PROJECT EVIDENCE

PROJECT EVIDENCE for Treatment of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[6] Standard Treatment

a) Outpatient psychotherapies, medication and procedures

b) Inpatient psychotherapies, medication and procedures

c) Ancillary support services

[6 a] Outpatient psychotherapies, medication and procedures

Specialist mental health services should offer a range of therapeutic programs for disabling mental health problems in the community. Service provision, clinical research and training are closely linked in the Tier Three facilities but the practice guidelines published by those services should be implemented at all levels of their service delivery facilities.

These are grouped under nine headings: (i) organic brain disorders, (ii) substance abuse disorders, (iii) psychotic disorders, (iv) mood disorders, (v) anxiety disorders, including stress-related, somatoform and obsessive-compulsive disorders, (vi) physiological disorders, including eating, sleeping and sexual, (vii) personality disorders, (viii) intellectual disability and developmental disorders including autism spectrum disorders, (ix) behavioural and relationship disorders of childhood.

All disorders in childhood require wholistic management involving caregivers. See PE4 for a general outline of case identification and assessment and PE2a(i) for infant mental health. See PE6a(ix) for a general outline of case management for young people.

PE6a (v) Anxiety Disorders,

Childhood anxiety disorders involve excessive fear or anxiety that differs from normal developmental fears through its intensity or persistence beyond the appropriate developmental period. The fears or anxiety can manifest in physical symptoms of distress (headaches, stomach aches, skin disorders), perfectionism, excessive reassurance seeking, great difficulty dealing with change, nightmares and difficulty going to sleep at the beginning of the night. Anxiety disorders in children can include separation anxiety disorder, specific phobias, social anxiety disorder and generalised anxiety disorder, and can also lead to school refusal.

This paper is in five sections:

- Anxiety Disorders in general,
- Obsessive-Compulsive Disorders,
- School Refusal/ Separation Anxiety Disorder
- Somatisation Disorders
- Stress-related Disorders

1) Anxiety Disorders in general

The Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society provide information and clinical practice guidelines for the treatment of anxiety disorders in children. The guidelines set out below are an amalgam of information put out by these two groups.

Anxiety disorders in children have an ongoing, pervasive and negative impact on relationships, family life and school adjustment. Anxious children develop a pattern of avoidance of many family and school activities, which prevents them from enjoying developmentally appropriate activities. Many of the anxiety disorders that develop in childhood will persist into adulthood if not treated.

Various published studies have reported that one in five children and adolescents are identified with a range of elevated symptoms of anxiety throughout development.

Cognitive behavioural therapy (CBT) aims to teach children to identify and regulate their emotions. However, when working with children it is essential that these skills are delivered in a developmentally appropriate way. Play therapy techniques and parenting skills training are highly valuable in ensuring children are engaged and understanding skills, and it is important that parents have the knowledge to reinforce coping at home. There are specific treatment components to give skills to families and teachers in order to maximise positive treatment gains. Both individual and group formats have proven to be effective, with the key target of normalisation, rather than stigmatisation, being emphasised in both formats.

Key targets for CBT treatments should include: increasing self-awareness; promoting empathy skills; relaxation skills and self-management training; mindfulness and attention training; challenging and replacing unhelpful thinking; increasing positive coping role models and support networks; building step plans and exposure exercises; problem-solving skills training; friendship skills; and maintenance and generalisation of skills. (Barrett 2014).

Where children are exhibiting anxiety symptoms it is important for parents to be involved in the process. It is increasingly documented that anxiety patterns run in families and where there is an anxious child it is likely that others in the family also have had to manage anxiety. Involving parents in the process of helping their children can be very reassuring for everyone in the family if it is done compassionately and cooperatively. The accepted wisdom is that anxiety is an instinct which is adaptive and that when it becomes clinically intrusive, needs to be managed rather than taken away. Management strategies for anxiety are a lifelong process and teaching them to children is important

Whilst initial treatment options for anxiety disorders are cognitive-behavioural therapy (face-to-face or delivered by computer, tablet or smart-phone application), cost and accessibility can be factors which hinder treatment.

