Trauma and Related Disorder Guidelines for PCPs

Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood. These adverse experiences are linked to poor outcomes in children. Children who experience 4 or more ACEs are:

- 10-12x greater risk of intravenous drug use and attempted suicide.
- 2-3 times greater risk for developing heart disease and cancer.
- **32x more likely to have learning and behavioral problems.**

For more information about ACEs click HERE to visit the CDC website and recommendations.

If there are concerns that a patient has or is being exposed to traumatic events, click HERE to use the CATS as a screening tool.

- CATs less than 15 = not clinical elevated
- CATs 15-20 = Moderate trauma related stress
- CATS 7-17 - probably PTSD

*Remember to always assess for safety. If there is suspected abuse or neglect DO NOT investigate but DO report. If there is imminent danger to self or others refer to the ED for an emergency assessment.

Post-Traumatic Stress Disorder (PTSD):

Disturbances/symptoms lasting longer than one month. Includes exposure to actual or threatened death, serious injury, or sexual violence, and is associated with negative mood, dissociative symptoms, and avoidance/arousal symptoms.

*Clinical Pearl: PTSD or childhood trauma can often present like ADHD with hyperarousal, distractibility, and inattention. Typically, when these symptoms stem from trauma they are more dependent on environmental cues and less continuous symptoms when compared with ADHD.

PTSD and trauma treatment:

First-line treatment includes trauma focused CBT.

Other considerations include:

- Child-Parent Psychotherapy (CPP) – ages 0-5
- Parent-Child Interaction Therapy (PCIT), ages 2-7

- Attachment Regulation and Competency (ARC) – ages 2-21
- Eye movement desensitization and reprocessing (EMDR)

NOTE: Psychological debriefing has not been shown to be beneficial and may worsen symptoms.

If therapy fails or there are severe symptoms consider medications.

For hyper arousal symptoms: clonidine, guanfacine

Nightmares: prazosin Do not mix prazosin (alpha 1 antagonist) with guanfacine or clonidine (alpha 2 agonists); the combination may cause hypotension.

Depression and anxiety: SSRIs: citalopram, fluvoxamine, fluoxetine, sertraline

Aggression, self-injurious, dissociative symptoms, pseudopsychotic symptoms - may consider antipsychotic medications include aripiprazole or risperidone.

NOTE: Benzodiazepines can impede processing of trauma and delay improvement. They can also cause significant disinhibition in children and adolescents.

Differential Diagnosis

Adjustment disorder:

- Symptoms occurring within 3 months onset of stressor. Development of emotional or behavioral symptoms in response to identifiable stressor. Symptoms include a marked distress out of proportion to the stressor and/or are causing impairment in functioning.

Acute stress disorder:

- Symptoms lasting no more than one month. Includes exposure to actual or threatened death, serious injury, or sexual violence, and is associated with negative mood, dissociative symptoms, and avoidance/arousal symptoms. In acute stress disorder these symptoms start after the exposure but last no more than one month. Symptoms persisting more than one month are then classified as PTSD.

Trauma and stressor related disorders:

- Children who have been neglected or abused can often have persistent behavioral and emotional symptoms which may not meet full criteria for PTSD.

Reactive Attachment Disorder:

- Caused by severe disruptions in attachment including neglect, abuse, separation, institutional care. This leads to a consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers and persistent social and emotional disturbances.

Disinhibited Social Engagement Disorder:

- Caused by severe disruptions in attachment including neglect, abuse, separation, institutional care. This leads to a pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits socially disinhibited behaviors.

Resources:

National child traumatic stress network:
- https://www.nctsn.org

The role of pediatric providers in identifying, treating, and referring traumatized children:
- https://jamanetwork.com/journals/jamapediatrics/fullarticle/379539

AACAP PTSD:
- https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Posttraumatic-Stress-Disorder-PTSD-070.aspx

AACAP Practice parameters for PTSD:
- https://www.jaacap.org/article/S0890-8567%2810%2900082-1/pdf

Disaster and Trauma Resource Center:
- https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Disaster_Resource_Center/Home.aspx

ACEs fact sheet:
- https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf

Preventing ACEs:
- https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

US department of health and family services trauma resources:
- https://eclkc.ohs.acf.hhs.gov/mental-health/article/trauma-responding-crises-fostering-recovery

AAP Helping foster and adoptive families cope with trauma:
- https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf