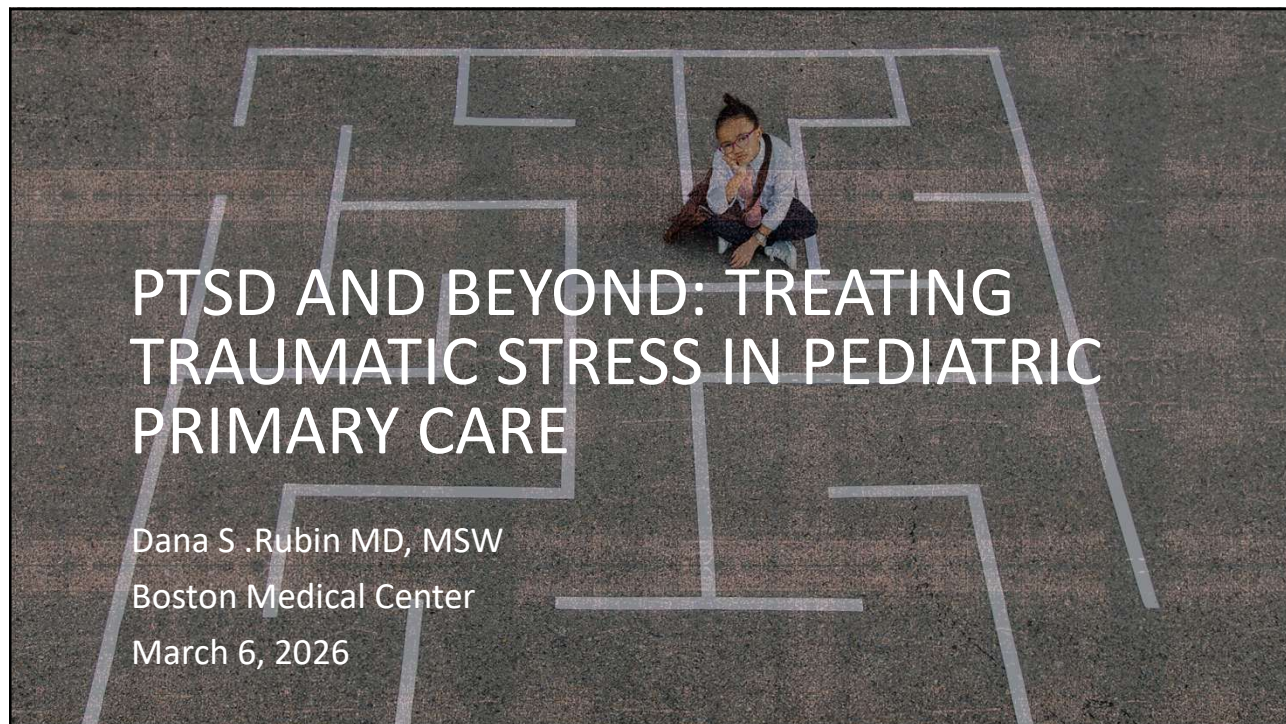




1

Trauma impact	• Review of impact of traumatic events that may impact child development and behavior and factor that improve resiliency
Lumping or Splitting	• Consider the differential diagnosis and comorbidities associated with trauma exposure
Cases to consider	• Case 1: Behavioral dysregulation • Case 2 : Pain and trauma
Treatment options	• Therapy interventions • Psychopharmacology

LEARNING GOALS



2

TYPES OF CHILDHOOD TRAUMA

 Bullying Unwanted aggression intended to hurt based on a power imbalance	 Complex trauma Repeated exposure to traumatic events leading to long-term effects	 Disasters Experiencing natural disasters like earthquakes, hurricanes, wildfires, etc	 Early trauma Going through a trauma as a child aged between 0 - 6
 Physical abuse When a caregiver or parent physically injures/touches a child	 Domestic violence When a parent abuses their spouse/partner affecting the child	 Medical trauma Experiencing illness both for the child themselves and/or in the family	 Religious trauma When a child's wellbeing is negatively impacted due to religious beliefs
 Refugee trauma Experiencing trauma due to war, persecution or fleeing a country	 Terrorism When a child is affected by a terrorist attack or form of mass violence	 Grief trauma Due to loss or any death of a loved one close to the child	 Emotional trauma Trauma as a result of chronic emotional abuse often by caregivers

TRAUMATIC EVENTS

Are there others ?

3



General population:

- 25% have experienced trauma
- 50% have at least one Adverse childhood experience that can result in trauma
- National Survey of Children's Exposure to Violence: 60 % have exposure to violence at home or school

Referred children and teens

- 70% experienced multiple traumas
- 11% reports all types of complex trauma

4

MALADAPTIVE RESPONSES TO TRAUMA: VOCABULARY (SUMMARY OF NCTSN: INTEGRATED CARE COLLABORATIVE GROUP, COMPLEX TRAUMA AND DTD COLLABORATIVE GROUP)

Adverse Childhood Experiences:
Abuse, neglect, parental mental illness or substance use, community violence, poverty, loss of a parent

Toxic Stress: 'excessive or prolonged activation of the physiological stress response systems in the absence of the buffering protection afforded by stable, responsive relationships' (AAP, 2012)

