Wilder Research

Increasing the accessibility of trauma-focused services

Strategies for working with youth difficult to engage in services

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Executive summary

Many of the youth and children who receive mental health services from the Amherst H. Wilder Foundations have experienced acute or chronic trauma. While clinicians have received training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and other innovative approaches to address trauma, Wilder clinicians have noted a need to find more effective ways to engage youth and families in trauma-focused services. This is especially true among youth and families from cultural communities who do not use Western concepts to express mental health issues or are otherwise distrustful of a traditional therapeutic approach, as well as youth who have cognitive or developmental delays that are organic in nature or a result of their experience with chronic, complex trauma.

This report identified strategies that show promise in engaging youth and families in trauma-informed services. The information presented in this report came through a focused literature review and key informant interviews with Wilder clinicians and local experts.

Lessons learned from Wilder's RAD Center

The 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 their approach was not explicitly developed as a trauma-focused therapeutic intervention, many of the youth receiving services have experienced and exhibited symptoms of past trauma.

Many of the youth served through 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 allowed them to be attentive and engaged in services. To do so, all staff and clinicians:

- Develop individualized treatment approaches 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 practices including "parts language," individual and group activities, Audio Visual Entrainment (AVE), and Eye Movement Desensitization and Reprocessing (EDMR), and Dialectical Behavioral Therapy (DBT) practices

■ Build strong relationships with parents by sharing common experiences and providing parents with skills training they can use with their children at home

Strategies to increase family engagement in trauma-focused services

Youth and family engagement is critical to successful therapeutic outcomes. Recent studies have demonstrated that perceived treatment barriers, low treatment expectations, and cultural norms that discourage seeking help outside the family can lead to early drop out from services. Increased severity of symptoms or behaviors can also be a predictor of early drop out from treatment. Therefore, it is important for clinical staff to not only describe the therapeutic process at intake to help families develop realistic expectations of treatment, but to take extra time to speak with parents and youth when new trauma-triggering events occur. 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 strategies

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. In order to reach these goals, clinicians must use a variety of developmentally-appropriate approaches to engage youth in services and help them develop the skills needed to benefit from cognitive behavioral therapy.

A number of Wilder clinicians have received training in Bruce Perry's Neurosequential Model of Therapeutics (NMT), which recognizes that the negative effects of early trauma alter brain development and functioning. Therefore, in order 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 serving 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

There is often a misunderstanding that therapy cannot be an effective approach for youth exhibiting more severe cognitive delays. While some clinicians have observed group therapy is less effective with this population, as these youth need a more highly structured and predictable treatment setting, 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.

To provide developmentally-appropriate services, clinicians must build a toolkit of approaches that can be used at various learning stages. While many current efforts focused on identifying effective, developmentally-appropriate approaches for youth who have experienced trauma, there is not a recommended set of intervention approaches that provides clinicians with a standard model. Wilder clinicians have participated in a variety of trainings to develop expertise in developmentally-appropriate interventions. Wilder Research suggests clinicians consider the following next steps to further enhance the use of developmentally-appropriate services at Wilder:

- Continue to provide clinicians with education and training about child development and developmentally-appropriate intervention strategies

- Develop procedures to regularly monitor the child's progress in treatment and reassess his/her developmental age

- Document the use and effectiveness of various intervention strategies

Culturally-competent intervention strategies

Across cultures, individuals share a number of common responses to trauma, including affect dysregulation, problems re-experiencing traumatic events, poor sleep, avoidance, and depression. However, within each culture, there are assumptions about the cause of the problem, essential requirements necessary for healing, appropriate behavioral and emotional responses to trauma, and the roles and responsibilities of the therapist or healer. While there is a growing amount of literature describing 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 intervention strategies used to treat depression, anxiety, hyperactivity, and disruptive behaviors were equally effective for White, African-American, and Latino youth. One study also found that cognitive behavioral therapy and EMDR were promising approaches for immigrant youth who demonstrated symptoms of post-traumatic stress disorder (PTSD). While these studies suggest common approach can be used with youth of multiple cultures, there is general consensus that adaptations of evidence-based practices or new approaches are needed to improve outcomes and retain youth and families in trauma-focused treatment. To begin to filling this research gap, clinicians and agencies who work with youth from diverse cultural communities need to document and share the therapeutic approaches they have found effective.

