiority over a wait list control condition in decreasing PTSD symptoms following
12 single episode traumas (Smith et al., in press [rct]). A cognitive-and family-therapy based
13 treatment model, Surviving Cancer Competently Intervention Program (SCCIP) which is
14 provided in four group and family sessions over a single day, was superior to wait list control
15 condition in improving hyperarousal symptoms in adolescent cancer survivors (Kazak et al, 2004
16 [rct]).

17

18 PSYCHODYNAMIC TRAUMA-FOCUSED PSYCHOTHERAPIES

19 Psychodynamic trauma-focused psychotherapies aim to promote personality coherence
20 and healthy development as well as the resolution of traumatic symptom resolution (Lieberman
21 et al., in press). In younger children, these treatments have focused on the parent-child
22 relationship in order to address traumatic situations in which the parent (typically the mother)
23 was either the victim of the trauma (for example, domestic violence) or was so personally
24 traumatized or emotionally compromised by the experience that she was unable to sustain the
25 child’s development. For older children psychodynamic trauma-focused therapies provide an
26 opportunity to mobilize more mature cognitive capacities, objectify and explain symptoms,
27 identify trauma reminders, identify environmental factors which may complicate recovery—
28 especially interactions which heighten regressive experience, and make more explicit ways in
29 which overwhelming fear and helplessness of the traumatic situation run counter to age-
30 appropriate strivings for agency, competence and self-efficacy. The relatively unstructured

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1 nature of the sessions may contribute to adolescents regaining more internal locus of control
2 which was lost during exposure to uncontrollable traumatic events (Lieberman et al., in press).

3 Child-Parent Psychotherapy is a relationship-based treatment model for young children
4 (aged infants to 7 years) who have experienced family trauma such as domestic violence
5 (Lieberman and Van Horn, 2005). It includes the following components: modeling appropriate
6 protective behavior; assisting the parent in accurately interpreting the child's feelings and
7 actions, providing emotional support to the child and parent, providing empathic communication,
8 crisis intervention and concrete assistance with problems of living; developing a joint parent-
9 child narrative about the family trauma and correcting cognitive distortions in this regard; and
10 interventions for addressing traumatic grief. As is clear from this description, this treatment
11 model is not easily characterized as one specific type of therapy; rather it includes elements of
12 psychodynamic, cognitive behavioral, social learning and attachment treatments.

13 Child Parent Psychotherapy (CPP) is provided in conjoint parent-child treatment
14 sessions. CPP has been tested in one randomized controlled trial for 3-5 year old children
15 exposed to marital violence and shown to be superior to case management plus individual
16 psychotherapy in improving child PTSD and behavior problems (Lieberman et al., 2005 [rct]).
17 Improvement in behavior problems was maintained at 6 month follow-up; child PTSD symptoms
18 were not assessed at follow-up due to financial constraints (Lieberman et al., 2006 [rct]). CPP
19 has been adapted for young children with traumatic grief (Lieberman et al., 2003) and is
20 currently being tested in an open study for this population.

21 Trowell et al. (2002 [rct]) found that individual psychoanalytic psychotherapy which
22 addressed sexual abuse related issues was superior to group psychoeducation in decreasing
23 PTSD symptoms among sexually abused children and adolescents. Although the total number of
24 hours spent in treatment between the two conditions was equivalent (psychoeducation groups
25 lasted 1.5 hours whereas individual psychotherapy sessions lasted 1 hour), the authors did not
26 state whether duration of treatment was equivalent across the two conditions (the mean number
27 of individual psychoanalytic sessions was 30 and the mean number of psychoeducation sessions
28 was 18.)

29

30 **Recommendation 7. SSRI's can be considered for the treatment of youth with PTSD**
31 **[OP].**

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1 SSRIs are approved for use in adult PTSD and are the only medications shown to
2 effectively decrease symptoms in all three adult PTSD clusters (Brady et al., 2000; Davidson et
3 al., 1996; van der Kolk et al., 1994). No randomized clinical trials have been published
4 documenting the efficacy of medication for treating PTSD in children. Only one small
5 randomized trial has evaluated the efficacy of SSRI medication for treating PTSD in children and
6 adolescents, and this study assessed an SSRI in combination with psychotherapy (Cohen et al., in
7 press).

