# Posttraumatic stress disorder in children and adolescents: Trauma-focused psychotherapy

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Literature review current through: **Oct 2023.**
This topic last updated: **Nov 02, 2023.**

## INTRODUCTION

Posttraumatic stress disorder (PTSD) in children and adolescents is a severe, often chronic, and impairing mental disorder. PTSD is seen in some children after exposure to traumatic experiences involving actual or threatened injury to themselves or others. Traumatic experiences leading to PTSD can include interpersonal violence, accidents, natural disasters, and injuries.

PTSD is characterized by intrusive thoughts and reminders of the traumatic experience(s), avoidance of trauma reminders, negative mood and cognitions related to the traumatic experience(s), and physiological hyperarousal that lead to significant social, school, and interpersonal problems [1]. PTSD can occur in toddlers as young as one to two years. The consequences of PTSD include elevated risk for other mental disorders and suicide, substantial impairment in role functioning, reduced social and economic opportunity, and earlier onset of chronic diseases, particularly cardiovascular disease [2].

This topic addresses the psychosocial treatment of PTSD in children and adolescents. The epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis of PTSD in children as well pharmacotherapy for PTSD in this population are addressed separately. Topics related to acute stress disorder and PTSD in adults are also addressed separately. An algorithm addresses the approach to selecting treatments for PTSD in children and adolescents ( algorithm 1).

- (See "Posttraumatic stress disorder in children and adolescents: Treatment overview".)
- (See "Posttraumatic stress disorder in children and adolescents: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis".)
- (See "Acute stress disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Dissociative aspects of posttraumatic stress disorder: Epidemiology, clinical manifestations, assessment, and diagnosis".)

## TRAUMA-FOCUSED PSYCHOTHERAPY AS PREFERRED TREATMENT

For most children and adolescents with posttraumatic stress disorder (PTSD) or prominent symptoms of PTSD, we suggest first-line treatment with trauma-focused psychotherapy (eg, trauma-focused cognitive-behavioral therapy [TF-CBT]) rather than other psychosocial or medication treatments. However, for individuals with severe symptoms requiring immediate stabilization (eg, suicidality, psychosis) we use pharmacologic management preferentially. Additionally for individuals with co-occurring anxiety or depression we often use combined treatment with TF-CBT and pharmacologic management. (See "Posttraumatic stress disorder in children and adolescents: Treatment overview", section on 'Pharmacologic management: For severe symptoms'.)

**Goal of trauma-focused psychotherapy** — The goal of trauma-focused psychotherapy is to help individuals correct exaggerated or irrational thought patterns (ie, cognitive distortions) and minimize symptoms of PTSD (eg, intrusive thoughts, avoidance) through exposure to reminders of the traumatic event. Individuals with PTSD associate stimuli (eg, people, places, smells, feelings) present at the time of a traumatic event (eg, “trauma reminders”) with the highly negative emotional responses resulting from it. Maladaptive cognitive and behavioral avoidance strategies are hypothesized to develop in an attempt to avoid distressing reminders of the event [3]. By exposing individuals to reminders of the trauma, cognitive distortions and maladaptive behaviors are addressed and through the therapeutic process, more adaptive skills can be learned.

Furthermore, trauma or witness to trauma may disrupt the child’s safety and trust in their parent/caregiver. Effective trauma treatment for young children must rebuild the trust that the parent/caregiver is able to keep the child safe. This is accomplished through therapies that focus primarily on the child-parent relationship by enhancing child-parent resiliency skills,

communication, positive parenting, and the parent/caregiver's ability to promote safety. (See 'Administering TF-CBT' below.)

**Modality and setting** — The choice between individual and group modalities is influenced by availability, patient preference, clinical presentation, and specific population needs. Trauma-focused psychotherapies include individual and group models as well as models tailored to meet the needs of specific subgroups (age of child, type of trauma). Any of these can be delivered in the practitioner's office, school, or other congregant settings (eg, group home). (See 'Individual trauma-focused psychotherapy' below and 'Trauma-focused group treatment' below.)

## INDIVIDUAL TRAUMA-FOCUSED PSYCHOTHERAPY

Our preference from among the trauma-focused psychotherapies varies primarily by patient age, clinical presentation, and availability. This is based on clinical trials comparing individual therapies with inactive controls, secondary data analysis, and our clinical experience.