Childhood traumatic stress:
response to trauma that overwhelms ability to cope with intense emotional/physiological distress

Acute Stress disorder and Post traumatic stress disorder: DSM 5 disorders that meets specific criterion for reaction and symptoms after traumatic event

Complex Trauma: multiple chronic traumatic events and relationships with impact on attachment and self regulation skills (Cloitre, 2009) (ICD-11)

Developmental Trauma: proposed for young children with complex trauma and lack of nurturing relationships that affects many developmental domains (Van der Kolk 2005)



5



Acute Stress Disorder

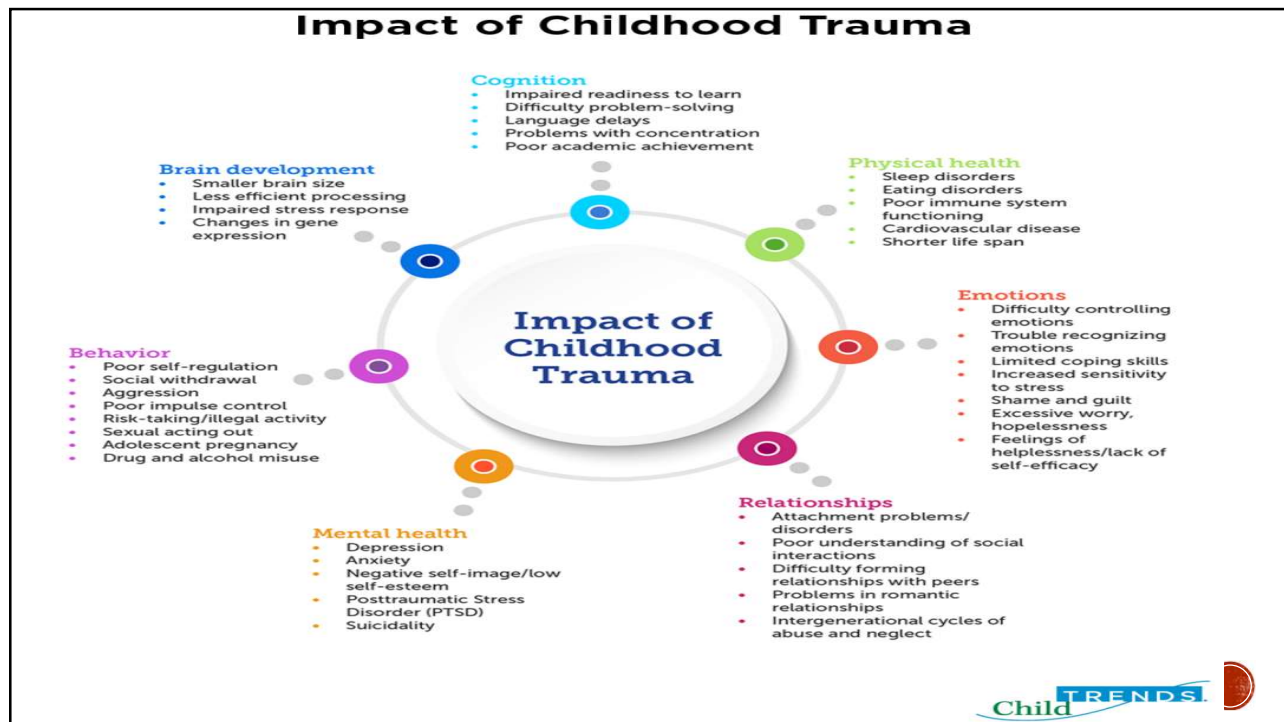
Post traumatic Stress Disorder

Adjustment Disorder

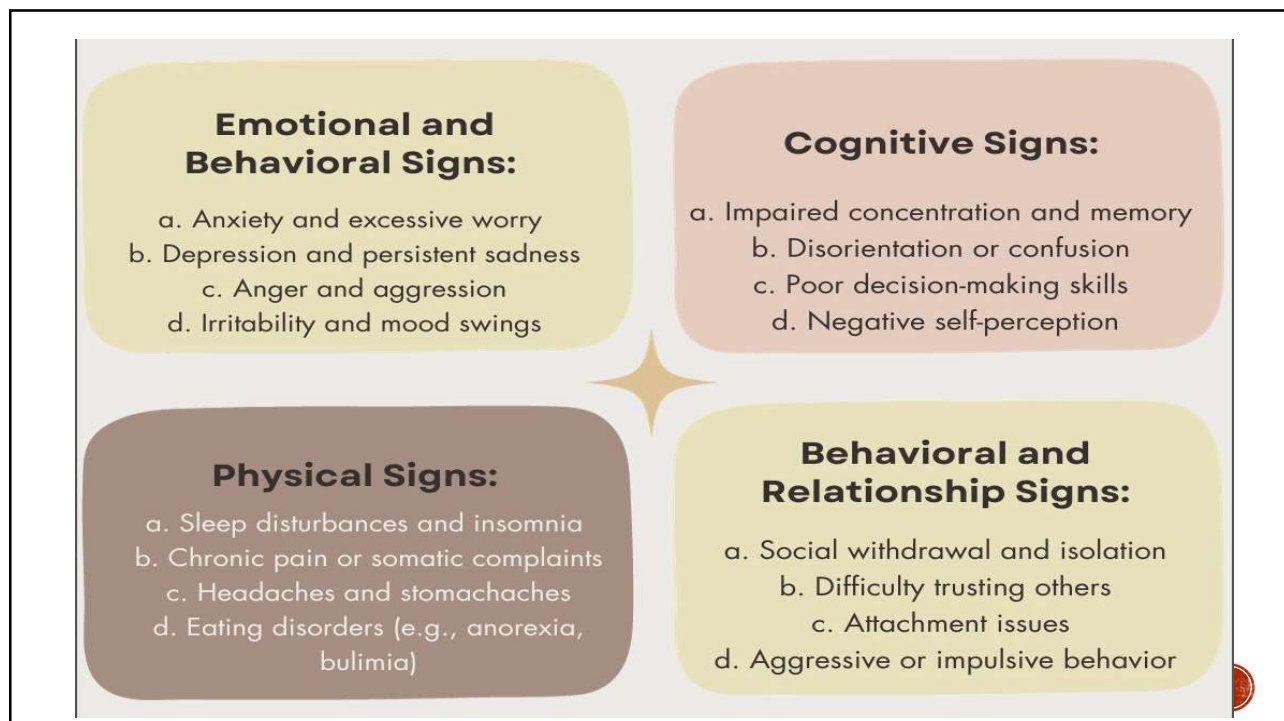
Reactive Attachment Disorder

Disinhibited Social Engagement disorder

6



7



8

- Trauma exposure: doubles the rate of all psychiatric disorders compared to non-exposed child, including
 - Anxiety/Depression
 - Substance abuse
 - Disruptive behavior
 - Neurocognitive changes /ADHD
 - **PTSD – 6-10% prevalence in children**
- Children with ‘subclinical’ diagnosis may have similar morbidity as PTSD
- Suicide: Adolescents with a history of sexual abuse are **8x more likely to attempt suicide** than non-traumatized peers
- Substance abuse:
 - Parental and personal substance abuse increases risk of trauma
