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Posttraumatic Stress Disorder in Youth

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DESCRIPTION OF POSTTRAUMATIC STRESS DISORDER

Posttraumatic stress disorder (PTSD) is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychological Association [APA], 2013) as a disorder that can occur following exposure to actual or threatened death, serious injury, or sexual violence (Criterion A) that is characterized by the presence of intrusion symptoms related to the traumatic event (Criterion B). In youth, these intrusion symptoms often manifest as repetitive play, frightening dreams without recognizable content, and trauma-specific re-enactment during play. Youth who have PTSD may also experience persistent avoidance of stimuli associated with the trauma (Criterion C), negative alterations in cognitions and moods (Criterion D), and hyperarousal and reactivity, often with little or no provocation (Criterion E). There are some minor differences in the diagnostic criteria for children younger than six years of age (e.g., fewer symptoms needed for diagnosis), and all symptoms must be considered in the context of the individual's developmental stage and in light of pre-trauma functioning.

Although information specific to PTSD prevalence rates in children is limited, some research suggests that 5% of adolescents have met the criteria for PTSD at one point in their lives, and that prevalence rates are higher for girls (8%) than for boys (2%; Kessler et al., 2012). Not every young person exposed to a traumatic event/s goes on to develop PTSD, and factors which occur before, during, and after the trauma may play a role in insulating—or exacerbating—the development of PTSD. Risk factors for developing PTSD include pre-trauma factors such as temperament, environment, genetics, and physiology. Symptom severity in young people may be especially connected to trauma perpetrated by caregivers, exposure to threat of harm to caregivers, the use of force of violence, and the repeated exposure to the traumatic experience (e.g., ongoing sexual abuse). Lastly, posttraumatic factors relate to the individual's temperament and the presence of a supportive environment may impact how a young person experiences a traumatic event (APA, 2013).

Resources:
Posttraumatic Stress Disorder:
http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/index.shtml

Posttraumatic Stress Disorder in Children: http://www.stanfordchildrens.org/en/topic/default?id=post-traumatic-stress-disorder-in-children-90-P02579

PTSD in Youth: http://www.ptsd.va.gov/public/family/ptsd-children-adolescents.asp

IDENTIFICATION/ASSESSMENT STRATEGIES

PTSD can be difficult to diagnose in youth for several reasons: many symptoms are highly internalized, children may not have the self-awareness or vocabulary to express themselves, and symptoms manifest differently depending on the individual's developmental stage (Scheeringa, 2011). Accordingly, clinicians

may fail to recognize and diagnose PTSD, resulting in an underreported prevalence in youth. We recommend combining reports from children, parents and/or guardians, and important others with formal assessments to obtain the most clear picture of young peoples' functioning. A number of formal assessments can aid counselors in assessing for history of exposure to trauma and the impact of trauma using symptoms and distress indices (Strand, Pasquale, & Sarmiento, 2003).

Comprehensive assessment of PTSD symptoms can be facilitated using the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA; Pynoos, et al., 2015), which asks the young person to respond to 33 items describing PTSD symptoms (e.g., recurrent distressing dreams). The CAPS-CA is an especially useful assessment as it allows clinicians to follow up on responses using open-ended questions (e.g., "How long have you been having these dreams?"; Nader et al., 1996). Another useful assessment is the Child PTSD Symptom Scale (CPSS), which instructs children to write down the most distressing event that they recall, indicate how much time has passed since it happened, and respond to a 22-item assessment by rating symptoms based on how often they occur (e.g., never, once in a while, half the time, or almost always). The National Center for PTSD produces another useful assessment, the Traumatic Events Screening Inventory (TESI) which screens for general trauma and associated issues in functioning based on exposure to 16 potential traumatic experiences (e.g., being in an accident, witnessing an accident, hospitalization, lengthy separation from primary caregivers). The TESI comes in forms for children and parents and is available to be downloaded for free online.