Next steps

While there is a growing research base describing effective trauma-focused intervention strategies, there is a great need for more information describing ways to use or adapt evidence-based practices, such as TF-CBT, to work effectively with youth who are more difficult to engage in services. In addition to seeking ongoing training opportunities that will help clinicians develop comfort using a variety of developmentally-appropriate approaches, clinicians and agencies working with youth who have experienced trauma can help build the research base by documenting their work and sharing lessons learned from the field.

Background

As the Foundation considers ways to expand and enhance its ability to provide trauma-focused services to youth, it is important to consider how these services can be adapted to address the unique needs of specific populations. During the past year, clinical staff noted some youth do not start services ready to begin cognitive behavioral therapy. The characteristics of these youth fall into two broad, sometimes overlapping categories: 1) youth from cultural communities that do not use Western concepts to express mental health issues or are distrustful of a traditional therapeutic approach; and 2) youth who have cognitive or developmental delays that are organic in nature or a result of their experience with chronic, complex trauma.

Using information gathered through literature review, as well as interviews with Wilder staff from the Center for Children with Reactive Attachment Disorder (RAD Center) and other clinicians with experience providing trauma-focused services, this report provides Wilder staff with information and recommendations to further enhance their ability to engage youth and families in trauma-focused services. These suggested strategies are broken into three major topic areas: agency-level family engagement strategies; developmentally-appropriate intervention strategies; and culturally-competent intervention strategies.

Overview of the current literature

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a widely-used treatment model, shown to effectively reduce the symptoms associated with past traumatic experiences. The information gathered for this report was intended to identify strategies to better engage hard-to-reach youth and families in treatment and to identify promising or effective strategies for using this treatment model with youth who have cognitive delays or experience cultural barriers to treatment. Alternative approaches to TF-CBT were not reviewed.

As with all evidence-based practices, there is ongoing debate regarding how closely clinicians must adhere to the treatment model, while allowing flexibility to apply thoughtful adjustments to the model to work more effectively with specific clients or populations. Despite the use of adaptations by clinicians intended to better meet the needs of youth of various cultural communities and identification of strategies to work with children and adults with cognitive delays experiencing emotional problems, there is a limited amount of research describing applications of the TF-CBT model that are effective with these populations. Therefore, this report does not identify a specific set of evidence-based treatment interventions that should be used to further enhance clinical practice at Wilder, but offers a set of recommendations and strategies to improve family

engagement, further apply a developmental framework to the services provided, and offer culturally-competent therapeutic services.

Lessons learned from Wilder's RAD Center

Using a variety of innovative treatment strategies and lessons learned through their own clinicians, the Wilder Center for Children with Reactive Attachment Disorder (RAD Center) developed innovative strategies to engage youth and parents in services and improve youth behavioral outcomes. Although their approach is not explicitly developed to be a trauma-focused therapeutic intervention, many of the youth receiving services have experienced chronic trauma and exhibit the same types of symptoms as youth seeking outpatient services through the Child Guidance Center. Therefore, before reviewing information from the national literature and other clinicians interviewed for this report, it is helpful to consider the strategies already used and identified as effective by Wilder staff.

RAD Center participants have a range of diagnoses, but share a number of common behaviors, including: difficulty responding to adult requests; poor self-regulation skills; difficulty accepting nurturing actions; difficulty picking out social cues from peers and others; dissociation from situations (often perceived as "zoning-out"); limited forethought and accurate prediction of risks associated with actions; and aggression towards others. According to RAD Center staff, because these youth are so dysregulated, they often experience difficulty sleeping. The resulting combination of already challenging behaviors and chronic sleep deprivation often leads to other poor outcomes, such as low academic achievement.

