

Evidence-Informed Practice Models Addressing Trauma

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is a specialized form of cognitive behavioral therapy (CBT) used to address traumatic experiences in children and teens ages 3-18. CBT focuses on examining the impact of thoughts/beliefs (cognitions) and feelings on behavior. TF-CBT is a structured, evidence-based treatment that can be effective in as few as 12-18 sessions and helps target cognitive distortions or irrational thoughts (blame, shame) surrounding traumatic experiences. TF-CBT typically involves a parent or guardian, a steady attachment figure who could be the foster parent or prospective adoptive parent. Involvement of this attachment figure helps promote healing for the family as a whole.

TF-CBT goes through different units to teach the child and guardian coping and relaxation skills, parenting skills, provides psychoeducation about the impact of trauma and normalizes the child and family's response, discusses safety skills to seek to prevent further trauma, and the therapy builds to a child creating a narrative or their unique story of their traumatic memories in order to lessen PTSD or other symptoms (depression, anxiety, behavior problems, shame, relationship issues, sexualized behavior) connected to the trauma. It has been widely researched and found effective with improving child and family functioning, even up to two years post-treatment, and can be used for a variety of traumatic experiences, also with a wide range of ages (3-18). It has been shown to be effective for children in foster care. TF-CBT may not be the best first line of treatment if the child or adolescent is severely depressed, suicidal, actively abusing drugs or alcohol, or showing violent or delinquent behaviors. In these situations, other forms of treatment to target these urgent needs are indicated initially, although TF-CBT may be used later. The Child Welfare Information Gateway's factsheet on TF-CBT at this link describes its 6 practice components: <https://www.childwelfare.gov/pubPDFs/trauma.pdf>

Components of the TF-CBT protocol can be summarized by the word "PRACTICE":

- *P - Psychoeducation and parenting skills—Discussion and education about child abuse in general and the typical emotional and behavioral reactions to sexual abuse; training for parents in child behavior management strategies and effective communication*
- *R - Relaxation techniques—Teaching relaxation methods, such as focused breathing, progressive muscle relaxation, and visual imagery*
- *A - Affective expression and regulation—Helping the child and parent manage their emotional reactions to reminders of the abuse, improve their ability to identify and express emotions, and participate in self-soothing activities*
- *C - Cognitive coping and processing—Helping the child and parent understand the connection between thoughts, feelings, and behaviors; exploring and correcting of inaccurate attributions related to everyday events*

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- *T - Trauma narrative and processing—Gradual exposure exercises, including verbal, written, or symbolic recounting of abusive events, and processing of inaccurate and/ or unhelpful thoughts about the abuse*
- *I - In vivo exposure—Gradual exposure to trauma reminders in the child’s environment (for example, basement, darkness, school), so the child learns to control his or her own emotional reactions*
- *C – Conjoint parent/child sessions—Family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse and for the child to share his/her trauma narrative.*
- *E – Enhancing personal safety and future growth—Education and training on personal safety skills, interpersonal relationships, and healthy sexuality and encouragement in the use of new skills in managing future stressors and trauma reminders.*

For further information on an analysis of the research documenting TF-CBT’s efficacy:

<http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed>

Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP) is a form of therapy used for young children, ages 0-5, and their primary caregiver, focused on the impact the trauma has had on the parent-child relationship. CPP seeks to enhance the parent-child relationship and improve the child’s overall mental health and development. It is used primarily for children who have experienced maltreatment. CPP is based in attachment theory but involves many other theories. It is a longer form of treatment typically involving weekly sessions for a year or more. CPP targets safety, being able to control emotions and responses to trauma, maladaptive coping patterns, and negative behaviors. It creates a joint narrative of the traumatic event with the child and parent, seeking to identify and change negative reactions to trauma triggers or reminders. CPP can be done in home (foster, adoptive, birth family, kinship care) or in an office, and its effectiveness is enhanced through the involvement of the caretaker. It is one of a few treatments supported by research for children under the age of 6, and because it is a flexible intervention tailored to the child and family, it works well across different cultures.

<http://www.cebc4cw.org/program/child-parent-psychotherapy/>

http://www.nctsn.org/sites/default/files/assets/pdfs/cpp_general.pdf

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Eye Movement Desensitization Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is another evidence-based trauma treatment with the highest scientific rating that can be used for children ages 2-18. It involves bilateral stimulation such as side to side eye movements, alternate tapping on knees, or alternating sounds in left and right ears while processing traumatic memories. This type of stimulation taps into memories stored in different areas of the brain and reduces the bodily responses to traumatic reminders. It has been recognized by the U.S. government for its effectiveness in treating PTSD in veterans, and it works for a variety of trauma events as well as grief and loss. EMDR is used to target symptoms of PTSD yet the youth does not have to have this diagnosis for EMDR to be effective. It decreases the lasting effects of distressing memories and enhances adaptive coping skills. EMDR incorporates CBT principles and explores the child's thoughts/beliefs, emotions and bodily responses to the trauma event, seeking to neutralize these responses. It is effective in reducing immediate distress and integrates relaxation training, strengthening positive thoughts and coping, to promote recovery from trauma. It is also a time limited form of treatment, and often improvements can be seen in a few sessions.