Resources:
Child and Adolescent Trauma Measures: A Review: http://www.ncswtraumaed.org/wp-content/uploads/2011/07/Child-and-Adolescent-Trauma-Measures_A-Review-with-Measures.pdf

Child Measures of Trauma and PTSD: http://www.ptsd.va.gov/PTSD/professional/assessment/child/index.asp

Child PTSD Symptom Scale (CPSS): https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/misc/child_ptsd_symptom_scale.pdf

Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA): http://www.ptsd.va.gov/professional/assessment/child/caps-ca.asp

Traumatic Events Screening Inventory (TESI): http://www.ptsd.va.gov/professional/assessment/child/tesi.asp

INTERVENTION STRATEGIES

There is no one single treatment that has been identified for use with all young people; each young person needs to be considered individually. Although the National Child Traumatic Stress Network has identified over 40 treatments with some degree of evidentiary support for the symptoms of trauma, it is apparent that the best approaches to treating trauma with children and adolescents are those that: (a) provide education about trauma responses, (b) engage non-offending family members or other collaterals, (c) promote use of community resources, and (d) target recovery from traumatic response through the development of coping skills and attitudes.

Trauma-Focused Cognitive Behavior Therapy

Trauma-focused cognitive behavior therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) is a components-based approach to treating traumatic response symptoms that has demonstrated notable usefulness across age groups and types of trauma (Lenz & Hollenbaugh, 2014). TF-CBT applications are

typically between 12 and 16 sessions, include working with both the child/adolescent and a caregiver, and feature a core set of skills training and cognitive processing modules that attend to: (a) psychoeducation and parent training, (b) relaxation training, (c) affective modulation and expression, (d) cognitive coping and processing of traumatic memories, (e) developing a trauma narrative, (f) activities that promote in vivo mastery of trauma reminders, (g) conjoint teen-parent sessions, and (h) developing strategies to enhance future safety. During the TF-CBT treatment process, counselors will provide psychoeducation about their type of trauma, develop coping skills, engage in gradual and in vivo exposures, correct misappraisals about trauma-causing events, and disassociate affective responses to traumatic memories through constructing a formal trauma narrative. Children who complete TF-CBT programming achieve recovery from PTSD symptoms through a greater understanding of the type of trauma they experienced, increased parent support, learning a practical set of coping skills, processing traumatic events as one piece of their life, not their whole life, and a sense of efficacy for enhancing future safety.

Trauma Systems Therapy

Trauma systems therapy (TST; Saxe, Ellis, & Kaplow, 2007) is an integrative case management and counseling strategy intended to increase emotional regulation of trauma response systems across age groups that is culturally responsive. TST interventions are informed by a systematic assessment of a client's social environmental stability, identification of phase of intervention within TST modules (surviving, stabilizing, enduring, understanding, and thriving), and implementation of TST modules (stabilization, services advocacy, emotion regulation, cognitive processing, meaning making, psychopharmacology). Children and families who complete TST programs with fidelity can expect to make meaningful changes to their social and environmental system, increase degree of engagement with their socio-environmental system, and develop a coping skills repertoire that includes grounding, impulse control, and problem solving capacity.

Child-Parent Psychotherapy

Child-parent psychotherapy (CPP; Lieberman & Van Horn, 2008) is a multi-theoretical approach to treating young children -up to age five years of age- that promotes recovery from traumatic response by improving the relational connection between children and their primary caregiver. CPP practitioners primarily use play as their mode of intervention and rather than engaging directly, counselors instead encourage, guide, support, explain, and direct play between the child and the parent. CPP is postulated to mediate positive change through fostering familiarity, confidence, mutuality, pleasure, and emotional reciprocity within the child-caregiver dyad that is healing and protective in nature.

Integrating Play into Therapies

Given that children naturally engage in play as a means for creative expression and personal exploration of interpersonal dynamics, counselors should consider the degree that integrating play into the treatment of trauma symptoms is a prudent activity. If not used as a primary or adjunct strategy for promoting development and recovery, play-based activities may be helpful during the initial phases of establishing rapport and developing a working alliance, as a way to facilitate engagement, and support assessment of relational dynamics and intrapersonal experiences. Particular modalities of interest that have at least a modest degree of empirical support include child-centered play therapy, Adlerian play therapy, and theraplay-based approaches.

Resources:
National Child Traumatic Stress Network: Treatments that work: http://www.nctsn.org/resources/audiences/parents-caregivers/treatments-that-work

Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project: http://www.nctsn.org/sites/default/files/assets/pdfs/CCG_Book.pdf

International Association for Play Therapy: http://www.a4pt.org/

Trauma-Focused Cognitive Behavior Therapy: Educational development, resource for clinicians, and review of research findings: http://tfcbt.musc.edu/

Trauma Systems Therapy: http://www.nctsnet.org/sites/default/files/assets/pdfs/tst_general.pdf

Child Parent Psychotherapy: http://www.nctsn.org/sites/default/files/assets/pdfs/cpp_general.pdf

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