8 There are important differences between adults and children with regard to the
9 physiology and manifestations of PTSD (Cohen, 2001) that may have ramifications for the
10 efficacy and use of medications in this age group. The history of antidepressant use in children
11 (Birmaher et al., 1996) provides an illustration of why child clinicians should be cautious about
12 basing treatment decisions on the adult literature, and why more medication trials are needed for
13 children with PTSD. A recent acute PTSD treatment study involving over 6000 participants
14 illustrated that those who agreed to take medication had significantly worse PTSD symptoms
15 than those who agreed to receive psychotherapy (Shalev et al., 2006).

16 There is some evidence to directly suggest that SSRIs may be beneficial in reducing
17 PTSD symptoms. Seedat et al. (2002 [ut]) compared the rate of improvement in 24 child and
18 adolescent subjects to 14 adult subjects provided with 20-40 mg/day of citalopram and
19 demonstrated equivalent improvements between groups. A Turkish open trial of fluoxetine
20 showed effectiveness in improving earthquake-related PTSD symptoms among 26 participants
21 ages 7-17 years old (Yorbik et al, 2001). Another small study attempted to evaluate the benefit of
22 adding an SSRI to trauma-focused CBT (TF-CBT) by comparing TF-CBT + sertraline to TF-
23 CBT+ placebo in 24 10-17 year olds with sexual abuse-related PTSD symptoms (Cohen et al., in
24 press [rct]). Although all children significantly improved, no group X time differences were
25 found except on Children's Global Assessment Scale scores. This study concluded that although
26 starting treatment with combined sertraline and TF-CBT might be beneficial for some children, it
27 was generally preferable to begin with TF-CBT alone, and add an SSRI only if the child's
28 symptom severity or lack of response suggested a need for additional interventions.

29 Children with comorbid MDD, GAD, OCD or other disorders known to respond to an
30 SSRI may benefit from the addition of an SSRI earlier in treatment. Interestingly more than 60%
31 of the participants in the RCT described above (Cohen et al., in press) had comorbid MDD yet

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1 the results did not indicate a clear benefit of adding sertraline to TF-CBT with regard to
2 improvement in PTSD or depression scores.

3 Recent findings suggest that some risks may be associated with SSRI medications
4 (Hammad, 2004; Mitka, 2003). Additionally, SSRIs may be overly activating in some children,
5 and lead to irritability, poor sleep or inattention; since these are symptoms of PTSD
6 hyperarousal, SSRIs may not be optimal medications for these children. In these situations
7 alternative psychotropic medication options may need to be considered. On the basis of the
8 above information, there are insufficient data to support the use of SSRI medication alone (i.e.,
9 in the absence of psychotherapy) for the treatment of childhood PTSD.

10

11 **Recommendation 8. Medications other than SSRIs may be considered for youth with**
12 **PTSD [OP].**

13 Algorithms and guidelines for treatment of adults with PTSD suggest the following:
14 SSRIs can be recommended for the treatment of adult PTSD as a medication monotherapy;
15 antiadrenergic agents such as clonidine and propranolol may be useful in decreasing
16 hyperarousal and reexperiencing symptoms; anticonvulsants may show promise for treating
17 PTSD symptoms other than avoidance; and benzodiazepines have not been found to be
18 beneficial in treating PTSD-specific symptoms (Alarcon et al., 2000; Friedman et al., 2000).

19 Some evidence from open clinical trials suggests that medications other than SSRIs may
20 be helpful for youth with PTSD symptoms. These include alpha- and beta-adrenergic blocking
21 agents, novel antipsychotic agents, non-SSRI antidepressants, mood stabilizing agents and
22 opiates. Robert et al. (1999 [rct]) randomly assigned hospitalized children with ASD secondary
23 to burns to receive either imipramine or chloral hydrate. This study demonstrated that at 6
24 months, children receiving imipramine were significantly less likely to have developed PTSD
25 than those receiving chloral hydrate. However, due to concern about rare but serious cardiac side
26 effects, tricyclic antidepressants are not recommended as a first line preventive intervention for
27 PTSD in children. Saxe et al. (2001 [ut]) conducted a naturalistic study of the relationship
28 between morphine dosage and subsequent development of PTSD in acutely burned hospitalized
29 children and found that controlling for subjective experience of pain, there was a significant
30 linear association between mean morphine dosage (mg/kg/day) and 6 month reduction in PTSD
31 symptoms.