Parents who seek services from the RAD Center have frequently tried other residential, day treatment, and out-patient services, often incorporating cognitive behavior therapy (CBT), without success. As a result, RAD Center staff work under the assumption that in order to help these youth make long-lasting gains, a set of approaches must be used to help youth develop the self-regulatory skills they need to benefit from CBT.

While the individual treatment plans developed for each child include different activities, these approaches are grounded in a framework that focuses on the child's developmental, not actual, age. According to RAD Center staff, individual outcomes improve for all youth if trauma is addressed through the right set of developmentally-appropriate activities for each child, rather than using a generalized trauma-focused approach that will likely be effective for many, but not all, youth. Another overarching theme is their emphasis on creating a safe, structured environment with opportunities for youth to be introduced to a variety of sensory experiences. These various sensory activities create an atmosphere of exploration and playfulness where cognitive behavioral therapy can be woven in.

RAD Center staff spoke about clinicians using a variety of approaches from their "toolkit" to meet the individual needs of youth in a developmentally-appropriate way. Some of the strategies used by clinicians include:

- **Multi-sensory therapy.** There are a number of objects, tastes, scents, and sensations that may be calming for a child. By exploring a variety of different options, the child can start to identify the things that work well. These objects can then be incorporated into the treatment plan.

- **Individual and group activities**. The RAD Center uses a combination of individual and group activities, including independent library time or group outings to a local swimming pool, to help youth work on their individual goals, increase their recognition of social cues, and practice self-regulatory skills.

- **Use of object relations practices, including "parts language."** This approach helps the child identify and talk about his/her "parts" (i.e., the part of him/her that feels happy, mad, or sad). This strategy allows the child to see that they can experience negative emotions without being overwhelmed by them, and gives clinicians an opportunity to talk about a child's behavior in a non-shaming way.

- **Audio Visual Entrainment (AVE) and Eye Movement Desensitization and Reprocessing (EMDR).** The use of technology or AVE activities can be used to help youth understand the connections between their emotions and physical sensations (i.e., changes in heart rate, respirations), and then develop strategies to better regulate the physical symptoms of stress or anxiety.

- **Dialectical Behavioral Therapy (DBT) Techniques.** Some clinicians use DBT techniques to encourage the development of specific skills, including mindfulness, self-regulation, tolerance to stress, and interpersonal communication/relationships. RAD Center staff found DBT techniques, when combined with object relations practices, to be particularly effective with adolescents.

New therapeutic approaches are difficult to implement, and the RAD Center supervisors found clinicians are often hesitant to try new approaches with client. They noted staff must not only receive training in new therapeutic approaches, but encouragement or a more directed push from clinical supervisors to use and further develop new skills. RAD Center staff also found it helpful to clearly articulate any new therapeutic approaches being a part of, rather than addition to, the treatment program.

The RAD Center model also incorporated focused work with parents and caregivers whose children received residential services. Prior to the child entering the residential program, a meeting was held with the child's parents. Clinicians recognized that parents

were often grieving at this point, and experiencing feelings of guilt or shame for not being able to help their child in their home. All staff were trained in narrative therapy, and found this to be an effective way to learn about the parents' experiences with the child, encourage parent engagement, and help parents develop a new script describing their perceptions of their child's and family's future. Home visits were seen as critical, and provided parents with opportunities to re-build their relationship with their child in a safe way. Staff worked with parents to develop a home visit plan, which incorporated strategies to address challenging behaviors or contact staff if a problem did arise. In addition to these visits which helped the child build or maintain connections to the family and community, home visits also allowed parents and staff to deepen their relationships. Through their interactions with parents, staff gave value and honor to what parents know about their child and, through the discussion of shared experiences in working with the child in different settings, built trusting relationships.

While some of the strategies used by the RAD Center worked particularly well in a residential setting when a more structured environment can be created, there are lessons that apply to out-patient settings, as well. The first is the importance of clinicians using a developmental framework to assess the child's current functioning and identify appropriate therapeutic activities. Second, RAD Center staff recommended clinicians have a tool-kit of effective therapeutic strategies, activities, and approaches they feel comfortable using to meet the needs of the child and family. Finally, successful parent engagement can be promoted by staff and parents sharing common observations and experiences, and providing parents with skills training they can use with their children at home.