 - Trauma exposure increases risk of substance use and abuse
- Parental trauma history:
 - Decreases parenting capacity for maintaining safety for child
 - Maternal PTSD > maternal depression are associated with increase in children’s exposure to traumatic events (Chemtob, 2013)



9

TRAUMA SYMPTOM OVERLAP: DIFFERENTIAL DIAGNOSIS VS COMORBIDITY

- ADHD symptoms ↔ Hypervigilance, reactivity, arousal
- Anxiety symptoms ↔ Hypervigilance, reactivity
- Depression ↔ less interest in play, poor sleep, nightmares
- Mood disorder (bipolar) ↔ irritable, tantrums, avoidance
- Autism ↔ withdrawn, avoidant, poor eye contact
- ODD and CD also overlap with ADHD symptom, irritability, reactivity
- Emotional and behavioral dysregulation prior to trauma may increase risk of developing PTSD.
- **Most children with trauma exposure and PTSD , have psychiatric comorbidity**



10

RESILIENCE: SUPPORTING RESILIENCE WITH POSITIVE CHILDHOOD EXPERIENCES (PCE) (SONU, ET AL, 2024)



Social determinants of health

- Housing
- Food
- Access to supports

Encourage social and community involvement

- School or community activities

Office based assessment and interventions (Keeshin, 2025)

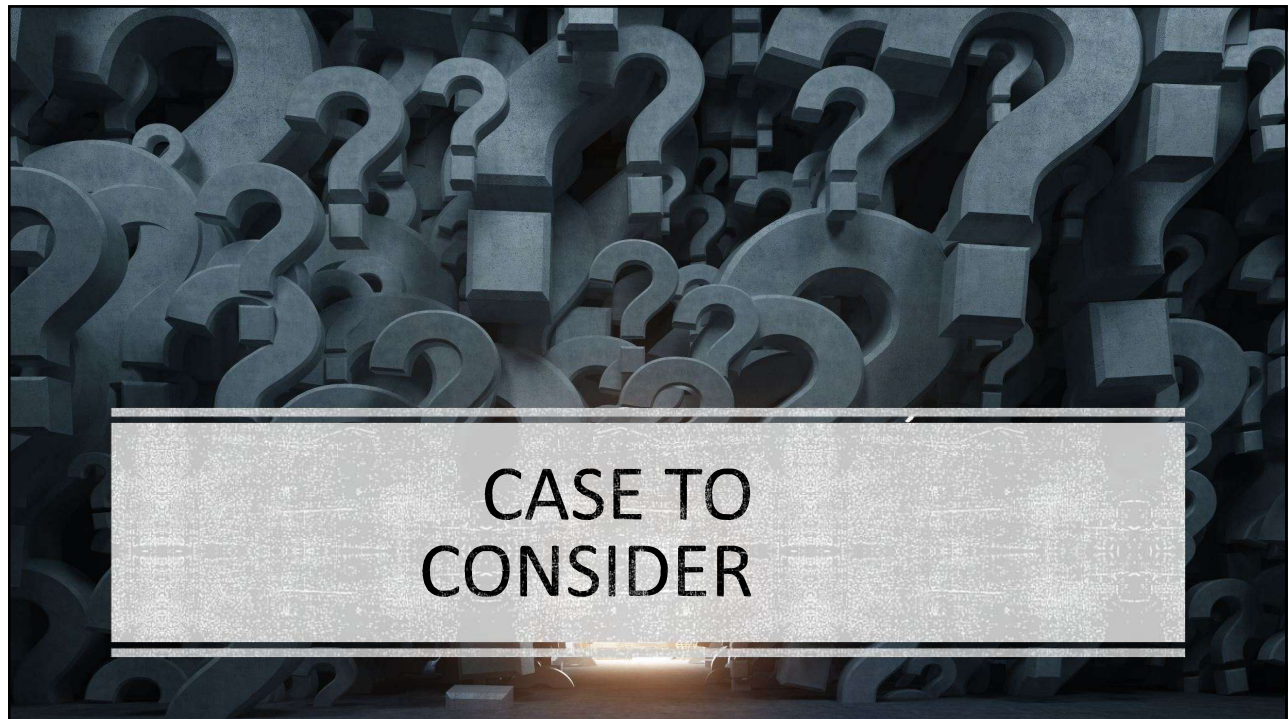
- Screening for trauma and co-morbidities
- Relaxation and emotional regulation tools
- Progressive relaxation techniques