We typically favor individual therapy for more severe cases, when patients have significant comorbidities, when symptom severity limits working in groups, or when parent/caregiver involvement is deemed important to recovery (group treatment often does not include parents/caregivers to as great a degree as individual models). When groups are conducted in schools, individual therapy is generally preferred for patients whose primary trauma involves child abuse or domestic violence (due to the complexity of systems and legal issues). (See 'Co-occurring depression' below and 'Trauma-focused group treatment' below.)

**Age seven years and older** — For children and adolescents age seven years and older, we treat with individual trauma-focused cognitive-behavioral therapy (TF-CBT). TF-CBT is the intervention most strongly supported by evidence from clinical trials ( algorithm 1) [4-6].

**Administering TF-CBT** — TF-CBT for children and adolescents with posttraumatic stress disorder (PTSD) is a parallel child and parent/caregiver treatment model that incorporates cognitive-behavioral, developmental, neurobiological, attachment, family, and empowerment principles.

- **Frequency of sessions** – TF-CBT is typically provided to individual children once weekly during hourly sessions for a duration of 12 to 25 sessions. The duration of treatment and the time spent in any of the components are influenced by the child's clinical presentation. Children who have less complex PTSD receiving a shorter duration (12 to 16 sessions), and children who have more complex PTSD receiving a longer duration (16 to 25 sessions) [7].

- **Phases and components** – TF-CBT is comprised of three phases, each comprised of several components. Within each treatment session, therapy is provided individually to the child and to the parent/caregiver. Towards the end of treatment, two to three conjoint sessions are also provided, during which the child and parent are seen together as described below.

  - **Stabilization phase**

    - Psychoeducation – We provide information about the connection between the child's past (or ongoing) trauma experiences, trauma reminders, and the child's presenting trauma symptoms. We discuss the common expression of these responses following trauma.

    - Parenting/caregiver skills – We provide and practice effective parenting strategies with the parent/caregiver. These include skills such as praise and selective attention. Additionally, we help parents/caregivers to understand the effect and consequences of trauma on behavior and work together to change them to more adaptive behaviors.

    - Relaxation skills – We individualize and practice relaxation strategies (eg, focused breathing, progressive muscle relaxation, exercise, visualization) to reverse the physiological effects of the trauma and trauma reminders.

    - Affect modulation skills – We individualize and practice skills such as verbal expression of negative feelings, seeking social support, positive distraction strategies, and problem solving.

    - Cognitive processing skills – We help to identify relationships among general negative thought patterns, feelings, and behaviors to generate more accurate thoughts. By gaining mastery over negative feelings and behaviors the individual may be better prepared for more specific trauma-related cognitive processing in the next phase.

  - **Trauma narration and processing stage** – We help the child to develop a detailed narrative of their personal trauma experience and to cognitively process these experiences by leveraging the skills learned above. This component is an interactive, therapeutic process that occurs between the therapist and child (and between the therapist and parent/caregiver as the therapist shares the content of the child's narrative with the parent/caregiver).

  - **Integration and consolidation phase**

- In-vivo mastery of trauma reminders – We have children expose themselves to trauma reminders (eg, going to a bedroom or bathroom where past trauma occurred) while employing the techniques learned in the prior phases. This can help to overcome the overgeneralized fears of trauma reminders and reduce maladaptive avoidance behaviors.

- Conjoint sessions – We use one or more conjoint child-parent sessions to enhance direct child-parent communication about trauma (eg, sharing the child's trauma narrative directly with the parent/caregiver, safety planning, and other individualized issues).

- Enhancing safety – With the child and their parent/caregiver, we discuss, provide, and practice safety skills appropriate to the child's developmental level and living circumstances. Trauma entails disruption of safety; reconstituting the child's actual and sense of safety is critical for recovery.

- **Monitoring response** – We typically monitor children's responses to treatment through child self-reported ratings such as the Child PTSD Symptom Scale or the Child and Adolescent Trauma Screen-2 (for children age 7 to 17 years.) For younger children (ie, <7 years old), we use the parent-reported instrument Young Child PTSD Checklist. We administer these at baseline, and after each treatment phase. Some clinicians may also administer these at additional points in treatment if clinically indicated. Clinically significant improvement (eg, from the very severe to moderate range; or from the severe to mild range using the norms established on the respective instrument; or a decrease in score of >40 percent) defines response.