Where access to these treatments is not possible and/or where the symptoms are severe and not responding to psychological treatments, pharmacotherapy (a selective serotonin reuptake inhibitor or serotonin and noradrenaline reuptake inhibitor together with advice about graded exposure to anxiety triggers), or the combination of cognitive-behavioural therapy and pharmacotherapy can be offered. Whilst results of medication can be effective in terms of reduction of symptoms and enhanced

capacity for daily living activities, review of side effects and plans to reduce or cease medication over a period of time are important.

Where children are exhibiting anxiety symptoms it is important for parents to be involved in the process. It is increasingly documented that anxiety patterns run in families and where there is an anxious child it is likely that others in the family also have had to manage anxiety. Involving parents in the process of helping their children can be very reassuring for everyone in the family if it is done compassionately and cooperatively. The accepted wisdom is that anxiety is an instinct which is adaptive and that when it becomes clinically intrusive, needs to be managed rather than taken away. Management strategies for anxiety are a lifelong process and teaching them to children is important.

Andrews, Gavin et al., *Australian & New Zealand Journal of Psychiatry* 2018, Vol. 52(12) 1109-1172 DOI: 10. 1177/0004867418799453

Barrett, P. (2014) Treatment guidance for common mental health disorders: Childhood anxiety disorders *InPsych* 2014 Vol 36. October | Issue 5

2) Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) is a common neuropsychiatric disorder characterized by the presence of obsessions and/or compulsions that are time consuming and cause distress or interference in the patient's life.

Obsessions are intrusive, unwanted ideas, images, fears, thoughts or worries that are experienced as uncomfortable, unpleasant, distressing or anxiety provoking.

Compulsions are repetitive behaviors or mental acts performed to ignore, reduce or eliminate the anxiety or distress caused by the obsessive thoughts. Compulsions are usually executed according to certain rules the patient feels driven to follow. Obsessive compulsive symptoms vary considerably not only from patient to patient but also in the same patient over time.

Even though there are many similarities in the clinical presentation across the lifespan, children and adolescents with OCD also show specific features. For instance, the younger the patient the higher is the probability of having compulsions without obsessions. Children are also less likely to realize that their symptoms are not normal, making them less willing to resist the urge to perform a compulsive behavior. Therefore, it is not necessary for children to have insight to qualify for the diagnosis. Children may also present *tic-like compulsions*, which may be confused with complex tics, mainly if the compulsions are simple rituals of touching. In these cases, compulsions may be preceded or accompanied not only by obsessions but also by various types of sensory phenomena.

Sensory phenomena is a term used to define uncomfortable or disturbing sensations, perceptions, feelings or urges that either precede or accompany repetitive behaviors such as compulsions or tics. OCD patients might feel driven to repeat compulsions until they experience a sense of relief from these uncomfortable sensations. Sensory phenomena can be divided into physical and mental. Examples include sensations in the skin, "just-right" perceptions, and feelings of incompleteness. For instance, people can "feel" an oily sensation on their hands and wash them repeatedly for this reason. Another person may feel "uncomfortable" with the way some objects are arranged on a shelf and may

feel an urge to arrange them many times, until they look “just right”. Evaluation of the presence and severity of sensory phenomena is relevant because some studies have reported that patients with early-onset and tic-related OCD show more sensory phenomena and some report that these sensory phenomena cause even more distress than the compulsions.

OCD affects all age groups independent of race, socioeconomic status or religion. Age at onset is important because there is emerging evidence that early onset OCD may represent a distinct subtype of the disorder. Previous research has shown that adults who report an early onset display greater severity and persistence of symptoms and may be less responsive to treatment. Moreover, early-onset has been associated with fewer obsessions, more tic-like compulsions, more sensory phenomena, and a higher rate of comorbid tic disorders

Pediatric OCD may resemble adult OCD but often presents particular clinical features. Recent studies support the idea that OCD is clinically and etiologically heterogeneous and that early-onset OCD may represent a unique subgroup. Furthermore, in 50% to 80% of OCD cases symptoms start before 18 years of age, which highlights the importance of understanding OCD as a developmental disorder.

Despite being frequent and disabling some studies suggest that almost 60% of OCD patients wait too long to seek treatment or do not receive treatment due to a lack of health professionals trained to identify OCD.