Support positive parenting

- Anticipatory guidance
- Sleep hygiene and routines
- Parental/family referral to BH support
- Referral to EI for at risk families



11



12

ADHD OR SOMETHING ELSE?



- 10 year old Maurice for WCC and school concerns
- School : Easily agitated and has a hard time concentrating in class.
- Social: Arrived 5 years ago from Haiti. Mother moved family due to Hurricane. Parents are divorced.
- Mother had a relationship in US that ended with a restraining order.
- Pt is having trouble sleeping with frequent nightmares. Family hx: Maternal depression,



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What else do you
want to know ?

What is your
differential ?

Where would you
start?

WHAT ARE
YOUR
THOUGHTS?



14

RECOMMENDATIONS FOR PTSD IN CHILDREN



Trauma Focused therapies



Somatic therapies



Psychopharmacology ONLY if urgent and/or other therapies are not available



15

TREATING YOUNG CHILDREN

Child-Parent Psychotherapy (CPP) (Lieberman, et al. JAACAP, 2005)

- Developed for children exposed to interpersonal violence (IPV) and the affected parent
- Supports developmentally appropriate interactions between parent and child
- Assists in the development of a joint trauma narrative
- Both parents and children show improved PTSD symptoms and decreased maladaptive behavior.

Attachment , Regulation and Competency Model ARC (Kinniburgh & Blaunstein, 2024)

- Based in normative development
- Understanding childhood traumatic stress
- Attachment theory
- Supporting caregivers to enhance resilience



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TRAUMA FOCUSED CBT: CORE COMPONENTS

P: Psychoeducation and parenting skills

R: Relaxation skills

A: Affective regulation

C: Cognitive coping skills

T: Trauma Narrative

I: In vivo mastery

C: Conjoint child parent

E: Enhancing safety

For children ages 3- 17, demonstrate improvement in PTSD symptoms in children as well as trauma related distress in parents.



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Focus on emotional and behavioral dysregulation secondary to trauma exposure

Supports caregivers in helping child to manage the environment and minimize response to trauma triggers

Increase capacity for emotional regulation

Create / support a team that includes school, community and family to support family