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1 There is some evidence of increased dopamine presence in children and adults with
2 PTSD (DeBellis et al., 1999), which is believed to contribute to the persistent and
3 overgeneralized fear characteristic of PTSD. Dopamine blocking agents such as neuroleptics
4 may therefore decrease some PTSD symptoms. One open study of risperidone resulted in 13 out
5 of 18 boys experiencing remission from severe PTSD symptoms (Horrigan and Barnhill, 1999
6 [ut]). These children had high rates of comorbid symptoms which could be expected to respond
7 positively to risperidone; for example, 85% had coexisting ADHD and 35% had bipolar disorder.

8 There is also evidence of increased adrenergic tone and responsiveness in children with
9 PTSD (DeBellis et al., 1999). Both alpha and beta adrenergic blocking agents have been used
10 with some success in children with PTSD symptoms. Clonidine has been found in two open
11 studies to decrease basal heart rate, anxiety, impulsivity and PTSD hyperarousal symptoms in
12 children with PTSD (Harmon and Riggs, 1996 [ut]; Perry, 1994 [ut]). In a case study, clonidine
13 treatment resulted in improved sleep and increased neural integrity of the anterior cingulate
14 (DeBellis et al. 2001 [cs]). Propranolol was found in an open study to decrease reexperiencing
15 and hyperarousal symptoms in children with PTSD symptoms (Famularo et al., 1988 [ut]).

16 The hypothalamic-pituitary-adrenal (HPA) axis is also dysregulated in children with
17 PTSD, in ways that are complex. This suggests a potential mechanism for future
18 pharmacological intervention, for example through the use of corticotrophin release factor (CRF)
19 antagonists (Friedman et al., 2000, p 97). However no trials of these medications have been
20 conducted in children to date.

21 22 **Recommendation 9. *Treatment planning may consider school-based accommodations* [CG].**

23 As noted above children with significant PTSD symptoms may have impaired academic
24 functioning. This is often due to hypervigilance to real or perceived threats in the environment,
25 and may be a particular issue if trauma reminders are present in the school setting. One example
26 of a school-based trauma reminder would be if sexual assault or bullying occurred at school,
27 particularly if the perpetrator still attended the same school. Another example of a school-based
28 trauma reminder is demonstrated by a school in New Orleans which overlooks a levee which was
29 breached and houses which were destroyed by the flooding following Hurricane Katrina.
30 Children attending this school are faced with unavoidable daily reminders of the original trauma.

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1 Although every reasonable effort should be made to assist children in overcoming
2 avoidance of *innocuous* trauma reminders (that is, people, places or situations that are inherently
3 innocuous or safe, which only seem frightening to the child because of generalized fear),
4 children should also be protected from *realistic* ongoing threats or danger whenever possible.
5 Children who are experiencing significant functional impairment related to trauma reminders
6 may benefit from school accommodations up to and including placement at an alternative school
7 where reminders are not present. This is especially true if safety is an issue, for example, if the
8 perpetrator(s) of interpersonal violence and/or their peers are harassing the victimized child on
9 an ongoing basis.

10
11 **Recommendation 10.** *The use of restrictive “rebirthing” therapies and other*
12 *techniques which bind, restrict, withhold food or water or are otherwise coercive, are not*
13 *endorsed [NE].*

14 Restrictive “rebirthing” or “holding” therapies that forcibly bind, restrict, withhold food
15 or water or are otherwise coercive have been used for children who have experienced severe
16 early childhood trauma or losses. Often these children have been diagnosed with a more severe
17 disorder, Reactive Attachment Disorder, rather than PTSD. There is no empirical evidence to
18 support the efficacy of these treatments, and in some cases these interventions have led to severe
19 injury or death (AACAP, 2005). These interventions are therefore not endorsed.

