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Clinical guidance

Prescribing in children and adolescents CHAPTER 5 Post-traumatic stress disorder (PTSD) in children and adolescents Diagnostic issues Traumatic events and PTSD are common in young people. One in three children experiences traumatic events1 and about 1 in 13 children develops PTSD before age 18.1 The prevalence of PTSD in adolescents can be much higher in at-risk groups, for example those attending emergency departments, in forensic settings or among refugee/asylum seekers. Young people with PTSD are at high risk of self-harm (nearly 50%) and suicide attempt (20%) and are often functionally impaired, for example not being in education, employment or education (NEET) (more than 25%).1 Of note, more than three out of four young people with PTSD have comorbid psychiatric diagnoses, most commonly depression, conduct disorder, alcohol dependence or generalised anxiety disorder.1 Furthermore, PTSD is not the most common diagnosis in trauma-exposed young people – disorders that are most prevalent in the general population (e.g. depression, conduct disorder, alcohol dependence) are also more prevalent in trauma-exposed young people.1 A diagnosis of PTSD is based on the triad of intrusive re-experiencing, avoidance of stimuli associated with the trauma and hyper-arousal after trauma exposure. Because of the abnormal processing of traumatic memories, young people with PTSD may suffer persistent re-experiencing of the traumatic event(s) through nightmares or unwanted and distressing memories, which are often experienced as if they were happening in the ‘here and now’ and often do not appear as frank dissociative symptoms or flashbacks. In order to minimise re-experiencing symptoms, young people with PTSD often develop overt or covert avoidance strategies, keeping themselves busy or distracted or staying away from people or places that remind them of the traumatic event. As a result of the symptoms, young people with PTSD often feel under continued threat and, therefore, display physiological hyper-arousal, appearing alert and vigilant for danger, irritable and struggling to concentrate on daily tasks. Because of the varied clinical manifestations, the assessment and treatment of PTSD in children and adolescents should be undertaken by clinicians who have expertise in the clinical presentations seen in trauma-exposed children and can appreciate developmental variations in the manifestation of symptoms. Clinical guidance The UK NICE guidelines2 advise that treatment of PTSD in young people should focus on psychotherapy, with 12 sessions of trauma-focused CBT (TF-CBT) for PTSD resulting from a single traumatic event or longer for chronic or recurrent events. If TF-CBT is not effective, or based on the young person’s preference, treatment may also include eye movement desensitisation and reprocessing (EMDR). Based on the current evidence in NICE guidelines,2 the AACAP3 and the International Society for Traumatic Stress Studies (ISTSS),4 pharmacotherapy is not recommended for treatment of PTSD in young people. The evidence for efficacy of pharmacotherapy (SSRIs and SGAs) in adults is also somewhat limited at present.5,6 However,

because of the high rates of comorbidity,1 pharmacotherapy may be needed to target co-occurring psychiatric disorders. In adult PTSD, the best supported treatments are fluoxetine, paroxetine and

596 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 5 venlafaxine.7 3,4--Methylenedioxymethamphetamine (MDMA),8 ketamine9 and psychedelic drugs10 also show promise. Prazosin appears to be effective in reducing PTSD-related nightmares in children aged 4--18 years.11 None of these agents is currently used to any extent in children and adolescents.

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