- **Training and availability** – Resources to improve access to services are available at the National Child Traumatic Stress Network website. Training is available at the TF-CBT website. The therapy has been implemented internationally, yet availability varies widely and efforts to scale up dissemination and implementation continue. Efforts are underway to disseminate a validated model for training lay counselors in low-resource countries and to use telemedicine to implement TF-CBT [8-11]. Trained, experienced therapists can be identified at the TF-CBT website.

**Benefits of TF-CBT** — Randomized trials have compared TF-CBT with active treatments or control for the treatment of PTSD in children, collectively finding that TF-CBT reduced PTSD symptoms compared with controls [12-22]. Trials have shown efficacy for children exposed to sexual abuse, domestic violence, war, or multiple or complex PTSD [12,13,15-19]. Few trials have directly compared the TF-CBT with other trauma-focused psychotherapies and these have not

consistently shown differences between PTSD outcomes but have shown benefits of TF-CBT for comorbid problems such as depression or ADHD [21].

- In a large multisite trial, 220 children (age 8 to 14 years) with a history of multiple traumas (mean = 3.4) including an index trauma of validated sexual abuse and a diagnosis of PTSD, were randomly assigned to receive 12 weekly sessions of TF-CBT or child-centered therapy (CCT; a treatment model that focuses on establishing trust between child and parent/caregiver) [15]. At the end of treatment, the TF-CBT group experienced greater reductions in measures of PTSD symptoms, depression and behavior problems as compared with the CCT group. Additionally fewer individuals in the TF-CBT group continued to meet full criteria for PTSD at posttreatment evaluation than those in the CCT group (21 versus 46 percent, respectively).

- In a meta-analysis of three trials including 98 youth with PTSD, treatment with TF-CBT led to reduced PTSD symptoms one month after treatment compared with controls (standard mean difference -1.34, 95% CI -1.79 to -0.89) [14]. Other trials have supported the efficacy of TF-CBT [23], including trials showing efficacy for 18 months [24], and efficacy in treatment of the International Classification of Diseases, 11$^{th}$ Version (ICD-11) complex PTSD [25]. (See 'Teens with complex PTSD' below.)

**Children three to six years** — We treat children with PTSD in this age range with either child-parent psychotherapy (CPP) or TF-CBT for preschoolers. Our choice is based on availability of treatment and family preference. Additionally, our choice of treatment is influenced by the presence of sexualized, high internalizing behaviors (eg, social withdrawal) or externalizing behaviors (physical assault, lying), or when the child is manifesting symptoms of an attachment difficulty or developmental delay ( algorithm 1) [4,5].

**Sexualized or high internalizing/externalizing behaviors** — For children with sexualized behavior problems or high levels of internalizing (eg, depressed affect, social withdrawal) or externalizing behaviors (eg, aggression, delinquent behavior, substance misuse) we prefer TF-CBT for preschoolers [6,16].

TF-CBT utilizes structured play strategies to implement the CBT components with preschoolers. Clinical trials have supported the use of TF-CBT for preschoolers. As examples:

- In a trial comparing variations in TF-CBT administration, 210 children (age 4 to 11) with PTSD related to sexual abuse were randomly assigned to one of four different treatment conditions: 8 or 16 sessions of TF-CBT with or without the trauma narrative phase (see 'Administering TF-CBT' above) [26]. At treatment end, TF-CBT, regardless of the number of sessions or the inclusion of the trauma narrative component was effective in improving

participant symptomatology, parenting skills, and children's personal safety skills. Improvement in internalizing symptoms (eg, fear, anxiety), externalizing symptoms (eg, aggression) and changes in parenting practices varied by TF-CBT type. Results among participants age four to six were similar to older participants.

- In a trial, 86 children age three to six with at least five symptoms of PTSD following an index trauma of sexual abuse were randomly assigned to either TF-CBT or nondirective supportive therapy [16]. Children receiving TF-CBT experienced greater improvement on parental measures of behavior and adjustment problems, including internalizing and sexualized behaviors.

A stepped care model of TF-CBT for preschool children has been developed allowing parents/caregivers to provide much of the intervention at home. This model has demonstrated similar impact to standard TF-CBT at lower cost [27]. (See 'Other treatments with limited support' below.)

**Attachment difficulty or developmental delay** — For children age three to six, with attachment difficulty or developmental delay, our first choice of treatment is CPP.