<http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/>

<http://www.emdr.com/what-is-emdr/>

Multisystemic Therapy (MST) for Child Abuse and Neglect

Multisystemic Therapy (MST) can be used for children and youth, ages 6-17, who are at risk of being placed out of the home and/or have delinquent behaviors and possible involvement with juvenile justice systems. While MST is often targeting youth ages 12-17, MST for Child Abuse and Neglect (MST-CAN) is used for youth ages 6-17. MST is well supported in research and MST-CAN is shown to reduce recurrence of abuse and neglect and prevent out of home placement, improve parenting and family functioning while increasing other social supports. MST is an intensive, often short term (3-9 months) in-home or community based program where multiple systems (child welfare, juvenile justice, courts, schools, family supports, other treatment providers) collaborate regularly with extensive safety protocols, problem solving, enhancing family communication, and CBT for anger management and addressing PTSD. MST typically involves a team of 3 clinicians collaborating with other systems and in contact with the family many times a week, available on-call for crisis 24/7. It is helpful in stabilizing families and emergent issues.

<http://www.cebc4cw.org/program/multisystemic-therapy/>

<http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/>

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Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP)

This treatment is specifically adapted to be used with those with developmental disabilities or impaired cognitive functioning, who are ages 8-21. It is based on CBT (cognitive behavioral therapy) and teaches specific coping skills in these four core areas: mindfulness, emotion regulation (being able to control emotional responses to stressors), distress tolerance (stress management), and relationship effectiveness. DBT-SP typically involves about 18 sessions per skill group mentioned above.

http://www.nctsn.org/sites/default/files/assets/pdfs/dbtsp_general.pdf
<https://mha.ohio.gov/Portals/0/assets/HealthProfessionals/About%20MH%20and%20Addiction%20Treatment/TIC/ResourceLibrary/DBT-SP%20Skills%20Training%20Manual%20v3%204.pdf>

SMART

SMART stands for Safety, Mentoring, Advocacy, Recovery, and Treatment. SMART is used specifically for children ages 4-11 who have been sexually abused and are showing sexualized behavior. This form of treatment targets the family unit, looking at the family values and beliefs, power structure, family beliefs about sexuality and gender roles, identity. It is unique in addressing the dual treatment needs of the child as a victim of sexual abuse as well as someone who victimizes others with sexualized behavior. SMART helps to build strong resources and support structure that will continue to support the family following completion of treatment.

https://www.nctsn.org/sites/default/files/interventions/smart_fact_sheet.pdf
<http://www.cebc4cw.org/program/safety-mentoring-advocacy-recovery-and-treatment/>
https://www.kennedykrieger.org/sites/kki2.com/files/smart_pub.pdf

SPARCS

SPARCS stands for Structured Psychotherapy for Adolescents Responding to Chronic Stress and is a group model intervention for chronically traumatized adolescents. SPARCS is a group model, typically consisting of 16, hour long weekly sessions over several months, and can be done in a variety of settings such as schools, group homes, residential treatment programs and in foster care programs. It teaches teens to cope more effectively in the moment and helps the teenager to improve their overall emotional and mental health as well as creating supportive relationships. Rather than targeting the specific instances of trauma and involving the caregiver, SPARCS operates on peer support and helps teens learn to cope with ongoing stressors. It draws upon CBT and is somewhat similar to DBT mentioned above in teaching coping and relationship skills yet more user-friendly language and exercises, adapted to teenagers living in unstable or stressful environments. SPARCS views the youth's symptoms as their best efforts to cope with chronic

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stress. Group members often process their personal experiences and find comfort and support through this. SPARCS is strengths-based and was developed specifically for adolescents and takes into account their developmental stage is separating more from the parent/caregiver.

http://www.nctsn.org/sites/default/files/assets/pdfs/sparcs_general.pdf

Other models described earlier:

Parent-Child Interaction Therapy (PCIT)

https://www.childwelfare.gov/pubPDFs/f_interactbulletin.pdf

<http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed>

<http://www.pcit.org/>

Attachment, Self-Regulation, & Competency (ARC)

http://www.nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf

Dyadic Developmental Psychotherapy (DDP)

<http://www.cebc4cw.org/program/dyadic-developmental-psychotherapy/>

Trust-Based Relational Intervention (TBRI)

<http://child.tcu.edu/about-us/tbri/>

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