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SOMATIC THERAPIES



Focuses on Mind –Body connections



Used relaxation techniques including grounding, breathing exercise



Goal is regulation of nervous system



Less focused on disclosing the trauma or creating a narrative



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TRAUMA, COMORBIDITIES AND PSYCHOPHARMACOLOGY

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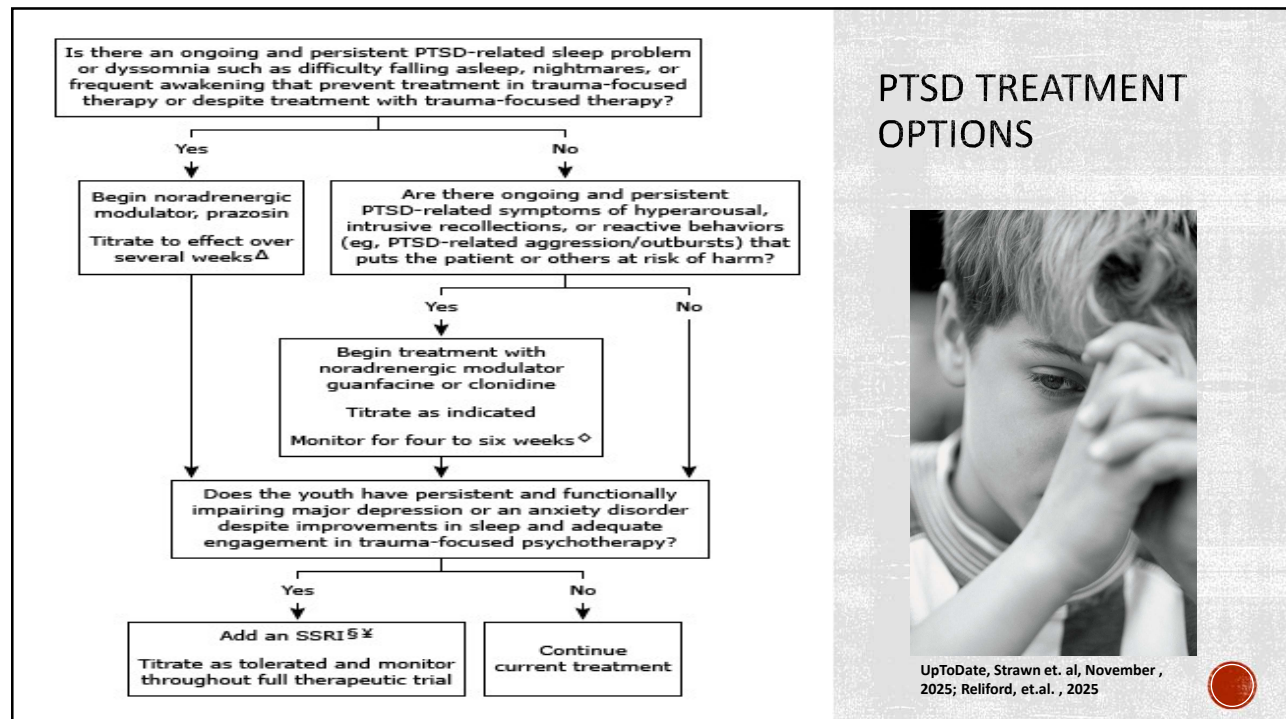
NO MEDICATIONS APPROVED FOR PTSD IN CHILDREN



- Focus is on symptom management and
- Diagnosis of comorbidities
- CBT therapies have become the 'gold' standard for treatment



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BACK TO MAURICE

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ADHD OR SOMETHING ELSE?



- 10 year old Maurice for WCC and school concerns
- School : Easily agitated and has a hard time concentrating in class. He has always been an active child with some difficulty following directions. Loses his belongings and very emotional.
- No thoughts about harming self; but cannot report anything he is excited about.
- Social: Arrived 5 years ago from Haiti. Mother moved family due to Hurricane. Parents are divorced. Housing and food are stable
- Mother had a relationship in US that ended with a restraining order.
- Pt is having trouble sleeping with frequent nightmares. Less interest in soccer his favorite sport
- Family hx: Maternal depression, Paternal substance use



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Sleep and Hyperarousal



Attention and Focus



Mood

WHERE CAN WE MAKE A DIFFERENCE?

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SLEEP,
NIGHTMARES,
AND
HYPERAROUSAL
IN TRAUMA
RELATED
DISORDERS

- **First line: Behavioral support**
 - Limit nighttime screen time
 - Sleep hygiene
 - Relaxation techniques
- **Alpha agonists** : Clonidine , Guanfacine
- **Alpha antagonist**: Prazosin: 1-6 mg at night
- **B-Blocker** : Propranolol: 10-20 mg 3 x a day / or long acting for older teens
- **Atypical antidepressants**
 - Mirtazapine: 7.5 -45 mg
 - Low dose may be more effective for sleep and anxiety
 - Increases appetite
 - Trazadone: 25 -100 mg
 - Groggy in the morning
 - Small risk: priapism

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OTHER OPTIONS FOR TRAUMA REACTIVE SYMPTOMS/ANXIETY/SLEEP

Hydroxyzine – anti-histamine

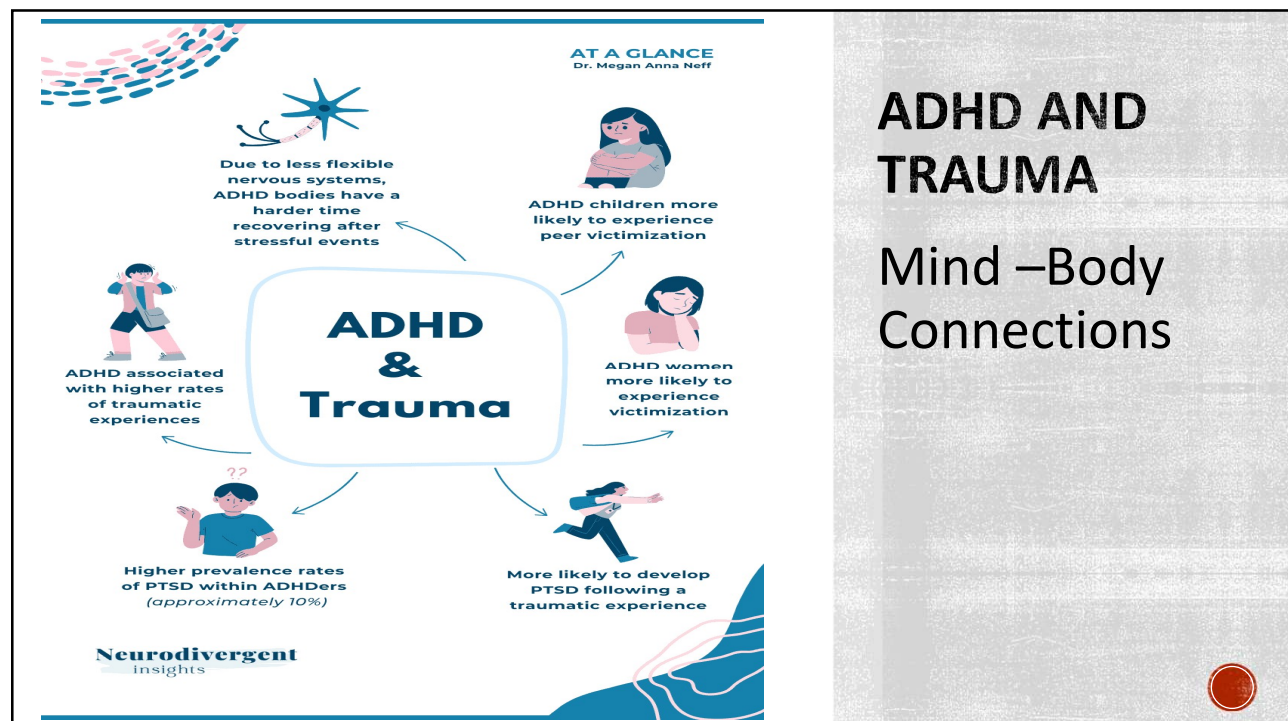
- Anxiety and sleep
- Initial dose 10mg- max 50 -100 mg
- May be used 4x a day
- Usually short term

