Snapshot

MARCH 2009

Children's mental health

Trauma-informed care

Taking a trauma-informed approach to care allows practitioners to understand "problem behavior" as adaptive responses to traumatic events, such as death, natural disasters, abuse, or neglect.

Traumatic experiences can have a devastating impact on the well-being of a child or youth. Research shows that trauma-informed mental health services – care that addresses behaviors in the context of past and present underlying traumatic experiences – can be more successful than conventional approaches. Trauma-informed services help mental health practitioners and others better understand both the immediate consequences of traumatic events and their subsequent impact on long-term coping and well-being. While individuals can experience trauma following a broad range of events, including national disasters, war, or witnessing a severe crime, this snapshot focuses on childhood trauma that results from family violence, neglect, or abuse.

Impact of trauma

Exposure to trauma can affect a child in a number of ways, but is often seen in the following areas:

- Emotional regulation, including difficulty with anger
- Information processing, including attention and concentration problems
- Self-concept, including guilt and shame
- Behavioral control, including aggression and substance abuse
- Interpersonal relationships, including difficulties establishing trust and intimacy
- Biological processes, including delays in development

Specific consequences of trauma depend on the age of the child. Early exposure to trauma can interfere with age-appropriate development and place a child at greater risk of future post-traumatic stress disorder (PTSD), anxiety, depression, and conduct disorders. Traumatized children may develop disconnected and distorted ways of processing emotions such as anger and fear, and have difficulty forming healthy relationships with others. Teenagers who have symptoms of PTSD are at greater risk for a variety of other problems, including alcohol and drug use, suicide, eating disorders, school truancy, criminal activity, and dating violence.

Individual responses to trauma, including violence, vary significantly. Not everyone who experiences trauma suffers adverse consequences. Several factors appear to protect children, such as positive attachments with supportive adults and having a sense of purpose or meaning. Personal traits that help to promote resilience include positive self-concept, sense of self-control, relationship-

Trauma symptoms and behaviors may be difficult to understand until they are viewed in the context of past relationships and events. For example, consider a child who appears distracted in the classroom and has difficulties taking turns when playing with peers, making it challenging to develop friendships. These behaviors may be symptoms of attention-deficit hyperactivity disorder (ADHD) or, if the child experienced past trauma, the behaviors may indicate the child has not developed age-appropriate self-regulatory skills. Although the symptoms are similar in either scenario, the intervention approach used to address the behaviors will be quite different.

building skills, emotional regulation skills, and problem-solving skills.

Among those who do develop problems, symptoms may fluctuate in severity, vary in response to different settings or events, or emerge long after the initial trauma. As children experience new stressors or developmental milestones, their response to past or ongoing trauma may change.

Promising interventions

A number of trauma-focused interventions have emerged in recent years. Though few have undergone rigorous evaluation, cognitive-behavioral therapy, which helps youth understand and modify their responses to situations, is a common component of many intervention approaches. Other individualized treatment elements that are often incorporated to promote resiliency and build coping skills include: trauma re-exposure, violence education and cognitive restructuring of experiences, emotional regulation, social problem solving, safety planning, and, when age-appropriate, parent training. While all components are important, trauma re-exposure, which encourages recounting the trauma, is considered especially critical, as it helps children constructively integrate their experience into their understanding of themselves and their world.

Trauma-specific interventions for young children often focus on strengthening positive attachment between a child and his/her caregiver. Two of the most established interventions are Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT).

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a flexible model designed for children age 3-17. It typically consists of 12 to 20 parent-child therapy sessions, and is offered concurrently with individual parent therapy. It includes components to teach parents new parenting skills and to help children process past trauma and develop coping, self-regulatory, and safety skills. In a recent review of interventions for children exposed to trauma, it was the only program ranked as "well-established."
- Parent-Child Interaction Therapy (PCIT) teaches parents appropriate child management skills to minimize parent-child interactions that escalate behavior problems. In addition to sessions with the parent alone, the model provides coaching with the parent and child together, so that parents receive immediate feedback about their interactions with their children. Studies show this model can increase positive parenting skills and effectively reduce disruptive behaviors among children.

While these approaches are promising, they may not be appropriate for all children, especially those currently experiencing abuse or exhibiting other serious mental health symptoms.

Intervention approaches for adolescents often incorporate group therapy. A number of promising trauma-informed group therapeutic models have been developed for adolescents, though no single model stands out as the most effective approach. A group setting allows adolescents to learn and practice new skills for building healthy relationships,

and to regulate emotions. While these models work well for many teens, individual therapy may be more appropriate for adolescents who have difficulty connecting with their peers. Adolescents who experience trauma are more likely to abuse drugs, so it is important that intervention programs assess substance use and adopt strategies to address substance use within the context of trauma.

Programs may need to offer a range of services to fully meet the needs of children and families. Children and families experiencing trauma often have complex needs that change over time. Some programs have established partnerships between mental health professionals, case managers, advocates, and others to provide an array of services to meet these changing needs, such as emergency housing, employment, peer support, and mental health therapy. Although there are funding challenges to providing co-located services or expanding the service roles for professionals beyond tasks reimbursed by health insurance, these partnerships can provide all family members with a comprehensive set of services, regardless of how they enter the service delivery system.