Even though subdividing patients according to age of onset has proven to be useful in identifying more homogenous subgroups, a dimensional approach has proven to be of even greater value. Factor-analytic studies have reduced OCD symptoms to a few consistent and clinically meaningful dimensions: contamination/cleaning, obsessions/checking, symmetry/ordering, and hoarding. These symptom dimensions, which are similar in all age groups, can be understood as overlapping clinical features that may be continuous with "normal" worries first evident in childhood, are temporally stable, and correlate with various genetic, neuroimaging and treatment response variables

Assessment

When OCD is suspected, a comprehensive clinical evaluation – including detailed interviews with parents and, if possible, teachers – is required in order to assess the compulsions, obsessions and sensory phenomena. In younger children, OCD features might appear subtly during play activities or drawing. It is vital to differentiate between obsessive compulsive symptoms and normal childhood ritualistic behavior, typical of specific developmental phases, such as mealtime or bedtime rituals. In this regard, detailed information about degree of distress, impairment and time consumed performing rituals should provide enough data to decide whether or not treatment is warranted. Moreover, it is also important to assess insight and the family’s perception of the symptoms, as well as how family members deal with the patient.

Rating scales are useful to obtain detailed information regarding OCD symptoms, tics, and other aspects relevant to the diagnosis. Symptoms may remain undisclosed unless specifically questioned. Scales are also used to assess severity at baseline and to evaluate improvement in a more objective way during follow up treatment. The most widely used scale is Children’s Yale-Brown Obsessive-Compulsive Scale (CYBOCS).

Treatment

Treatment of OCD in children and adolescents relies on cognitive behavioral therapy (CBT), medication and psychoeducation. Both selective serotonin reuptake inhibitors (SSRIs) and CBT have been systematically studied and empirically shown to be useful. CBT is the only psychological therapy shown to be effective in the treatment of childhood OCD. Treatment of pediatric OCD should preferably start with CBT for mild to moderate cases, or a combination of CBT and pharmacotherapy for more severe cases, or when CBT is not available.

Literature

CBT manuals and self-help books available for therapists and families interested in these techniques (AACAP, 2012):
• *Talking Back to OCD: The Program that Helps Kids and Teens Say "No Way/ and Parents Say "Way to Go"* by John March
• *Obsessive Compulsive Disorders: A Complete Guide to Getting Well and Staying Well* by Fred Penzell
• *Freeing Your Child from Obsessive Compulsive Disorder* by Tamar Chansky
• *What to do When your Child has Obsessive Compulsive Disorder: Strategies and Solutions*, by Aureen Pinto Wagner.

The information on OCD is reproduced from: Alvarenga PG, Mastrorosa RS , Rosário MC. Obsessive compulsive disorder in children and adolescents. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012.

3) School Refusal/ Separation Anxiety Disorder

Separation Anxiety Disorder (SAD) is characterized by an abnormal reactivity to real or imagined separation from attachment figures that significantly interferes with daily activities and developmental tasks. The anxiety is beyond what is expected for the child's developmental level, lasts longer than four weeks, begins before age 18 and causes significant distress or impairment.

SAD can cause marked distress and impairment, can lead to several negative psychosocial outcomes, and is predictive of adult psychiatric disorders, especially panic disorder. In spite of this, the disorder has seldom been studied, and children are not usually clinically assessed until SAD results in school refusal or marked somatic symptoms.

There are three key characteristics of separation anxiety disorder:
• Excessive and persistent fears or worries before and at the time of separation.
• Behavioral and somatic symptoms before, during and after the separation, and
• Persistent avoidance or attempts to escape the separation situation.

The child *worries* that something may happen to his parents (e.g., that they will disappear, get lost or forget about him) or that the child will get lost, kidnapped or killed if he is not near his parents. *Behavioral symptoms* include crying, clinging, complaining upon separation, and searching or calling

for the parent after their departure. *Physical symptoms* are similar to those in a panic attack or somatization disorder, such as:
• Headaches
• Abdominal pain
• Fainting spells, lightheadedness, dizziness
• Nightmares, sleep difficulties
• Nausea, vomiting
• Cramps, muscle aches
• Palpitations, chest pain.

Due to these physical symptoms, SAD is a frequent cause of school absenteeism and multiple visits to the family doctor or pediatrician to rule out a medical problem. Symptoms only appear on school days and usually disappear as soon as the parents decide the child will stay at home. Separation anxiety symptoms appear more frequently in situations such as a change of school, starting a new school term (after summer vacation, or when starting high school), changing friends, experiencing adverse events such as being bullied, or suffering a medical illness.

