

## Post-Traumatic Stress Disorder (PTSD) Clinical Pearls for Primary Care Providers

### I: Clinical History

Recommended Procedure	Clinical Pearls
<input type="checkbox"/> Multi-informant assessment: gather history from youth, parent/guardian, others who know youth well as indicated, including therapist if already in treatment	<b>Pearl:</b> PTSD can develop in response to experiencing a traumatic event, witnessing a traumatic event, or being indirectly exposed to details of a traumatic event (vicarious trauma).
<input type="checkbox"/> Assess for PTSD symptom clusters: <b>Re-experiencing</b> (nightmares, intrusive thoughts/memories, flashbacks) <b>Avoidance</b> (internal or external reminders) <b>Hyperarousal</b> (hypervigilance, increased startle, anger/irritability, risk taking, concentration difficulties, sleep disturbance) <b>Negative alterations in mood and cognitions</b> include negative thoughts about oneself, other people, and/or the world; can overlap with depressive and anxious symptoms	<b>Pearl:</b> The Child and Adolescent Trauma Screen (CATS) caregiver or youth self-report measure screens for traumatic events and also PTSD symptoms. On the CATS caregiver report for ages 3-6, questions 1-5 screen for re-experiencing symptoms, 6-7 for avoidance symptoms, 8-11 for negative cognitions, and 12-16 for hyperarousal symptoms. On the CATS caregiver and youth self-report for ages 7-17, questions 1-5 screen for re-experiencing symptoms, 6-7 for avoidance symptoms, 8-14 for negative cognitions, and 15-20 for hyperarousal symptoms.
<input type="checkbox"/> Assess for single vs. multiple traumas	<b>Pearl:</b> A high number of small-scale traumas in the context of chronic toxic stress may be more complicated to treat than a single discreet trauma in context of many supports.
<input type="checkbox"/> Assess timing of the trauma	<b>Pearl:</b> Symptoms in the month after a traumatic event are classified as acute stress reactions and are common. <b>Pearl:</b> PTSD symptoms persisting three months after a trauma are unlikely to remit without treatment.
<input type="checkbox"/> Assess level of psychosocial stress	<b>Pearl:</b> Chronic and severe stress can cause psychological difficulties even in absence of abuse/neglect/violence.
<input type="checkbox"/> Assess for co-morbid depression and/or anxiety	<b>Pearl:</b> Depression and anxiety are common co-morbid conditions with PTSD – consider MCPAP consultation or referral to specialty care.
<input type="checkbox"/> Assess for prior episodes of treated or untreated mania/hypomania	<b>Pearl:</b> Prior episodes of mania or hypomania will likely alter treatment planning- consider MCPAP consultation or referral to specialty care.
<input type="checkbox"/> Assess for presence of substance use and abuse	<b>Pearl:</b> Active substance abuse or dependence may complicate assessment and treatment planning – consider MCPAP consultation or referral to more-specialized care.
<input type="checkbox"/> Assess for history of non-suicidal and suicidal thinking and behavior (self-harm, suicide attempts) and previous suicidal crises	<b>Pearl:</b> History of active suicidal planning or intent or recent suicidal behavior increases safety risk – consider Psychiatric Crisis referral or urgent MCPAP phone consultation.
<input type="checkbox"/> Assess for family history of trauma	<b>Pearl:</b> Trauma can have an intergenerational legacy.
<input type="checkbox"/> Assess for current abuse/neglect	<b>Pearl:</b> Safety must be ensured before psychological treatment can be effective. If there are concerns re: current or recent abuse, file a 51A.

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## II: Mental Status Examination

Recommended Procedure	Clinical Pearls
<input type="checkbox"/> Assess affect (dysregulated, flooded, constricted, withdrawn, dissociated)	<b>Pearl:</b> Children who have experienced trauma may have repetitive play or reenact the trauma through their play.
<input type="checkbox"/> Suicidality: suicidal thoughts, degree of planning, degree of intent, sense of control, ability to communicate with others and reach out for help, reasons for living	<b>Pearl:</b> Reports of active suicidal planning or intent or recent suicidal behavior increases safety risk – consider Psychiatric Crisis referral or urgent MCPAP phone consultation.
<input type="checkbox"/> Psychosis: hallucinations, delusions, abnormalities of thought processes or content	<b>Pearl:</b> Hallucinations due to PTSD are typically brief experiences related to the trauma and in the context of intact reality testing. Consider MCPAP phone consultation. If there are abnormalities in the thought process or behavior, we recommend Psychiatric Crisis referral for further assessment.