CPP is a dyadic attachment-based psychotherapy that has elements of CBT but is primarily based on attachment and psychodynamic theory. CPP focuses on supporting and strengthening the parent-child relationship as a way to heal the negative impacts of interpersonal trauma. CPP is particularly valuable for very young children (birth to three years) and other young children (eg, those with developmental delays) who cannot express their emotions verbally but do so through play; the CPP therapist helps the parent/caregiver to understand and make more benign meaning of the child's play, behaviors, and interactions with the parent/caregiver.

- **Training and administration** – CPP is provided in 40 to 50 weekly dyadic child-parent sessions with additional parent/caregiver sessions provided as needed.

  CPP provides more sustained interventions to the child and parent/caregiver than TF-CBT, and thus may be particularly helpful for parents/caregivers who are highly dysregulated due to personal experiences of domestic violence. Targets of intervention include addressing parent/caregiver and child maladaptive representations of self and each other, developing a joint trauma narrative to identify and address triggers and developing more satisfying interpersonal relationship, activities, and goals.

  CPP training is available through the National Child Traumatic Stress Network website [28-30]. A CPP certification program is under development.

- **Efficacy of CPP** – In a trial, 75 preschool children (and their parent/caregiver) with PTSD stemming from domestic violence were randomly assigned to treatment with CPP versus case management plus community treatment referral [31]. After one year of weekly sessions monitored for fidelity, children receiving CPP experienced greater improvement in PTSD symptoms (medium effect size), as well as for total behavior problems (small effect size), relative to children receiving the comparison condition. Mothers receiving CPP also exhibited significantly greater decrease in avoidance symptoms and a trend toward reduction in their own PTSD symptoms.

**Children under three years** — For children under three years old with PTSD symptoms, we suggest the use of CPP rather than TF-CBT or Preschool PTSD Treatment. Children under three are typically too young to participate in cognitive-based interventions and would benefit more from attachment-based therapy. To date, no adequately powered empirical data are available to guide decision making for this age group ( algorithm 1). (See 'Attachment difficulty or developmental delay' above.)

**Considerations for specific populations**

**Teens with complex PTSD** — We prefer to treat teens with complex PTSD with TF-CBT as data in support of this treatment is stronger than other treatments. However, when this is unavailable, we use Trauma Affect Regulation: Guide for Education and Therapy (TARGET), a relational and cognitive behavioral-based intervention developed specifically for teens with complex trauma.

Complex PTSD (not included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-5] but described in the ICD-11) differs from noncomplex PTSD in the subject's history of chronic trauma and, in addition to core PTSD features, the presence of prominent features of affective dysregulation, negative self-concept, and interpersonal disturbances [32]. (See "Dissociative aspects of posttraumatic stress disorder: Epidemiology, clinical manifestations, assessment, and diagnosis" and "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis", section on 'Diagnosis'.)

Support for TF-CBT includes:

- In a randomized trial 159 German youth with PTSD or complex PTSD were assigned to treatment with TF-CBT or waitlist control. TF-CBT was superior to waitlist/control in improving symptoms of PTSD, as measured by the Clinician-Administered PTSD Scale for Children and Adolescents [25]. Among the TF-CBT group (n = 76) youth meeting ICD-11 criteria for complex PTSD experienced comparable improvement in PTSD symptoms as those with PTSD while also experience improvement in complex PTSD symptoms.

- In a clinical trial, 73 Norwegian youth with complex PTSD (n = 45) or PTSD (n = 28) were treated with TF-CBT (mean = 17 sessions). Individuals with complex PTSD experienced a steeper decline in symptoms of PTSD and complex PTSD than those with PTSD. Dropout rates were similar between groups [33].

TARGET may have specific applicability for the juvenile justice population. Key components of TARGET are emotional regulation, trauma processing and relational repair; it differs from TF-CBT in placing less emphasis on the parenting component. Support for TARGET includes:

- In a clinical trial, 59 females (age 13 to 17) with delinquent behaviors and full or partial PTSD were randomly assigned to TARGET or relational supportive therapy, each delivered over 12 50-minute sessions [34]. At treatment end, TARGET led to a greater reduction in average PTSD symptom severity as compared with the relational support group (62 versus 35 percent) as measured by the Clinician Administered PTSD Scale for Children and Adolescents). Treatment with TARGET appeared to result in greater improvements on secondary measurements such as anxiety, while treatment with relational therapy appeared to show greater improvements in secondary measures of hope and anger [25,33].