Strategies to increase family engagement in trauma-focused services

Many of the lessons learned by RAD Center staff are consistent with the recommendations made in the available literature and by other clinicians who have experience providing trauma-focused services to youth and families.

Agency-level family engagement strategies

Although the questions initially posed by clinicians focused on strategies to reach specific populations, engagement in services is an important issue for all families who receive therapeutic services. Common individual barriers to treatment, including poverty (and related financial and transportation difficulties), accessibility, stigma, and negative past experiences with therapy, have been identified in a variety of sources. However, there is growing recognition that parent understanding and expectation of treatment can be a strong predictor of treatment completion and level of effectiveness. Recent studies demonstrate parent expectations regarding treatment and perceptions of barriers to treatment can lead to early drop-out (Nock & Kazdin, 2001). Cultural issues may also play a role in treatment continuation. In a study examining the factors leading to early termination of outpatient services among Mexican American parents, services were more likely to be discontinued if the parents were less educated, felt the problems should be handled within the family, and felt the appropriate intervention strategy was to increase discipline (McCabe et al., 1999). These studies demonstrate the importance of discussing information about the treatment process during the initial interactions clients and families have with intake staff and clinicians.

A series of studies have shown success engaging adolescents and families in treatment through intensive engagement strategies done on the telephone or during an initial intake appointment (McKay, et al., 1996, 1998, 2004). Through this intervention, the purpose of the initial meeting became not only a time to gather diagnostic information, but to clarify parental expectations of treatment and identify and address perceived barriers to attending the next appointment. The effectiveness of this strategy relied 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.

Parents also need time and often one-on-one sessions to understand the behaviors of their children from a developmental perspective and as a reaction to stress instead of an intentionally disruptive behavior. In describing an alternative strategy when working with families who have experienced chronic trauma, one of the key informants

interviewed explained, "Don't say to parent, 'you know your child so much better than I do.' That isn't fair – they don't know that part of their child [who is behaving differently as a response to the stress they have experienced], and often don't know that part of themselves. Instead, say 'this is what I see in your child and this is what I can do to help.'" This approach validates the parent's feelings and allows the therapist to first discuss what approach will be taken during therapy. 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 assess their strengths and weaknesses in engaging families at an individual, therapeutic level (NCTSN, 2008). The tool is not intended to provide an objective measure of the agency's ability to engage families, but to help the agency identify areas where improvements can be made and develop plans and goals to meaningfully address these issues. Using the self-assessment results, agencies can then refer to a list of goals, objectives, and possible activities that can be pursued in each area. The assessment content helps clinicians and agency staff identify ways to address family safety issues and concerns, collaboratively define the needs and issues to be addressed in treatment, address barriers to treatment participation and completion, recognize the role culture plays in assessment and treatment activities, use appropriate trauma and assessment and treatment practices, and define and report youth and family improvement.

Families seeking trauma-focused services may also be experiencing feelings of anxiety or fear about sharing information about difficult events. A recent study of child and adolescent trauma victims found that while differences in symptom severity at intake did not significantly impact treatment participation, increased symptom severity just before termination of services did significantly predict early dropout (Chasson, Vincent, & Harris, 2008). Specifically related to TF-CBT, the researchers suggest parents may choose to end treatment if they notice their child is having anxiety about an exposure-based treatment component, or if they are not fully convinced that, or understand why, exposure-based therapy is necessary. While it is important to note the study did not explore other key factors that influence ongoing participation in treatment, such as the accessibility of services or overall service satisfaction, it does suggest the need to monitor and respond to changes in anxiety due to new traumatic experiences or the perceived likelihood of a trauma-inducing experience.

Implementing family-engagement strategies

A number of strategies to increase youth and family engagement were identified by the clinicians interviewed. While many of the strategies were relatively straightforward, all require additional time and effort by the clinician and/or agency to implement. Based on the information gathered for this report, Wilder Research suggests clinicians consider the following next steps to increase family-engagement in trauma-focused services:

- **Provide youth and families with clear information about what they can expect during therapy and as a result of the services provided.** Although youth and families may have a general idea of what to expect during a therapy session, mental health services may be unfamiliar to many families, especially those from cultural communities who do not traditionally use Western therapeutic approaches. Even families who have had received services in the past may never have received basic information about what they can expect as a result of therapy.

