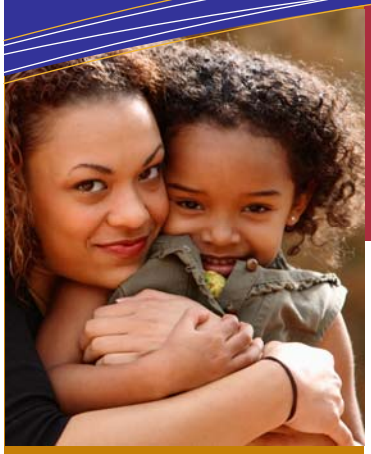
Snapshot

APRIL 2010



Children's mental health

Engaging youth and families in trauma-informed services

Children who experience childhood traumatic stress have been exposed to one or more traumatic events and develop reactions that persist after the events have ended. These reactions may include behavioral changes, difficulty with attention, and physical symptoms, such as difficulty sleeping.

Many of us may experience these reactions from time to time. However, when a child experiences traumatic stress, these symptoms can interfere with the child's daily life and ability to function and interact with others.

-The National Child Traumatic Stress Network

If a child or adolescent is experiencing traumatic stress, a variety of therapeutic approaches can reduce the symptoms associated with the trauma. However, to be effective, both the youth and the youth's family must be fully engaged in the effort. Services may also need to be adapted to ensure that they are culturally and developmentally appropriate.

This snapshot identifies some promising strategies to increase youth and family engagement through changes in agency practice, integration of developmentally-appropriate interventions, and use of culturally-appropriate therapeutic approaches. It also outlines the need for clinicians and agencies to document and share lessons from the field to add to the currently-limited research base.

Parent engagement in services

Youth and family engagement is critical to successful therapeutic outcomes. For a mental health intervention to succeed, youth and families must remain engaged long enough to receive the full array of needed services. Families may discontinue services early for a variety of reasons, such as perceived treatment barriers, low treatment expectations, and cultural norms that discourage seeking help outside the family. Symptoms of mental health issues tend to become more severe following early drop out from services.

Several studies have shown success engaging adolescents and families in treatment when agencies modified their intake process. In addition to gathering diagnostic information from families at intake (the traditional approach), intake staff also spent time clarifying parental expectations of treatment and identifying and addressing any barriers to attending the next appointment. The effectiveness of this strategy relies heavily on the involvement of support staff who, from the perspective of parents, are seen as service providers and often have the first contacts with clients.

While the child may be the primary client, parents also need time to meet with a therapist, often in one-on-one sessions. Although parents are typically experts in understanding their children, they may not understand their child's seemingly uncontrollable behavior. They may need information to help them understand their child's behavior from a developmental perspective and as a reaction to stress, instead of as intentionally disruptive. Parents seeking intensive services have often tried other intervention approaches

Working with youth who have more severe cognitive delays

There is a common misperception that therapy is not effective for youth with cognitive delays. Some clinicians have observed that group therapy is less effective, as youth with cognitive disabilities need a more highly structured and predictable treatment setting. However, individualized therapy can be used to provide trauma-informed services.

Treatment can be more effective when clinicians introduce one topic at a time, focus on concrete examples, use visuals, help youth develop a vocabulary to express their feelings, and provide many opportunities for repetition when teaching new skills.

without success, and may feel frustrated, discouraged, or guilty that they have not been able to resolve the problem on their own. Often, they look to the therapist to help them understand how to best meet the needs of their child.

When therapists provide parents with information about the services that will be provided to help their child, they validate parents' feelings and open the door to ongoing communication. As the partnership between the clinician and parent grows, the clinician can also begin to suggest strategies the parent can use at home to reinforce what is being emphasized in therapy, as appropriate.

The National Child Traumatic Stress Network (NCTSN) has developed a self-assessment tool for clinicians or agencies to use to appraise their strengths and weaknesses in engaging families at an individual, therapeutic level. While not an objective measure of the agency's ability to engage families, the tool can help the agency identify areas where improvements can be made and develop plans and goals to meaningfully address these issues.

To increase family involvement in trauma-focused services, clinicians and agencies can:

- Provide youth and families with clear information about what they can expect during therapy sessions and as a result of the services they receive.
- Assess the intake process from the perspective of parents and develop strategies to establish ongoing contact with families throughout treatment.
- Recognize the expertise parents bring to the table, while also validating their feelings of uncertainty regarding their child's behavior.
- Use data to identify when and why early termination of services occurs.

Developmentally-appropriate intervention approaches

According to the National Child Traumatic Stress Network, trauma-focused interventions include four common components: (1) ensuring child safety; (2) guiding skills development in self-regulation and interpersonal functioning; (3) revisiting and reframing past traumatic events; and (4) enhancing resiliency and integration into social networks. However, clinicians have noted that some children lack the self-regulatory skills needed to fully participate in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or other structured evidence-based therapies.

Bruce Perry's Neurosequential Model of Therapeutics recognizes that early trauma can negatively alter brain development and functioning. Stressors influence how the child understands a situation and responds to a perceived threat. To change behavior, trauma-focused interventions must be appropriate to the child's developmental age, focusing first on self-regulatory processes before moving into more complex therapeutic activities.