**Children with co-occurring conditions** — We treat individuals with comorbid disorders concurrently with the treatment for PTSD. However, the severity of the co-occurring symptoms such as suicidal thoughts or psychosis, may warrant treatment prior to addressing PTSD. In other cases, medication management may provide relief of symptoms of co-occurring disorder while benefitting aspects of PTSD ( algorithm 1). (See 'Co-occurring depression' below.)

**Co-occurring depression** — For individuals with co-occurring PTSD and depression, our preference is to treat both disorders concurrently. Small, randomized controlled trials support the efficacy of concurrently treating PTSD and depression with TF-CBT or CBT group model versus usual care or waitlist. For example:

- In a trial from Japan, 30 youth (age 6 to 18 years) with PTSD were randomly assigned to 12 sessions of TF-CBT versus waitlist. Treatment with TF-CBT led to greater reduction on measures of symptoms of PTSD and depression (as measured by the Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children and UCLA reaction index, respectively) as compared with the waitlist group [35].

- In a trial, 50 refugee youth (age 13 to 21 years) with significant PTSD symptoms were randomly assigned to six sessions of a brief CBT group model, “Mein Weg” (“My Way”) provided in community clinics versus usual care. Treatment with CBT resulted in greater improvement in posttraumatic symptoms (Cohen’s d = 0.61; as measured by the Child and Adolescent Trauma Screen self-report) and measures of depression (Cohen’s d = 0.63; as

measured by the Patient Health Questionnaire-8 versus usual care). However, parent/caregiver reports showed similar effects among treatment groups [36].

(See "Overview of prevention and treatment for pediatric depression" and "Effect of antidepressants on suicide risk in children and adolescents" and "Suicidal ideation and behavior in children and adolescents: Evaluation and management".)

**Co-occurring substance use disorder** — Our preference is treatment with Risk Reduction through Family Therapy (RRFT). RRFT is an application of TF-CBT that includes additional components for reducing risk of substance use.

Efficacy for RRFT has been shown in randomized trials [37,38]. In one trial, 124 adolescents (age 13 to 18 years) with substance use during the past 90 days and >4 PTSD symptoms (based on the UCLA PTSD Reaction Index for DSM-5), were randomized to a mean of 18 sessions of RRFT versus a mean of 12 session of treatment as usual (primarily TF-CBT) [37]. While each treatment led to similar outcomes on PTSD symptoms at 3- to 6-, 12-, or 18-month assessments, at 12- and 18-month assessments, RRFT yielded a greater reduction in days of substance abuse from baseline than treatment as usual.

Seeking Safety is alternative treatment model that we use when RRFT is unavailable. Seeking Safety is an adult CBT model for addressing comorbid PTSD and SUD that has been modified for teens. This treatment focuses on safety and grounding techniques. Support for Seeking Safety comes from a small randomized trial [39]. Seeking Safety for adults with PTSD and SUD is discussed separately. (See "Treatment of co-occurring anxiety-related disorders and substance use disorders in adults".)

## TRAUMA-FOCUSED GROUP TREATMENT

Group therapy is generally preferred for patients who have less severe symptoms, those without significant or severe comorbidities; and those who do not require a high level of parental treatment involvement. Additionally, group models are useful where there are resource constraints, an absence of trained therapists, or other barriers to access that preclude individual therapy [12,13,40-43]. However, for individuals whose primary trauma involves child abuse or domestic violence, individual therapy is preferred even if group therapy is available ( algorithm 1). (See 'Individual trauma-focused psychotherapy' above.)

**School based group treatments** — In schools and similar congregant settings, it is more efficient to provide trauma treatment in groups rather than individually. As a result, access to mental health services may be expanded.

**Cognitive-behavioral intervention for trauma in schools** — We typically recommend cognitive-behavioral intervention for trauma in schools (CBITS), a school-based, group treatment for schoolchildren age 10 to 15 years who have one or more disclosed traumas and symptoms of posttraumatic stress disorder (PTSD). CBITS incorporates cognitive-behavioral principles with peer support and resiliency modeling to help children overcome learned trauma avoidance and gain adaptive skills.

As noted above, many schools prefer individual therapy for students if their primary trauma involves child abuse or domestic violence due to legal and system complexities. Other considerations for preferring individual therapy may be PTSD complexity/severity or significant comorbid conditions that could disrupt the group or prevent the student from benefiting [41]. (See 'Individual trauma-focused psychotherapy' above and 'Trauma-focused group treatment' above.)

