Post-Traumatic Stress Disorder Screening Guide for Primary Care Physicians

Recognizing PTSD in Youth

PTSD may develop after a child or adolescent experiences or witnesses a traumatic event. Trauma exposure alone does **not** establish PTSD. Symptoms are persistent, impairing, and interfere with daily functioning; reactions lasting no more than one month may represent acute stress disorder.

Core Symptom Domains

Intrusion

Intrusive memories, nightmares, flashbacks, distress with reminders, or trauma reenactment in play.

Avoidance

Avoiding trauma-related thoughts, feelings, or conversations, and avoiding people, places, or other reminders.

Cognition and Mood

Memory gaps, negative or distorted beliefs, emotional disconnection, guilt or shame, and persistent negative mood.

Arousal and Reactivity

Hypervigilance, exaggerated startle, sleep problems, irritability or outbursts, concentration problems, or reckless behavior.

Developmental Presentation

Children Younger Than 6

Toileting regression after training; loss of speech or inability to talk; reenacting the event in play; unusual clinginess; developmental regression.

Older Children and Adolescents

More adult-like symptom clusters; disruptive or destructive behavior; guilt about not preventing harm; thoughts of revenge; school or social decline.

Clinical Pearl: PTSD Can Look Like ADHD

Hyperarousal, distractibility, inattention, sleep disruption, and impulsive behavior can resemble ADHD. Trauma-related symptoms are often linked to reminders or a change from baseline, while ADHD symptoms are typically more continuous across settings. The conditions can co-occur: review timing, triggers, developmental history, and symptoms present before the trauma. Also assess anxiety, depression, oppositional behavior, learning problems, and somatic complaints.

Screening, Safety, and Positive-Screen Response

Immediate Safety First

Assess current safety at every visit. If abuse or neglect is suspected, **do not investigate - do report** under mandated-reporting requirements. For imminent danger to self or others, arrange emergency assessment or send to the emergency department; call 911 when needed. Call or text 988 for crisis support.

Preferred Symptom Screen: CATS

Form	Age	Reporter	Time	Clinically relevant symptom level
CATS caregiver	3-6	Caregiver	10-15 min	Total symptom score >= 16
CATS self-report	7-17	Youth	10-15 min	Total symptom score >= 21
CATS caregiver	7-17	Caregiver	10-15 min	Total symptom score >= 21

Interpret the Result Correctly: CATS assesses traumatic events and current post-traumatic stress symptoms. A score at or above the cutoff indicates clinically relevant symptoms; it is **not a diagnosis**. Follow a positive result with a semi-structured clinical interview and assessment of impairment, comorbidity, and safety.

Responding to a Positive Screen

Step	Primary care action
1. Confirm safety	Assess suicide/self-harm risk, danger to others, ongoing exposure, abuse or neglect, and environmental safety.
2. Clarify symptoms	Use a semi-structured interview; review duration, triggers, symptom domains, impairment, and developmental context.
3. Assess the whole child	Review school, family, sleep, physical symptoms, substance use, anxiety, depression, ADHD, and other co-occurring concerns.
4. Support and explain	Normalize trauma responses without minimizing them; involve caregivers when safe; reinforce routines and school supports.
5. Connect and track	Use a warm referral to trauma-focused treatment. Confirm connection, monitor functioning, and repeat the same validated measure to track change.

Evidence-Based Treatment

First-Line Care

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has the strongest pediatric evidence and is the preferred first-line treatment. Engage caregivers when safe and appropriate, and use a warm handoff to a therapist trained in the selected trauma-focused model.

Approach	Ages	Best fit	Place in care
TF-CBT	3-18	PTSD or clinically important trauma symptoms; adaptable across trauma types	**Preferred first-line.** Skills, gradual trauma processing, caregiver work, and safety planning.
Child-Parent Psychotherapy (CPP)	Birth-5	Trauma affecting behavior, development, attachment, or the caregiver-child relationship	Evidence-based dyadic option for very young children; caregiver participation is central.
EMDR	School-age youth and adolescents	PTSD symptoms when TF-CBT is not effective or feasible	Second-line option; pediatric long-term evidence is more limited.
CBITS	10-18	School-based access for trauma-related symptoms	Group CBT with individual and caregiver/teacher components; useful after community or shared trauma.
PCIT	2-7	Prominent disruptive behavior or impaired caregiver-child interaction	Context-specific option; not equivalent to PTSD-specific TF-CBT.
ARC	Children through young adulthood	Complex or chronic trauma with significant dysregulation	Flexible complex-trauma framework; not equivalent to first-line treatment for diagnosed PTSD.

Medication Considerations

Not First-Line for Pediatric PTSD

Medication is not first-line and does not replace trauma-focused psychotherapy. Consider it only for severe target symptoms that impair functioning or therapy, or for a clearly diagnosed co-occurring condition. No medication is FDA-approved specifically for pediatric PTSD. Confirm the treatment target, continue trauma-focused therapy, monitor closely for adverse effects and suicidality, and consider NV PAL or child-psychiatry consultation.

What Not to Use Routinely

Single-session psychological debriefing has not shown benefit and may worsen symptoms. Supportive counseling, relaxation, sleep guidance, and school accommodations may help, but they should not replace trauma-focused treatment when symptoms are clinically significant.

Follow-Up, Support, and Nevada Resources

Planned Follow-Up

2-4 Weeks

Confirm safety and treatment connection. Review symptoms, function, barriers, and treatment effects. Escalate care if symptoms worsen.

4-6 Months

Reassess symptoms, function, treatment response, and ongoing needs. Repeat the same validated measure; adjust care as needed.

Primary Care Support While Treatment Is Arranged

Validate the child and caregiver; explain trauma responses; reinforce routines and supportive relationships; coordinate school supports and treat co-occurring conditions. Refer for significant symptoms or impairment; monitor when exposure is present without significant symptoms.

Nevada Resources

NV PAL consultation
(702) 553-4528 | Monday-Friday, 9:00 AM-5:00 PM PST
Text to consult; PCPs only

Nevada DCFS
Report suspected child abuse or neglect.

988 Suicide & Crisis Lifeline
Call or text 988, 24/7; use 911 for immediate danger.

National Child Traumatic Stress Network
Children's Advocacy Alliance Nevada

Selected sources: CATS / ISTSS | PEARLS | CDC pediatric PTSD | AAP trauma-informed care | JAMA Psychiatry treatment review | AACAP PTSD parameter | NCTSN trauma treatments | NCTSN care process model

nvpal.org

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