  Some agencies have hired cultural liaisons or other paraprofessionals to meet with families prior to the first appointment with the clinician to introduce the family to the services they will receive. This allows the family to make a connection to someone from the agency who is not directly providing services to their child and may have more time available to make ongoing reminder calls and assist the family in addressing transportation and other logistical barriers. The intake staff member may also be able to help bridge cultural barriers the family may perceive when beginning services.

- **Explore the intake process from the perspective of parents and develop strategies to establish ongoing contact with families throughout treatment.** The first contact clients and parents have with a representative of the agency sets the tone for services and can heavily influence whether the family follows through to attend the first therapeutic appointment. Ongoing engagement strategies, including reminder phone calls to parents and occasional telephone check-in calls to identify any barriers to attending appointments, can also increase treatment engagement. A self-assessment of the organization's practices may help identify areas where improvements can be made to better engage families in trauma-focused services.

- **Recognize the expertise parents bring to the table while also validating their feelings of uncertainty regarding their child's behavior.** Family advocates often encourage clinicians and service providers to recognize parents and caregivers as experts who best understand the needs and behaviors of their children. While this strategy does help clinicians build meaningful relationships with the family and lead to increased family involvement, some of the clinicians interviewed also noted it was important to validate the feelings of confusion, frustration, and uncertainty many

parents have. Some parents may have sought services for their child from multiple agencies and have received a variety of recommendations about ways to help their child at home without success. Parents need time to understand how the services currently being provided to their children are different than those they may have received in the past. They also need to know what their role will be in the treatment plan and how they can support their child.

■ **Use data to identify when and why early termination of services occurs.** Early termination of services may occur for a variety of reasons, including dissatisfaction with the services provided or client-therapist relationship, transportation barriers, or other accessibility issues (i.e., cost, childcare for siblings, etc.). However, there is also evidence suggesting dropout is more likely when new traumatic events occur, or when parents anticipate upcoming therapeutic components may cause their child to experience greater anxiety or other trauma-related symptoms. In addition to discussing the therapeutic approach with parents at intake, more frequent contact may be needed throughout the therapeutic intervention to identify new barriers or concerns and develop strategies to address these issues. Tracking this information may help staff identify when dropout is most likely to occur, and more clearly identify successful family engagement strategies.

Developmentally-appropriate intervention strategies

The National Child Traumatic Stress Network (NATSN) has identified four common components of trauma-focused interventions: 1) ensuring child safety; 2) guiding skills development in emotional self-regulation and interpersonal functioning; 3) revisiting and reframing past traumatic events; and 4) enhancing resiliency and integration into social networks (NCTSN, 2003). In order to meet these goals, a variety of developmentally-appropriate treatment approaches must be used to help the child develop healthy relationships and build self-regulatory skills.

Examples of developmentally-appropriate therapeutic models

Clinicians from the Wilder Foundation are familiar with, and have received training from, Bruce Perry and the Child Trauma Academy emphasizing a biologically-informed practice approach to address the needs of youth who have experienced maltreatment, neglect, and other trauma. Using concepts related to brain development and functioning, he and his colleagues have developed an assessment and intervention approach called the Neurosequential Model of Therapeutics (NMT) (Perry, 2006). At the most basic level, this approach recognizes the negative effects of early trauma lead to alterations in brain organization and functioning. These stressors influence how the child understands a situation and responds to a perceived threat. When the neural networks in the brain experience

chronic stress, areas of the brain become highly sensitized and overreactive, leading to a persistent state of fear. The adaptive behaviors that stem from this hyper-reactive state can include hyperviligance, impulsivity, anxiety, self-regulatory problems, inconsistent sleep patterns, and others. Therefore, in order to change behavior, trauma-focused therapeutic interventions must be appropriate to the child's developmental stage, focusing first on self-regulatory processes before moving into more complex therapeutic activities.