Benzodiazepines- Ativan / Klonopin

- Use limited in children and adults
- National Center for PTSD (VA) advises against use



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TREATING ADHD IN CONTEXT OF TRAUMA RELATED SYMPTOMS

Stimulants

Methylphenidate/Concerta

Adderal/Vyvanse

Focalin/Focalin XR

Alpha-2 agonist

Clonidine/Kapvay: 0.01
mg/kg/day – usually 0.3-0.4 mg

Guanfacine/Intuniv: 0.1
mg/kg/day

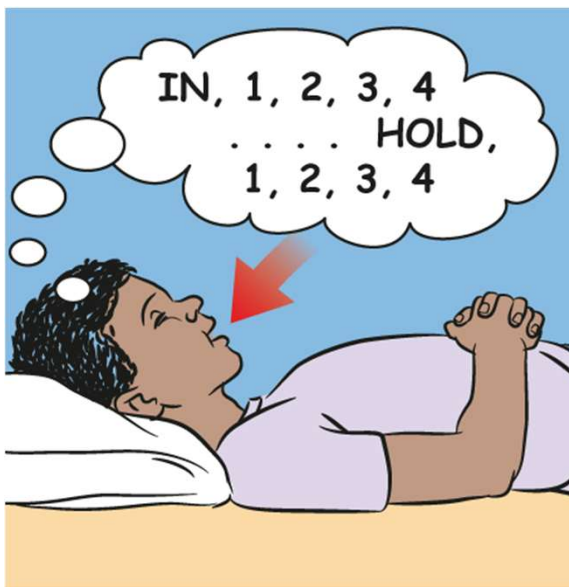
NRI (Norepinephrine reuptake Inhibitor)

Atomoxetine: 0.5 -1.6
mg/kg/day

Viloxazine: 100 -400 mg q day



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ADHD AND /OR HYPERAROUSAL

ADHD as a key component of school issues

- School assessment and accommodations
 - Consider ADHD medications
 - Stimulants are very effective in children with or without Trauma (Baweja, 2026)
 - Small risk of agitation or anxiety
 - Alternatives: Alpha antagonist or atypical ADHD medication (Atomoxetine)

Assess for other etiologies of emotional outbursts : anxiety, depression, trauma reactive behaviors/ PTSD

- Guidance on ways to calm his body
- Refer family to evidence based treatments/interventions



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MEDICATION MANAGEMENT FOR ANXIETY AND DEPRESSION

- **SSRI**-Fluoxetine, Sertraline, Lexapro
 - TAD study: teens with Trauma history had a differential response to interventions, CBT, Fluoxetine, and combined (Lewis, et al, 2010)
 - Fluoxetine, 10 -60 mg;
 - FDA approved for 8-18 yo MDD, OCD
 - Lexapro: FDA approved for children
 - Start with 5 mg ; max 20 mg
 - Sertraline, 25 mg -200 mg – FDA: OCD
 - Ages 6 and up
- **Serotonin partial agonist** – Buspirone (Buspar)
 - Minimal data to support-second line for anxiety
 - Dose: 5-20 mg tid with food
- **SNRI**- (Serotonin and Norepinephrine Reuptake inhibitor) Duloxetine
 - FDA approved for (7-17yo) anxiety and Juvenile Fibromyalgia
 - Starting dose 20 mg – max 60 mg



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ROLE OF MOOD STABILIZERS IN TRAUMA

Antipsychotics

- No clear data for PTSD
- Assess risk/benefit in context of metabolic side effects
- May be helpful if clear co-morbidity
 - Violent/Aggressive behavior (Oppositional defiant disorder/Conduct disorder)
 - Bipolar disorder
 - Psychosis