## III: Medical Workup

Recommended Procedure	Clinical Pearls
<input type="checkbox"/> Perform general standard medical assessment	<b>Pearl:</b> General medical assessment is part of good medical care for youth presenting with concerning psychiatric symptoms.
<input type="checkbox"/> Assessment of medical conditions that can present with depressive or anxious symptoms (i.e., thyroid abnormalities, cardiac arrhythmias, etc.)	<b>Pearl:</b> Identification and intervention for general medical problems presenting with psychiatric symptoms may help with assessment and treatment planning – consider MCPAP phone consultation to discuss complex situations.
<input type="checkbox"/> Assessment of medical treatments that can present with depressive symptoms as untoward reactions (i.e., steroid treatments, beta-blockers, anti-convulsants, etc.)	<b>Pearl:</b> Identification and intervention for medical treatments presenting with psychiatric symptoms may help with assessment and treatment planning – consider MCPAP phone consultation to discuss complex situations.
<input type="checkbox"/> Assessment of medical conditions and concurrent medical treatments that may affect treatment planning	<b>Pearl:</b> Identification of medical conditions that could impact medication treatment (i.e., liver disease, cardiac or renal problems) or medications with significant drug-drug interaction potential – consider MCPAP phone consultation for complicated situations.

## IV: Differential Diagnosis

Recommended Procedure	Clinical Pearls
<input type="checkbox"/> Acute Stress Disorder	<b>Pearl:</b> Clinically significant symptoms in the month following a trauma are more common than PTSD as symptoms tend to fade with time.
<input type="checkbox"/> PTSD	<b>Pearl:</b> Clinically significant symptoms that persist beyond one month after the trauma. Symptoms that persist past three months are unlikely to remit without treatment.
<input type="checkbox"/> Anxiety Disorder	<b>Pearl:</b> If a stressful but not traumatic life event is causing a lot of emotional distress, assess for underlying anxiety disorder. <b>Pearl:</b> Anxiety disorders are risk factors for PTSD. They are also frequently comorbid with PTSD.

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Recommended Procedure	Clinical Pearls
<input type="checkbox"/> Depression	<b>Pearl:</b> Depressive disorders are risk factors for PTSD. They are also frequently comorbid with PTSD.
<input type="checkbox"/> Bipolar Disorder	<b>Pearl:</b> The hyperarousal symptoms of PTSD, especially irritability and anger, can be confused with bipolar disorder.
<input type="checkbox"/> ADHD	<b>Pearl:</b> Difficulty concentrating is a symptom of both PTSD and ADHD. The hyperarousal symptoms of PTSD may also present as hyperactivity, especially in young children. In patients with history of trauma, assess for ADHD if difficulties concentrating remain after PTSD has been treated.

## V: Assessment of Risk

Recommended Procedure	Clinical Pearls
<input type="checkbox"/> Assess youth comprehensively for suicidal thinking or behavior as main short-term concern is risk of self-harm, suicidal behavior, or completed suicide	<p><b>Pearl:</b> Referral for immediate and emergent Crisis Assessment with Emergency Psychiatric Service providers in the following situations:</p> <ul style="list-style-type: none"> <li>• Any evidence of recent suicidal behavior</li> <li>• Current active intent to engage in suicidal behavior</li> <li>• Current significant planning for suicidal behavior</li> <li>• Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified</li> <li>• Evidence that youth or family will not or cannot access Emergency Psychiatric Service providers in times of worsening risk</li> <li>• Consider urgent MCPAP phone consultation for complex or confusing situations</li> </ul>