Childhood anxiety disorders are frequently comorbid with each other and with other forms of psychopathology. Thus, it is common that children with SAD also present with other anxiety disorders or other conditions such as depression, disruptive behavior disorders or attention-deficit hyperactivity disorder.

Assessment

As with any other psychiatric disorders, evaluation should include past psychiatric history, family psychiatric history, medical history and developmental history. Somatic symptoms generally have no physical origin. However, a careful physical examination with appropriate pathology testing is recommended to rule out physical causes,

Treatment

In all cases, it is essential to build a good therapeutic alliance between the patient (and family) and the clinician. This is best developed in the context of psychoeducation**,** which increases insight and motivation. Understanding the nature of anxiety and how it is experienced by the child will help parents and teachers sympathize with a child's struggles.

Psychoeducation should cover:
• Anxiety as a normal emotion, at all developmental stages
• Factors that may cause, trigger or maintain anxiety symptoms
• Treatment alternatives, including their advantages and disadvantages
• Prognosis

Behavioral management is indicated in all cases. It consists of informing family members and significant caregivers, how to manage mild symptoms and maladaptive attitudes such as avoidant behaviors or cognitive biases. It may be the only treatment required in cases of mild separation anxiety (which generally occur during pre-school). This should be combined with other therapies if there is no improvement or symptoms are moderately severe, or cause moderate dysfunction or distress. The

main objective of behavioral management is to provide the child a flexible and supportive environment to overcome his separation anxiety symptoms.

The clinician may recommend parents to:
• Listen to the child's feelings empathically
• Keep calm when the child becomes anxious (to model the child's behavior)
• Remind the child that he had survived similar anxious situations before
• Teach simple relaxation techniques such as deep breathing, counting to 10, or visualizing a relaxing scene. Learning how to relax gives the child a sense of control over his body
• Plan transitions, such as getting to school in the morning or preparing for bed at night
• Help the child prepare a list of possible strategies in case anxiety appears in "difficult" situations
• Support the child's prompt return to school (long absences make return to school more difficult)
• Encourage the child's participation in activities outside the home, without attachment figures (promote *exposure*). Do not let him stay at home to avoid distress (do not allow *avoidance*)
• Praise the child's efforts (not only his results) to address symptoms (reinforce repeatedly on his way to success)
• Assure the child/adolescent that somatic symptoms are indicators of a problem that requires attention, just not a physical problem.

Interventions at school
The clinician can recommend teachers to:
• Initiate a plan to promote the child´s return to school as soon as possible
• Maintain frequent meetings with parents to facilitate collaboration in strategies to help the child normalize schooling
• Assess the cause of the child's school refusal and address it (e.g., problems with friends, fear of a teacher)
• Supervise the child´s arrival to school, preferably the same person every time
• Allow an attachment figure to initially accompany the child
• Allow a shorter school day and lengthen it gradually
• Identify a safe place where the child can go to reduce anxiety during stressful periods
• Identify a safe adult to whom the child can ask for comfort at all times, most of all during stressful periods
• Promote practicing relaxation techniques developed at home
• Provide alternative activities to distract the child from physical symptoms
• Encourage small group interactions. This can start with only one classmate. With time, the child will increase his competency and the group may be enlarged progressively. Provide assistance with these peer interactions.
• Reward a child's efforts
• Allow extra time for transitioning to different activities.

Cognitive Behavior Therapy (CBT)
Several randomized controlled studies showed the short- and long-term effectiveness of CBT in ameliorating childhood anxiety disorders, including SAD. Because of this, CBT became the initial treatment of choice. The exception is when anxiety symptoms are too severe to allow CBT. In that case, medication or both concurrently, or a different therapeutic approach would be indicated.

Subsequent research by Tavistock and Portman Clinics has shown the effectiveness of relationship-based psychotherapies.

Reference
Figueroa A, Soutullo C, Ono Y, Saito K. Separation anxiety. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012.

4) Somatisation Disorders

This term describes a constellation of clinical and behavioral features indicating the experience and communication of psychological distress through physical (somatic) symptoms unaccounted for by pathological findings, and for these symptoms to be attributed to a physical illness, thus leading the patient to seek medical help. The production of symptoms is usually *not* under conscious control; however, in children and adolescents it is often particularly difficult to establish the level of conscious control. Physical (somatic) symptoms are extremely common in children and adolescents. Children and adolescents often find it difficult to express their feelings and emotions through language. Because of this, expression of psychological distress can manifest as physical (somatic) symptoms.