Perry outlines a number of considerations for clinicians to keep in mind when providing services to youth who have experienced trauma:

- The key to working with traumatized children is understanding what part of the brain is mediating the child's response and behaviors.
- Early intervention is critical to minimizing the impact of a potentially traumatizing experience.

- The therapeutic approach should include predictable therapeutic activities and developmentally-appropriate interventions.
- Ongoing monitoring of the child's symptoms is necessary, especially as children reach new developmental stages, such as puberty.

To provide developmentally-appropriate services, clinicians must build a toolkit of approaches that can be used at various learning stages. While many current efforts focus on identifying effective, developmentally-appropriate approaches for youth who have experienced trauma, there is not yet a recommended set of approaches that provides clinicians with a standard model.

Culturally-appropriate intervention approaches

Across cultures, individuals share a number of common responses to trauma, including mood swings (affect dysregulation), flashbacks (re-experiencing traumatic events), poor sleep, avoidance, and depression. However, within each culture, there are assumptions about the cause of the problem, requirements necessary for healing, appropriate behavioral and emotional responses to trauma, and the roles and responsibilities of the therapist or healer. While a growing amount of literature describes effective trauma-focused interventions appropriate for refugee and immigrant populations, much of this research focuses on the impact of war and resettlement. There is far less information available describing culturally-appropriate intervention strategies for youth who have experienced other types of trauma.

A few studies have demonstrated that interventions used to treat depression, anxiety, hyperactivity, and disruptive behaviors were equally effective for white, black, and Latino youth. One study also found that cognitive behavioral therapy, which uses a structured, goal-oriented process to address dysfunctional behaviors, feelings, and thoughts, and Eye Movement Desensitization and Reprocessing (EMDR), which uses brain stimulation and other techniques to desensitize traumatic memories, were promising approaches for immigrant youth with symptoms of post-traumatic stress disorder (PSTD).

While these studies suggest common approaches can be used with youth from multiple cultures, there is general consensus that adaptations of evidence-based practices or new approaches are still needed to improve outcomes and retain youth and families in trauma-focused treatment. To fill this research gap, there is a need for clinicians who work with youth from diverse cultural communities to document and share the therapeutic approaches they have found effective.

Sample program: Wilder's RAD Center

The Amherst H. Wilder Center for Children with Reactive Attachment Disorder (RAD Center) uses a number of innovative strategies to engage youth and parents in services and improve youth behavioral outcomes. Although the approach was not explicitly developed as a trauma-focused therapeutic intervention, most youth who receive services have experienced and exhibited symptoms of trauma.

Many of the youth enrolled in the RAD Center have tried cognitive behavioral therapy without success. Therefore, RAD Center staff work under the premise that in order to help these youth benefit from therapy, they need to develop the self-regulatory skills that allow them to be attentive and engaged in services.

To do so, all staff and clinicians:

- Develop individualized treatment plans that are based on the child's developmental, not actual, age.
- Offer youth a safe, structured environment with opportunities for a variety of sensory experiences.
- Use a variety of approaches from their "toolkit" of interventions, including object relations theory and techniques, individual and group activities, "parts language," Audio Visual Entrainment (AVE), Eye Movement Desensitization and Reprocessing (EDMR), and Dialectical Behavioral Therapy (DBT), before engaging youth in cognitive behavioral therapy.
- Build strong relationships with parents by sharing common experiences, and providing parents with skills training they can use with their children at home.

Next steps

While this snapshot highlights promising approaches to provide more effective services to youth who have experienced complex trauma, we need a more comprehensive practice-informed research base that provides clinicians and agencies with ways to help youth and families who often avoid or drop out of treatment. While additional time and effort is needed to document and share lessons learned when using a variety of developmentally– and culturally-appropriate approaches, these practical considerations are not always addressed in studies examining the effectiveness of evidence-based practices. Greater coordination and sharing of lessons learned among clinicians and agencies who are working to provide services to these hard-to-reach youth can help move the field of trauma-informed services forward.

Additional resources

The following resources were used in development of this snapshot:

Child Trauma Academy www.childtrauma.org

The National Child Traumatic Stress Network www.nctsn.org

Gearity, A. (2009). *Developmental Repair: A training manual.* Washburn Center for Children: Minneapolis, MN.

McKay, M., Hoagwood, K., Murray, L., & Fernandez. (2004). Integrating evidence-based engagement \interventions into "real world" child mental health settings. *Brief Treatment and Crisis Intervention*, 4 (2): 177-186.

Perry, B. (1993). Neurodevelopment and the psychophysiology of trauma II: Clinical work along the alarm-fear-terror continuum. *APSAC Advisor*, 6(2): 1-20. Retrieved October 10, 2009 from http://www.childtrauma.org.

Perry, B. (2006). The Neurosequential Model of Therapeutics: Applying principles of neuroscience to clinical work with traumatized and maltreated children. In Webb, N. B. (Ed.), *Working with Traumatized Youth in Child Welfare* (27-52). The Guilford Press: New York, NY.

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APRIL 2010

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