- **Administration** – CBITS is provided over the course of 10 school-based group sessions and is provided by trained school-based mental health professionals. Groups of six to eight children meet for approximately one hour during school for weekly sessions. The components of CBITS are the same as those in trauma-focused cognitive-behavioral therapy (TF-CBT). Parents/caregivers of each child are offered the opportunity to take part in parallel parent/caregiver groups. (See 'Administering TF-CBT' above.)

  We monitor PTSD and depressive symptoms at pre- and posttreatment using self-report instruments, such as the Child PTSD Symptom Scale.

- **Accessibility and training** – CBITS has been widely disseminated to schools in the United States and internationally, but many schools do not have CBITS therapists available. A primary trauma of child abuse or domestic violence may be a contraindication for CBITS participation in some schools since some administrators and/or parents/caregivers believe that these issues should not be addressed in the school setting. Such schools typically either provide school-based individual therapy or refer students for TF-CBT.

  Students assigned to school-based intervention may be more likely to access treatment than students assigned to clinic-based intervention [44]. As an example, in a study comparing CBITS and TF-CBT among 118 youth after Hurricane Katrina, while the interventions had comparable reduction in PTSD symptoms, students assigned to school-based intervention had a greater percentage of students access treatment than those assigned to clinic-based intervention (98 versus 37 percent). Evaluation of CBITS for primary school children is underway.

A variant of CBITS, Support for Students Exposed to Trauma, can be provided by educators, and thus could be disseminated more easily [45]. Preliminary study suggests that implementation of this approach is feasible and acceptable; further study of its efficacy is needed.

Clinician training, manual and other implementation materials are available at the Center for Safe and Resilient Schools website [41].

- **Efficacy** – CBITS has been shown to be effective when delivered by trained school-based mental health clinicians [40,42,44].

  In one trial, 126 sixth grade students with symptoms of PTSD who reported exposure to violence were randomly assigned to receive 10-session CBITS group treatment or to a waitlist control [42]. At three-month follow-up, the treatment group showed lower mean scores as compared to the control group for measures of depression (Child Depression Inventory: 9.4 versus 12.7, respectively; mean difference -3.4, 95% CI -6.5 to -0.4) and psychosocial dysfunction (Pediatric Symptom Checklist: 12.5 versus 16.5, respectively; mean difference -6.4, 95% CI -10.4 to -2.3).

**Children/adolescents exposed to war or terror** — Enhancing Resiliency Amongst Student Experiencing Stress (ERASE-Stress) is a 16-session, teacher-delivered resiliency-building intervention designed specifically for children and adolescents who have been exposed to terrorism or war. While CBITS is a clinician-delivered intervention provided to children with trauma-related symptoms, ERASE-Stress is provided by teachers to all exposed children, either to prevent the emergence of symptoms or as treatment of symptoms when present.

Two quasi-randomized controlled trials comparing ERASE-Stress with wait list control conditions for 142 children and 154 adolescents in Israel, respectively, found that children assigned to receive ERASE-Stress experienced greater improvement in PTSD symptoms (medium effect sizes), as well as in somatic complaints and anxiety [46,47]. Randomized trials have not been conducted.

**Other trauma-focused group treatment** — The following group treatments are used in nonschool settings. Trauma focused group treatment can provide more accessibility to treatment than individual TF-CBT.

**Group TF-CBT** — The group application of TF-CBT does not differ from the individual modality except that it is often provided in nonschool settings (eg, residential treatment centers, community or religious centers, or nongovernmental organizations). The trauma narrative TF-CBT treatment phase is provided in individual “break out” sessions that are provided in addition to the group sessions.

Two randomized trials have compared culturally modified group TF-CBT with wait list controls, one in 52 Congolese females who had been exposed to war and sexually exploited, and the other in 50 Congolese males who were exposed to war. Both trials found that TF-CBT, compared with the control conditions, resulted in greater improvement in symptoms of PTSD, depression, and anxiety, as well as in conduct and pro-social behaviors (large effect sizes for each result) [12,13].

