Opinion

Posttraumatic stress disorder treatment in children and adolescents

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ABSTRACT

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines traumatic occurrences as including "actual or impending death or significant harm, or a danger to the bodily integrity of self or others," and the person's reaction at the time involves "fear, helplessness, or terror" (or disorganized or agitated behavior in children). The second component of the definition is intended to be omitted in the DSM-V since it has limited value for adults or children. Recent epidemiological research in the United States has demonstrated that teenagers are frequently exposed to a variety of traumatic experiences classified in this manner. The population incidence of Post Traumatic Stress Disorder (PTSD) is, nevertheless, modest, at around 5%.

Key Words: *PTSD, DSM- IV*

INTRODUCTION

According to the Great Smokey Mountain Study, Following stressful events, the conditional chance of acquiring subclinical PTSD was around 3%. The relative rarity of PTSD in children compared to adults is most likely owing to the DSM-IV diagnostic' developmental insensitivity. Subsyndromal PTSD has long been associated with severe distress and functional impairment in children, according to a new analysis, and the best criteria for PTSD in children may require fewer symptoms than indicated in the DSM-IV.

This is particularly true for early preschoolers. Nonetheless, it is now apparent that the majority of traumatized young individuals do not acquire persistent PTSD. A recent study has looked into characteristics that may differentiate the minority of trauma-exposed young individuals who develop chronic PTSD from the majority who are resilient. The identification of potentially adjustable sustaining variables can help guide the development of successful therapies. Trickey's latest meta-analysis of risk variables adds some clarity to a growing body of evidence. Sixty-four PTSD studies including 32, 238 young individuals (6-18 years old) were included, and 25 risk variables were investigated. In general, and consistent with prior meta-analyses of risk variables in adults, per traumatic and posttraumatic characteristics were shown to have bigger impact sizes on persistent PTSD than trauma demographic factors and exposure severity.

In particular, demographic characteristics like age, gender, and ethnicity had minor impacts, but traumatic factors like dread and the feeling of a life danger during the incident had considerable effects. A variety of post-trauma components, including cognitive factors (thought suppression, blaming others, diversion), and social and familial factors, demonstrated significant to medium impact sizes.

Trauma-Focused Cognitive Behavior Therapy (TF-CBT) is the best empirically supported treatment for childhood PTSD since it is based on well-state dated and empirically validated ideas. Recent practice criteria from the United States are consistent with previous UK guidelines: both support TF-CBT as first-line therapy for young individuals suffering from PTSD. These suggestions have been backed by recent treatment outcome studies.

Until now, the bulk of RCTs assessing psychological therapy for children with PTSD has been conducted in academic institutions. There is also a modest but rising body of evidence that TF-CBT can be successful when provided in schools by education professionals or by community-based physicians to patients referred through regular therapeutic procedures. In the aftermath of Hurricane Katrina, for example, evaluated over 700 kids and identified 195 with heightened PTSD symptoms. These youngsters were then encouraged to either engage in a school-based group CBT program or to undergo TF-CBT at a nearby mental health facility. Both therapies were helpful in lowering PTSD symptoms, with TF-CBT having somewhat greater results.

However, some care is in order. We created a multiphase program to find therapists in community clinics who were interested in (but not currently employing) evidence-based therapy techniques for adolescents who had been abused repeatedly. Therapists were trained in two evidence-based PTSD therapies, and local monitoring groups were formed. The authors describe not just the high level of participation in the training program but also the challenges in convincing community practitioners to collect routine clinical outcome data. Adolescents (N = 79, aged 8-18 years) who had been exposed to various traumas underwent either individual TF-CBT or a group-based CBT method in a subsequent uncontrolled pilot assessment phase of the program. Youth in both treatment conditions reported decreases in PTSD, anxiety, and depression symptoms; however, these reductions were not significant.

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The phrase complex PTSD refers to the possible consequences of many, recurrent, or extended traumatic incidents. The phenomenology of complicated PTSD in adults is controversial. According to some scholars, the notion is not helpful and has little empirical backing as a separate entity. Others point out that emotional dysregulation, in addition to PTSD symptoms, is a differentiating trait. There have been relatively few empirical investigations on young persons with complicated PTSD. We meet teenagers in our clinic who were subjected to repeated traumas as youngsters. Typically, trauma histories entail recurrent seeing or experiencing abuse and interpersonal violence at home. These young people may have extremely evident, severe, persistent PTSD symptoms as well as significant mood instability.

Mood swings can be transient and appear to be prompted by interpersonal issues or sensitivities. Young people who appear in this manner might pose diagnostic issues and are sent to trauma services, depression programs, or services for young people with developing unstable personality disorders. We discovered that trauma-focused interventions can help young people who are experiencing such issues. Treatment components targeted at strengthening emotional stability are required prior to participating in trauma-focused work. Arousal reduction (relaxation training), functional analysis of triggers and reactions to mood shifts (chain analysis), and coping skills teaching of adaptive responses to triggers and mood shifts, including behavioral activation techniques, may all be included. Additional coping skills training for trauma-specific symptoms, such as image manipulation methods, may also be beneficial Multiple variations of TF-CBT have been demonstrated to be extremely successful for young individuals who acquire PTSD as a result of a single traumatic event: remission rates of about 90% have now been reported in several well-designed trials. Three recent experiments have demonstrated the value of both exposure and cognitive methods in therapy. In our clinical experience, the precise combination of these two core components is well tolerated and useful by young patients. Recent studies were small in scale, and larger-scale reviews with wide inclusion criteria are now required. Nonetheless, based on current research, doctors may confidently prescribe TF-CBT for young patients with PTSD. Recent findings on the efficacy of modified TF-CBT for PTSD in preschool children are very promising, but replication and expansion are now required. More effort is also needed to establish early intervention techniques; existing research shows that adopting screen-and-intervene approaches rather than universal single-session debriefing will be beneficial. School-based TF-CBT delivery may enhance adoption and accessibility, but further research is needed to establish that protocols are successful in these contexts. When applied to adults, complex PTSD is a disputed concept, and research on children is still sparse.