In somatic symptom and related disorders, there are physical symptoms suggesting a medical condition; however, no medical disease, substance misuse or other mental disorder can be found to account for the level and impact of the physical (somatic) symptoms. The symptoms cause significant distress or impairment in social, occupational or other areas of functioning. The physical symptoms are usually not intentional, with the exception of factitious disorder where there is deliberate falsification of physical or psychological symptoms (Munchausen syndrome).
The somatizing disorders most commonly seen in children and adolescents are:

- Somatic symptom disorder, especially pain syndromes
- Disorder of bodily distress, including pseudocyesis
- Dissociative disorders
- Conversion disorder and
- Chronic fatigue syndrome.

Assessment

A thorough diagnostic assessment should be undertaken as described in PE4. Consider somatic symptom and related disorders when the following are present:

- There is a time relationship between psychosocial stressor and physical symptoms
- The nature and severity or handicap from the symptom are out of keeping with the pathophysiology
- There is a concurrent psychiatric disorder.

Somatic symptom disorders can also coexist with organic disorders. If there is a medical illness, it is important to establish what physical symptoms are congruent with the organic illness and what are more likely to be attributed to identified psychosocial stressors.
A certain amount of health anxiety is normal and it is appropriate to investigate symptoms. It is only considered a disorder if the anxiety interferes with functioning.

Treatment

Following on from assessment, and once physical and psychiatric disorders have been addressed or excluded, treatment for the somatic symptom disorder should be planned. The first step is to engage the family. The following strategies may be helpful:

- Make an effort to understand the family's beliefs about the illness, level of conviction about physical causes, satisfaction with investigations, and views about the mental health referral and treatment
- Acknowledge that patients have a real illness disrupting their life and impacting on the family
- Investigate alternative explanations for the symptoms
- Emphasize that it may take time to recover but the majority of young people do very well
- Help the family and child develop ways of coping with the symptoms and reduce functional impairment.
- Use psychological interventions such as CBT and mindfulness
- Use family work to deal with family factors that may be contributing to the symptoms or interfering with their resolution.

Reference

Fiertag O, Taylor S, Tareen A, Garralda E. Somatic symptom, bodily distress and related disorders in children and adolescents. In Rey JM, Martin A (eds), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2019.

5) Stress-related Disorders

Most children and adolescents exposed to traumatic events will develop some psychological distress, which is generally short lived. In some, however, symptoms do not remit spontaneously and instead become clinically significant, persistent and impairing. Reactions to trauma exposure are defined according to their timeframe: immediate or peri-traumatic (lasting minutes to hours), Acute Stress Disorder [ASD] (lasting between two days and one month), and Post Traumatic Stress Disorder [PTSD] (when symptoms persist for more than one month).

In addition to specific reactions to trauma, children and adolescents may develop other psychiatric conditions after trauma exposure including depression, panic disorder, specific phobias (distinctively related to some aspect of the trauma), as well as behavioural and attentional problems (e.g., oppositional defiant disorder). Among pre-schoolers, other clinical presentations include developmental problems such as loss of previously mastered skills (regression), as well as the onset of fears not specifically associated with aspects of the trauma.

Peritraumatic distress can be measured with the 13-item Peritraumatic Distress Inventory (PDI) (Brunet et al, 2001) that evaluates feelings of helplessness, sadness, guilt, shame, frustration, fright, horror, passing out, worry for others, loss of bowel and bladder control, physical reactions, and thoughts of dying.

A diagnosis of ASD requires exposure to a traumatic event (i.e., exposure to death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation) and the main

diagnostic criterion requires meeting 9 of 14 symptoms (in any particular cluster), including symptoms of intrusion (i.e., recurrent distressing dreams, recurrent distressing memories of the trauma, intense or prolonged distress upon exposure to reminders, and physiological reactions to reminders); dissociative symptoms (i.e., derealization, emotional numbing and inability to remember an aspect of the trauma (typically dissociative amnesia)); avoidance symptoms (i.e., avoidance of internal or external reminders that arouse recollections of the traumatic event(s)); and arousal symptoms (i.e., irritable or aggressive behaviour, exaggerated startle response, sleep disturbance, hypervigilance, and problems with concentration). The duration of the symptoms may run from three days to four weeks after trauma exposure, with clinically significant distress or impairment.