**Treatment for children with PTSD related to death** — Children may develop PTSD related to the death of a parent or other important attachment figure. This may interfere with typical bereavement and result in prolonged grief disorder (which was introduced in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision [DSM-5-TR]). For children who have death-related PTSD with or without prolonged grief disorder, we recommend group TF-CBT or Trauma and Grief Component Therapy (TGCT). Our preference between the two is based on availability of the treatment and patient preference. TGCT differs from other group CBT interventions in that it is somewhat longer (17 sessions) and includes both trauma-focused and grief-focused treatment components that aim to address PTSD and maladaptive grief responses, respectively. Evidence supporting these treatments include:

- In a trial, 127 adolescents from Bosnia who had been exposed to war and had symptoms of PTSD, depression, or maladaptive grief were randomly assigned to treatment with TGCT plus classroom-based psychoeducation and skills intervention or classroom-based psychoeducation and skills interventions alone. TGCT with classroom intervention led to greater improvements than active control (eg, classroom intervention alone) on measures of maladaptive grief reactions, PTSD symptoms and depression with medium to large effect sizes [48].

- In Tanzania and Kenya, 640 children age 7 to 13 years with either PTSD or prolonged grief symptoms were randomized to either 12 sessions of group TF-CBT provided by lay counselors, or to usual community care [49]. Treatment with TF-CBT led to improvement in PTSD and prolonged grief symptoms at posttreatment in three of four sites [49].

## OTHER TREATMENTS WITH LIMITED SUPPORT

Other trauma-focused therapies based on cognitive and/or behavioral principles and supported by at least one clinical trial in youth with posttraumatic stress disorder (PTSD) or PTSD symptoms include:

- **Stepped care trauma-focused cognitive-behavioral therapy (TF-CBT)** – We use stepped care TF-CBT when parents are highly motivated to provide home-based interventions, cannot or do not want to attend in-person sessions, and when therapist availability is

limited. In stepped care TF-CBT, step 1 consists of three therapist-assisted sessions and nine parent-led meetings with the child at home. Step 2 consists of standard weekly therapist-led TF-CBT.

Stepped care appears to be as effective as standard TF-CBT. For example, in a noninferiority trial, 183 children (age 4 to 11) with PTSD symptoms and their parents/caregivers, were randomized to receive 12 sessions of stepped care TF-CBT versus standard TF-CBT [50]. Although baseline treatment acceptability was lower for stepped care TF-CBT parents/caregivers, stepped care TF-CBT was noninferior to TF-CBT for PTSD symptoms, impairment, and severity at all assessments (posttreatment, 6 and 12 months) except for impairment at the six-month assessment [50]. Predictors of nonresponse stepped care include parental depression, child anger and children of Hispanic parents/caregivers. When these negative prognosticators are present, we typically recommend standard TF-CBT rather than stepped care TF-CBT.

- **Combined parent-child cognitive-behavioral therapy (CPC-CBT)** – We use CPC-CBT in children who have PTSD symptoms related to experiencing child physical abuse or coercive parenting. CPC-CBT differs from TF-CBT in that it includes parents/caregivers who perpetrated physical abuse. In addition to components of TF-CBT, CPC-CBT offers a stronger focus in developing noncoercive parenting skills, joint parent-child meetings during every session, and abuse clarification. In abuse clarification, the abusive parent/caregiver takes full responsibility for the past abuse, alleviates any child blame, and addresses other child maladaptive cognitions related to the abuse.

  A clinical trial in children who were physically abused and their abusive parents/caregivers compared CPC-CBT provided to child and to parent/caregiver with cognitive therapy provided to parents/caregivers alone. At the end of treatment, the CPC-CBT group had greater reductions in children's PTSD symptoms and better parenting practices compared with the parent/caregiver cognitive therapy group, with a medium effect size [51].

- **Eye movement desensitization and reprocessing (EMDR)** – We use EMDR when it is the patient preference (eg, for those who prefer not to verbally describe the trauma experiences to the therapist). EMDR differs from TF-CBT in that [44]:

  - EMDR incorporates saccadic eye movements during exposure.
  - The trauma narrative is completed differently in EMDR: the child imagines a scene from the trauma, focusing on the accompanying cognition and arousal, while tracking the movement of the therapist's fingers in the child's visual field.

- Parental involvement is optional in EMDR.
- The duration of treatment is generally shorter for EMDR (approximately 8 sessions) than TF-CBT (8 to 16 sessions); however in a direct comparison, these treatments had equivalent efficiency [21].

Two well-designed randomized trials of EMDR in children showed mixed results [21,52]. Other clinical trials of EMDR in children have suffered from methodologic shortcomings, including small sample sizes [53].