## VI: Treatment Planning

Recommended Procedure	Clinical Pearls
<input type="checkbox"/> Using MCPAP algorithm, discuss recommended treatment plan with family	<b>Pearl:</b> Psychosocial interventions (therapy and family support) are very important. No medications are FDA-approved for PTSD in children and teens, and our evidence base regarding these medications is quite limited.
<input type="checkbox"/> Psychotherapy is the first line treatment for PTSD.	<b>Pearl:</b> Most good therapy for PTSD includes caregiver involvement, skills for coping/relaxation, challenging negative cognitive distortions related to the trauma, and building a trauma narrative and competent sense of identity.
<input type="checkbox"/> Ascertain from family preferences regarding treatment plan	<b>Pearl:</b> Family preferences regarding treatment choices can be taken into account along with many other factors in determining initial treatment plan in many situations – consider MCPAP phone consultation or face-to-face consultation for complicated situations.
<input type="checkbox"/> With medication treatment, utilize standard informed consent procedures discussing potential benefits of treatment, potential side effects, and that treatment is off-label as no medications have FDA approval for treatment of PTSD in children and adolescent	<b>Pearl:</b> Consult with MCPAP CAP as needed regarding any concerns about informed consent as it applies to treatment planning.

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<input type="checkbox"/> MCPAP currently does NOT recommend the use of routine pharmacogenetic testing for initial medication selection strategies in primary care for youth with PTSD.	<p><b>Pearl:</b> Pharmacogenetic testing is considered experimental and is not incorporated at this time into any standard practice guidelines for youth with depression. There may be specialized situations where pharmacogenetic testing is appropriate in specialty care. Consider phone consultation with MCPAP CAP to discuss further as warranted.</p>

## VII: Medical Monitoring

Recommended Procedure	Clinical Pearls
<input type="checkbox"/> Acute Treatment Phase (8-12 weeks)	<p><b>Goals:</b></p> <ul style="list-style-type: none"> <li>• Remission and/or reduction of symptoms, improvement in function</li> <li>• Initiation and close monitoring of medication treatment response and tolerance</li> <li>• Weekly to bi-weekly check-ins with youth and/or family</li> <li>• Monitor medication compliance and tolerance</li> <li>• If youth experiencing side effects from medication, do not advance dose until side effect remits fully</li> <li>• Re-assessment of symptoms at four weeks using CATS symptom monitoring form or PTSD screening form</li> <li>• Note that there is a six-question follow up version of the CATS that may be utilized for monitoring</li> <li>• Follow algorithm and consult with MCPAP CAP on call as needed</li> </ul>
<input type="checkbox"/> Maintenance Phase (6-12 months)	<p><b>Goals:</b></p> <ul style="list-style-type: none"> <li>• Youth will continue to demonstrate reduction and/or remission of symptoms and improvement in function after positive acute treatment response</li> <li>• Maintain active treatment plan (medication, psychotherapy) during this period</li> <li>• Monitoring generally less-involved or intensive assuming ongoing symptom improvement</li> <li>• Monitor medication compliance and tolerance</li> <li>• Ongoing collaboration with therapist if present</li> <li>• Consult with MCPAP CAP as needed</li> <li>• If symptoms and functioning improve for 6-12 months, reassess with CATS</li> <li>• Discussion of treatment discontinuation if positive response has been sustained for 6-12 months. This is less likely in situations with multiple and complex traumas and high levels of ongoing psychosocial stress.</li> </ul>
<input type="checkbox"/> Treatment Discontinuation Phase (3 to 6 months)	<p><b>Goals:</b></p> <ul style="list-style-type: none"> <li>• Safely and thoughtfully withdrawn treatment and monitor for symptom recurrence</li> <li>• Informed consent with family: potential benefits of withdrawing treatment, potential risks of withdrawing treatment, plan to deal with problems or recurrence if needed</li> <li>• Discuss medication strategies with family (consult with MCPAP CAP as needed)</li> <li>• Active monitoring for several months during this phase</li> <li>• Ongoing collaboration with therapist if present</li> <li>• Consult with MCPAP CAP as needed</li> </ul>