20 21 PREVENTION AND EARLY SCREENING

22 **Recommendation 11.** *School- or other community-based screening for PTSD*
23 *symptoms and risk factors should be conducted following traumatic events which affect*
24 *significant numbers of children [CG].*

25 Following community-level events which have the potential to traumatize large numbers
26 of children, conducting screening for PTSD in schools or other settings where children
27 commonly gather is important for secondary prevention and early identification. Typically such
28 screening efforts do not occur in the immediate aftermath (i.e., first four weeks) following a
29 community level trauma for a variety of factors including that usual services are often disrupted
30 following such events; adults (including teachers and school administrators) have also been
31 displaced, bereaved and/or traumatized; and schools are usually not proactively prepared for

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1 such screening efforts (Cohen, 2004). Thus, it is usually not too soon to screen for PTSD
2 symptoms in these circumstances. Models exist for successful universal school-based screening
3 following community level disasters (Pfefferbaum et al, 1999) and for providing school-based
4 treatment (Chemtob et al, 2002). Because symptoms may not develop immediately and PTSD is
5 not the only disorder that children develop after trauma exposure it makes sense to also screen
6 children for known risk factors for developing later mental health difficulties and to provide
7 follow-up for children at greatest risk for developing negative mental health sequelae.

8 Group interventions in school or other community settings can provide effective early
9 treatment for children with PTSD symptoms. Adaptation of protocol-based CBT interventions to
10 fit diverse populations and take into account the limitations of community resources, including
11 those of inner-city minority youth can make evidence-supported treatments feasible. This was
12 accomplished after the September 11th terrorist attacks through Project Liberty. TF-CBT was
13 provided to over 500 mostly multiply traumatized children from highly diverse ethnic
14 backgrounds, provided in English and Spanish in a variety of community, school, university-
15 affiliated settings in group, family and individual formats. Results indicated that this approach
16 was effective in improving children’s PTSD symptoms, and that clinicians were able to use
17 evidence supported treatments with fidelity. Programs that foster resiliency in youth are being
18 tested internationally to proactively “immunize” children against the potentially adverse affects
19 of traumatic events (Macy et al., 1999).

20

21 **PARAMETER LIMITATIONS**

22 AACAP practice parameters are developed to assist clinicians in psychiatric decision-
23 making. These parameters are not intended to define the standard of care; nor should they be
24 deemed inclusive of all proper methods of care or exclusive of other methods of care directed at
25 obtaining the desired results. The ultimate judgment regarding the care of a particular patient
26 must be made by the clinician in light of all the circumstances presented by the patient and
27 his/her family, the diagnostic and treatment options available, and available resources.

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Abbreviated UCLA PTSD Reaction Index for DSM IV

1.	I get upset, afraid or sad when something makes me think about what happened.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4
2.	I have upsetting thoughts or pictures of what happened come into my mind when I do not want them to.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4
3.	I feel grouchy, or I am easily angered.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4
4.	I try not to talk about, think about, or have feelings about what happened.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4
5.	I have trouble going to sleep, or wake up often during the night.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4
6.	I have trouble concentrating or paying attention.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4
7.	I try to stay away from people, places, or things that make me remember what happened.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4
8.	I have bad dreams, including dreams about what happened.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4
9.	I feel alone inside and not close to other people.	None <input type="checkbox"/> 0	Little <input type="checkbox"/> 1	Some <input type="checkbox"/> 2	Much <input type="checkbox"/> 3	Most <input type="checkbox"/> 4

Practice Parameter Member Comment Form

**PRACTICE PARAMETER FOR THE ASSESSMENT AND TREATMENT OF
CHILDREN AND ADOLESCENTS WITH POSTTRAUMATIC STRESS DISORDER**

*Please write your comments below, noting a specific page and line if appropriate. Please focus your feedback on content rather than editorial issues; the parameter will be professionally edited prior to approval. All comments are reviewed and discussed by the authors and the Work Group on Quality Issues. Please fax your comments to 202-966-9518 or email jmedicus@aacap.org **by January 25, 2008**.*

Name: _____ Date: _____ Email: _____