Trauma Systems Therapy (TST) is an intervention model that uses a matrix to consider the most appropriate treatment level, based on a child's skills and social environment. The model identifies five treatment phases with varying levels of service needs:

- Phase I - Surviving: Home-based services are used to help stabilize the child and environment. Advocacy support and coordination with other service systems (child welfare or inpatient treatment) may also be accessed.
- Phase II - Stabilizing: Interventions involve home-based services or clinical visits focused on emotion regulation training and advocacy.
- Phase III - Enduring: Clinical visits focus on helping the child develop emotion regulation skills and modifying the social environment to support the child's growing capacity to self-regulate.
- Phase IV - Understanding: Treatment is focused primarily on cognitive processing.
- Phase V - Transcending: Treatment is focused on making meaning out of the trauma experience and ending the therapeutic relationship.

Within each phase, a number of intervention options may be available to meet the specific needs of the child and family. The appropriate level of treatment is identified by assessing the child's ability to control, or regulate, his/her emotions, as well as the level of stability in the home.

SERVICE LEVEL MATRIX: TRAUMA-INFORMED SERVICES FOR YOUTH

		STABILITY OF SOCIAL ENVIRONMENT		
		Stable	**Distressed**	**Threatening**
Degree of self-regulation	**Regulated**	Phase V	Phase IV	Phase III
	Dysregulated emotion	Phase IV	Phase III	Phase II
	Dysregulated emotion and behavior	Phase III	Phase II	Phase I

- Saxe, et al, (2005). Comprehensive Care for Traumatized Children. Psychiatric Annals.

This model provides the clinician with a framework to focus on the specific needs of an individual child, consider the current strengths of the family, and offer a variety of intervention options to the child and family.

Trauma-informed care

Trauma-specific interventions may hold the best promise for meeting the needs of youth and families who have experienced violence or other traumatic situations. In addition, agencies could consider modifying other aspects of services to further promote trauma-informed care. A number of minor modifications can be made to further ensure youth and families have a positive experience with services and opportunities to build a strong, therapeutic relationship with staff. Although the recommendations listed below were developed for a residential setting, many are also relevant to working in a clinical outpatient setting:

- Develop consistent approaches and a common language across all staff to promote the development of effective social and coping skills.
- Modify the program's physical appearance to make it appealing, age-appropriate, and culturally competent so that children feel engaged, not coerced, to participate.

- Regularly initiate contact with the child's family to prevent crises and share treatment progress.
- Consider ways to support staff who are working with challenging clients so they can maintain positive interactions and avoid burnout.
- Adopt a consistent screening process that identifies all sources of trauma a child or family may have experienced.
- Provide flexible, individualized services that consider not only the child's behavior, but other environmental, school, or family issues that may be contributing to the child's response.

- Adapted from Hodas, G. (2006)

Additional resources

Child Trauma Academy www.childtrauma.org

The National Child Traumatic Stress Network www.nctsn.org

Cook, A., Blaustein, M., Spinazzola, J, & van der Kolk, B. (Eds.). *Complex trauma in children and adolescents*. National Child Traumatic Stress Network. www.nctsnet.org/nccts/nav.do?pid=typ_ct

Hodas, G. (2006). *Responding to Childhood Trauma; The Promise and Practice of Trauma Informed Care.* Pennsylvania Office of Mental Health and Substance Abuse Services. http://www.nationalcenterdvtraumamh.org./resources_trauma-services.php

Margolin, G. & Vickerman, K. (2007). Posttraumatic Stress in Children and Adolescents Exposed to Family Violence: I. Overview and Issues. *Professional Psychology: Research and Practice,* 38 (6): 613-619.

Saxe, G., Ellis, B., Fogler, J., Hansen, S., & Sorkin, B. (2005). Comprehensive Care for Traumatized Children. *Psychiatric Annals.* 35(5): 443-448.

Silverman, W., Ortiz, C., Viswesvaran, C., Burns, B., Kolko, D., Putnam, F., & Amaya-Jackson, L. (2008). Evidence-Based Psychosocial Treatments for Children and Adolescents Exposed to Traumatic Events. *Journal of Clinical Child and Adolescent Psychology*, 38(1): 156-183.

Walker, J.S., Weaver. A., Gowen, L.K. & Aue, N. (Eds) (2007) *Focal Point: Research, Policy, and Practice in Children's Mental Health: Traumatic Stress/Child Welfare*, 21 (1). http://www.rtc.pdx.edu/PDF/fpW07.pdf

To learn more about this issue go to www.wilderresearch.org

AMHERST H WILDER FOUNDATION
ESTABLISHED 1906

Wilder Research
Information. Insight. Impact.

Children and Family Services Division

451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700; FAX 651-280-3700

Authors: Melanie Ferris, Cheryl Holm-Hansen, Wilder Research
MARCH 2009