Antiepileptics

- Limited data on use of anti-epileptics in adults with PTSD
- Some reports in adults that helps with anger and anxiety
 - Depokote
 - Lamotrigine
 - Gabapentin
 - Topomax
- Case studies with variable outcomes in children for PTSD



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Diagnoses

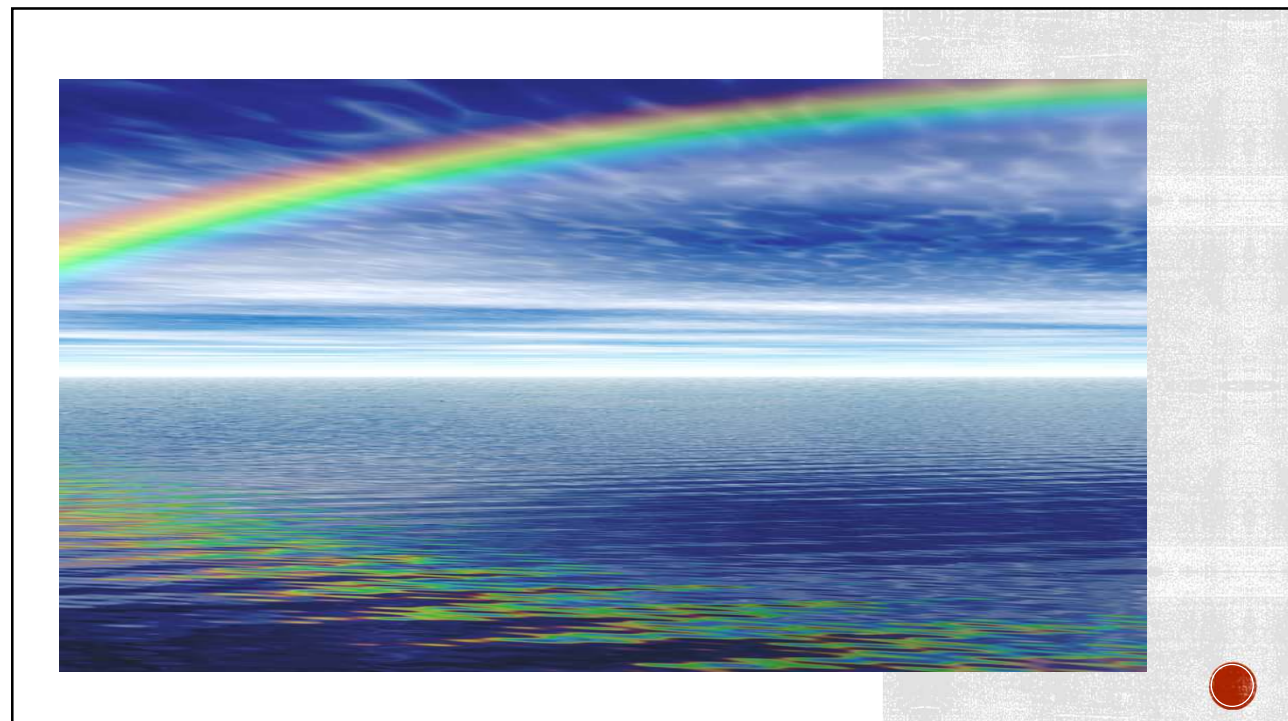
- ADHD
- PTSD
- Mood disorder: Persistent depressive disorder

Interventions

- Trauma focused therapy
- Support for Parental depression/PTSD
- School evaluation / support
- Medications to address sleep, inattention and possibly mood

MAURICE: YOUR THOUGHTS?

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IN SUMMARY



- **Primary care relationship is the key to prevention and promotion of resilience for at risk children**
- Know the signs of traumatic stress
- No magic pill! Screen for and treat comorbid disorders and trauma related symptoms
- Never worry alone !

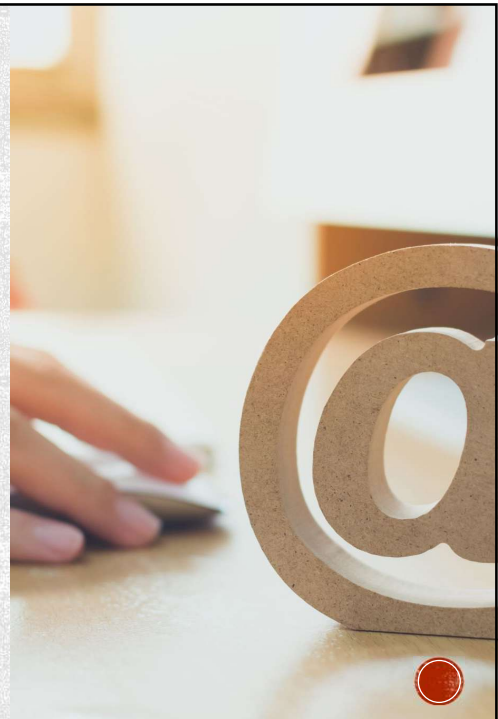


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QUESTIONS? COMMENTS?

Contact me!

