Summary of the Management of Posttraumatic Stress Disorder In Children and Adolescents

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In children and adolescents posttraumatic stress disorder (PTSD) is associated with significant morbidity including an increased risk for suicide attempts (Jacobson et al. 2008), an increased risk of co-occurring depression, substance use disorders, internalizing and externalizing disorders (Donnelly et al, 1999). Recently, there have been significant advances in our understanding of the pathophysiology of PTSD in the pediatric population and concomitantly, efforts have been made to develop effective diagnostic instruments for pediatric youth with PTSD. Paralleling these advances in our diagnostic and neurobiologic understanding of PTSD in children and adolescents, accumulating evidence suggests that a number of psychotherapeutic and psychopharmacologic interventions may be of benefit. Herein, the extant evidence for these strategies will be reviewed.

Psychotherapeutic Treatments

At present, the most empirically supported psychotherapeutic intervention for youth with PTSD is trauma-focused cognitive behavioral therapy (TF-CBT), a structured, 12-16 week, individual treatment which includes: (1) psychoeducation; (2) stress reduction techniques; (3) involvement of parents and caregivers; (4) development of a trauma narrative and (5) mastery of the trauma. Additionally, there is evidence from randomized controlled trials which suggest benefit for Child Centered Therapy (Cohen et al, 2004), Nondirective Supportive Therapy (Cohen et al. 2005) and eye movement desensitization therapy (EMIDE).

Psychopharmacologic Treatments

Selective Serotonin Reuptake Inhibitors (SSRIS)

SSRIs in pediatric patients with PTSD have generally failed, in randomized controlled trials, to separate from placebo. In the first randomized controlled trial of an SSRI in youth with PTSD, Cohen and colleagues compared adjunctive sertraline (mean dose 150 mg/day, range 50-200 mg/day) to placebo in patients receiving TF-CBT (Cohen et al, 2007). In this study, no statistically significant differences were observed in the Child Global Assessment Scale scores between the two groups (Cohen et al, 2007), nor were there any differences which were detected between placebo-treated and sertralinetreated patients with regard to intrusive, hyperarousal or avoidance symptoms. However, the study was under-powered to detect such differences and importantly, both patient groups were receiving an active treatment (TF-CBT) which likely made the detection of any sertraline-related improvement especially difficult. Similarly, Robb and colleagues (2010) evaluated sertraline monotherapy in children with PTSD (n=131, duration 10 weeks) and did not observe differences in the UCLA PTSD-I 17-item total score between sertraline-treated patients and those receiving placebo (Robb et al, 2010). Despite these two negative double-blind, placebo-controlled trials of SSRIs in youth with PTSD, some open-label trials suggest benefit. Seedat and colleagues evaluated flexibly dosed citalogram (20-40 mg/day, duration 8 weeks) and observed improvements in Clinician-Administered PTSD Scale (CAPS) total and symptom cluster scores as well as the Clinical Global

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