The diagnosis of PTSD includes the same exposure criteria as ASD (i.e., exposure to death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation). In addition, the adult and adolescent PTSD diagnosis requires: • One symptom of intrusion (criterion B) including recurrent distressing dreams, recurrent distressing memories of the trauma, dissociative reactions (e.g., flashbacks), or intense psychological or physiological reactivity to reminders of the trauma; • Persistent avoidance of internal or external stimuli associated with the trauma (criterion C); • Two symptoms of negative alterations in cognitions and mood associated with the trauma (criterion D) including persistent, distorted blame of self or others, persistent negative emotional state (e.g., fear, horror, anger, shame or guilt), diminished interest or participation in significant activities, detachment or estrangement from others, or persistent inability to experience positive emotions (e.g., emotional numbing); and • Two symptoms of alterations in arousal and reactivity (criterion E), including irritability or aggressive behaviour, reckless or self-destructive behaviour, hypervigilance, exaggerated startle, problems with concentration, or sleep disturbance. The diagnosis also requires symptoms to last more than one month, to be associated with clinically significant distress or impairment, and not to be associated with the effects of a substance or medical condition. In addition, a subtype of PTSD for preschool children aged six or younger highlights significant differences including the still developing abstract cognitive and verbal expression capacities.

PTSD can present concurrently with mood and anxiety symptoms, and the presence of mood and anxiety disorders should be ascertained. The main differential diagnoses to be considered are: • Adjustment disorder • ASD • Anxiety disorder • OCD • Major depression • Dissociative disorders • Conversion disorder • Psychosis • Substance intoxication • Traumatic brain injury.

Treatment

While children and adolescents in distress or seeking assistance should be offered the opportunity to ventilate individually about the trauma if they wish to do so, unrequested debriefing (in particular in a group setting) is not recommended. Guidelines recommend avoiding the use of benzodiazepines in the immediate aftermath of trauma, and there is also no evidence of the usefulness of antidepressant, antipsychotic or beta-blocking medications.

Exposure-based interventions delivered immediately after trauma may help prevent PTSD in youth exposed to trauma, based on their efficacy in treating PTSD in children and adolescents (see below) and in preventing PTSD among adults. Finally, it is recommended to provide psychological first aid, including education about the usual course and normal reactions to trauma, and ensure that basic

medical and safety needs are met, including shelter and food, increase social support, and provide appropriate referral.

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) has been shown to reduce PTSD symptoms, trauma-related depression, and improve adaptive functioning in a variety of populations, including children and teens traumatized by sexual abuse, terrorism, domestic and community violence, and traumatic loss. An adaptation has been tested in a sample of children ages three to six, with positive results.

TF-CBT is a time-limited (12-16 sessions) therapy that combines exposure, cognitive processing remodelling and enhancement of coping skills, delivered sequentially in 10 components: psycho-education, parenting skills (parent), relaxation skills, affect regulation skills, cognitive coping skills, trauma narrative, processing cognitive distortions, in vivo mastery of trauma triggers, parent-child sessions, and skills to increase safety from future exposures to trauma. Pre-School PTSD Treatment consists of 12 conjoint child-parent sessions and uses drawing as a developmentally appropriate expressive modality for the child to identify thoughts and feelings and to process the child's trauma narrative.

Parental involvement leads to better outcomes by reducing drop-outs, providing children an ally when completing homework assignments, in maintaining a positive outlook, and practicing skills to maintain gains post-treatment.

Finally, although the mechanism of action is unclear, eye movement desensitization and reprocessing (EMDR) has been found to be effective in adult PTSD.

Reference

Bui E, Ohye B, Palitz S, Olliac B, Goutaudier N, Raynaud JP, Kounou KB & Stoddard FJ Jr. Acute and chronic reactions to trauma in children and adolescents. In Rey JM (ed), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2014.

Brunet A, Weiss DS, Metzler TJ et al (2001). The Peritraumatic Distress Inventory: A proposed measure of PTSD criterion A2. American Journal of Psychiatry 158:1480- 1485.

[To go to Best Practice Model BP6a close this file and go via Best Practice Index]

[To go to Policy POL6a close this file and go via Policy Index]

Last updated 15/1/2022