Dana.Rubin@bmc.org



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RESOURCES



- National Child Traumatic Stress Network (NCTSN): www.nctsn.org
- PICC: <http://web.jhu.edu/pedmentalhelth/Plcc%20Toolkit.pdf>
- AAP: Trauma tool kit: <https://www.aap.org/Topamax-us/advocacy-and-policy/aap...care.../Trauma-Guide.aspx>
- AACAP- Facts for Families : https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Posttraumatic-Stress-Disorder-PTSD-070.aspx
- Trauma Center: <https://www.ptsd.va.gov>
- [Http://www.Kidsmentalhealthinfo.com](http://www.Kidsmentalhealthinfo.com)
- SMART therapy: <https://traumaresearchfoundation.org>
- CDC: <https://vetoviolence.cdc.gov/apps/aces-training>
- From the Center for Racial Justice in Education: [Resources for Talking About Race, Racism and Racialized Violence With Kids](#)



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SSRIs: First Line Medications for Pediatric Anxiety and Depression

Drug (Brand)	FDA Approval	Formulations	Dosing	Pharm. Props.	Side Effects	Comments
Fluoxetine (Prozac)	MDD ≥ 8yo, OCD ≥ 7yo	Capsules: 10/20/40mg Tabs: 10/20/60mg Sol: 20mg/5mL	- Start 10mg QD (5mg/day for younger) - Initial target 20mg QD - Monthly increments/decrements 10-20mg - FDA Max 60mg/day (20-30mg/day for younger children)	o Long half-life (days) o Out of system 1 m after stopping o Strong P450 interaction (2D6, 2C19 inhibitor)	SAME FOR ALL SSRIs: COMMON: • Nausea • Headaches • Dry mouth • Fatigue • Diarrhea • Constipation • Sweating • Sexual side effects • Activation/anxiety RARE: • Increase suicidal ideation (<u>not</u> completed suicide) • Hypo/mania EXTREMELY RARE: • Seizures (OD) • Serotonin syndrome	• ALL SSRIs: Usually takes 2-4 weeks to see effects; 4-8 weeks to see full effects • Good for nonadh. pts due to long T _{1/2} • Discontinuation symptoms less likely • More potential for drug-drug interactions
Sertraline (Zoloft)	OCD ≥ 6yo	Tabs: 25/50/100mg Sol: 20mg/mL	- Start 25mg QD; 12.5 mg for younger children - Initial target ~50mg QD - Monthly increments/decrements 25-50 mg - FDA Max 200mg/day	o Medium half-life (1 day) o Out of system 1 week after stopping o Weak P450 interaction		• Unlikely to have drug-drug interactions • May have discontinuation symptoms; taper off
Escitalopram (Lexapro)	MDD ≥ 12yo GAD ₂₇	Tabs: 5/10/20mg Sol: 5mg/5mL	- Start 5 mg QD, - Initial target ~10mg QD - Monthly increments/decrements 5-10mg - FDA Max 20mg/day	o Medium half-life (1 day) o Out of system 1 week after stopping o No P450 interaction		• Unlikely to have drug-drug interactions • May have discontinuation symptoms; taper off

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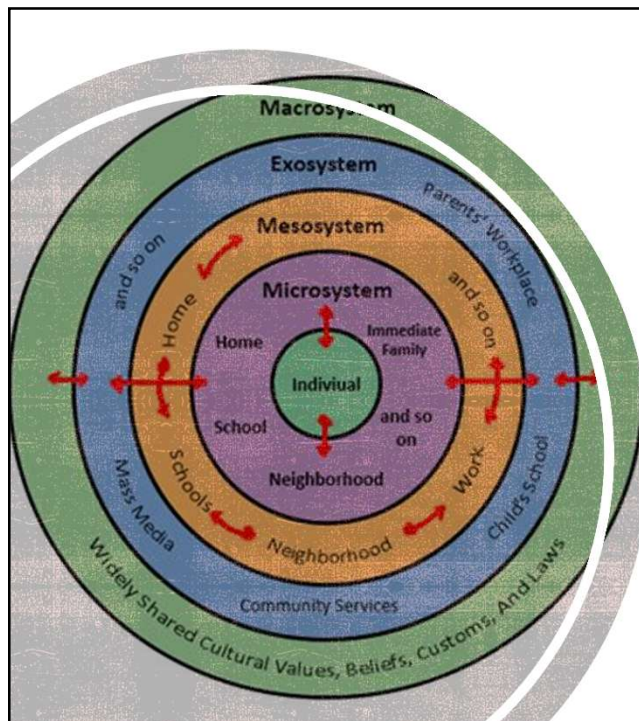

ProjectTEACH

Questions? Call Project TEACH: Clinical Consultation Line: 1-855-227-7272 (Monday-Friday • 9 am – 5 pm)

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ECOLOGICAL MODEL -BRONFENBRENNER

- Model for Trauma Systems Therapy



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BIDIRECTIONAL RELATIONSHIP OF PTSD AND ADHD (SPENCER, ET AL, 2016, 2017)

- Meta-analysis from 13 studies
- Relative risk for ADHD in PTSD, 1.7
- ADHD onset prior to PTSD diagnosis
- Those with ADHD **have 4x risk** of developing PTSD
- Note similar abnormalities with fMRI for those with ADHD and PTSD.
- **Increased morbidity when both disorders present**