EMDR for adults is described separately. (See "Posttraumatic stress disorder in adults: Psychotherapy and psychosocial interventions", section on 'Eye movement desensitization and reprocessing'.)

- **Preschool PTSD treatment (PPT)** – We use PPT based on availability and patient/family preference. PPT is a modified TF-CBT in which parents/caregivers participate fully throughout entire treatment sessions. Limited data support the use of PPT [54].
- **Child and Family Traumatic Stress Intervention (CFTSI)** – CFTSI is a short-term (four to six session) CBT-based intervention for children who have experienced acute trauma or who have just disclosed a trauma (eg, after a disaster, community violence or new disclosure of abuse) [55]. Programs that only offer brief intervention such as Children's Advocacy Centers may prefer CFTSI.
- **Cognitive-based trauma therapy (CBTT)** – CBTT differs from TF-CBT in that it does not include relaxation and has a specific focus on integrating cognitive restructuring throughout treatment [56]. It is specifically recommended for children who have experienced single episode traumas.
- **Kid narrative exposure therapy** – This treatment differs from TF-CBT in that it primarily utilizes the trauma narration and cognitive processing components (see 'Administering TF-CBT' above). It is particularly applicable for children exposed to war, refugee, or migrant conditions [57].

## SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Anxiety and trauma-related disorders in children".)

## SUMMARY AND RECOMMENDATIONS

- **Trauma-focused psychotherapy** – For initial treatment of most children and adolescents with posttraumatic stress disorder (PTSD) or prominent PTSD symptoms, we prefer trauma-focused psychotherapy rather than medication or other psychosocial treatments. (See "Posttraumatic stress disorder in children and adolescents: Treatment overview", section on 'Initial treatment' and 'Trauma-focused psychotherapy as preferred treatment' above.).

  Trauma-focused psychotherapy can be delivered in individuals or group settings and have varying parent/caregiver involvement. These are often customized to focus on different components of the treatment to meet the needs of a specific subgroup. (See 'Modality and setting' above.)

- **Choosing a trauma-focused psychotherapy** – Trauma-focused therapy is typically administered in individual sessions. Group models are useful where there are resource constraints, an absence of trained therapists, or other barriers to access that preclude individual therapy.

  Our preference from among the trauma-focused psychotherapies varies primarily by patient age and clinical presentation. This is based on clinical trials comparing individual therapies with inactive controls, secondary data analysis, and our clinical experience ( algorithm 1). (See 'Individual trauma-focused psychotherapy' above.)

  - **Children seven years and older** – For children age seven years and older, we suggest individual trauma-focused cognitive-behavioral therapy (TF-CBT) rather than child-centered therapy or other psychotherapies (**Grade 2C**). (See 'Age seven years and older' above.)

  - **Children three to six years** – We treat children age three to six years with either child-parent psychotherapy (CPP) or TF-CBT depending on patient characteristics, availability of therapies, and family preference. As examples:

    - For children age three to six years with attachment difficulty or developmental delay, we prefer CPP. (See 'Attachment difficulty or developmental delay' above.)

    - For children age three to six years with sexualized or high levels of internalizing or externalizing behaviors, we prefer TF-CBT for preschoolers. (See 'Sexualized or high internalizing/externalizing behaviors' above.)

- **Children under three years** – We treat children under three years with CPP. Children under three are typically too young to participate in cognitive-based interventions and benefit more from attachment-based therapy. (See 'Children under three years' above.)

- **Teens with complex PTSD** – For teens with complex PTSD, we suggest TF-CBT (**Grade 2C**) rather than other forms of psychotherapy. Trauma Affect Regulation: Guide for Education and Therapy (TARGET), a type of CBT tailored specifically for teens with complex trauma is an acceptable alternative treatment if TF-CBT is unavailable. (See 'Teens with complex PTSD' above.)

- **Children with co-occurring conditions** – We treat individuals with comorbid disorders concurrently with the treatment for PTSD. However, the severity of the co-occurring symptoms such as suicidal thoughts or psychosis, may warrant treatment prior to addressing PTSD. (See 'Children with co-occurring conditions' above.)

- **School-based and other group treatments** – School-based screening and group therapy interventions greatly expand access to mental health services. Cognitive-behavioral intervention for trauma in schools incorporates cognitive-behavioral principles with peer support and resiliency modeling to help children overcome learned trauma avoidance and gain adaptive skills. (See 'Trauma-focused group treatment' above.)



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