Perry outlines a number of considerations clinicians should keep in mind when providing therapeutic interventions (Perry, 1993):

■ **The key to working with traumatized children is understanding what part of the brain is mediating the child's response and behaviors.** Individuals who have experienced profound trauma also have experienced changes to the areas of the brain that regulate their physiological responses to trauma or stressful situations. Cognitive and verbal interventions alone will not alter the parts of the brain mediating PTSD symptoms. Instead, he suggests clinicians work to provide predictable, nurturing, supportive, and cognitive- or insight-oriented interventions that make the child feel safe, comfortable, and loved.

■ **Early intervention is critical to minimize the impact of a potentially traumatizing experience.** When working with children who are in the midst of a crisis or who experience chronic trauma, it is important that age-appropriate information is given to the child to help him/her better understand what is happening. Avoiding this discussion often leaves the child feeling more confused and may allow the child to let his/her perceptions of the situation build into something more traumatic.

■ **The therapeutic approach should include predictable therapeutic activities and developmentally-appropriate interventions.** A predictable schedule that includes both quiet, planned activities and self-directed play will help the child feel safe and nurtured. Some of the therapeutic interventions that could be used include: psychoeducational and cognitive interventions that help the child understand their body's response to trauma; family psychotherapy; individual psychotherapy focused on building a positive relationship between the therapist and child; group therapy focused on specific tasks or building social skills; and pharmacotherapy, when necessary.

■ **Ongoing monitoring of the child's symptoms is necessary, especially as children approach new developmental stages.** Symptoms and problems can reemerge when a new developmental phase begins. For example, when children enter adolescence, anxiety, impulsiveness, aggressive/assaultive behaviors and hypersexuality can reemerge. Ongoing monitoring of symptoms will help clinicians identify and respond to new concerns quickly.

A developmental approach to therapy is also outlined in Ann Gearity's Developmental Repair model (Gearity, 2009). The model has been implemented in a day treatment setting for young children (approximately ages 3-10) who have been referred to services because their aggressive behaviors has been harmful to themselves or others, and other treatment interventions have been unsuccessful. The model incorporates tools and strategies focused on four developmental domains: 1) Relating – joining with children to help them seek and use adult help; 2) Thinking – repairing reflective thinking to help children organize and understand interpersonal expectations; 3) Feeling – helping children understand their emotions and develop self-regulatory skills; and 4) Acting – guiding children to develop motivation to learn new behavioral patterns, develop new skills, and improve social inclusion.

The models identified here, as well as the strategies used by Wilder's RAD Center, focus on understanding child behavior as a learned response to stress, teach children how to understand their emotions, and use therapeutic strategies that help children develop self-regulatory skills that will help them work through past trauma and new, stressful experiences. It is important to note that none of the models presented are step-by-step intervention guides. Instead, they provide clinicians with a framework for their work, encouraging clinicians to build a variety of skills in order to develop a toolkit of developmentally-appropriate intervention strategies and approaches they can use.

Approaches to working with children who have greater cognitive delays

While the Developmental Repair model has been successful with young children, clinicians have noted children with developmental delays or Fetal Alcohol Spectrum Disorders (FASD) have difficulty in the group setting. Whereas behavioral outbursts in a classroom with higher functioning children offer an opportunity for learning, the behaviors of others can be difficult for children with greater cognitive and social delays to understand. A more highly structured and predictable setting is needed to provide effective services to these children with greater needs.

When providing services to youth with developmental disabilities or cognitive delays, it can be helpful to consider how their thought processes or communication patterns may be different than other clients who receive services. While not applying to all youth who experience trauma, these characteristics may be common among many youth who have experienced chronic trauma and subsequent delays in their ability to process and communicate information:

■ Focus on one aspect of a situation, and neglect other important elements

■ Find it difficult to be flexible in their thinking, preferring clear, black and white scenarios to more ambiguous situations

- Have difficulty generalizing concepts and skills from one situation to another

- Misunderstand or be unaware of social cues and nonverbal communication

- Ask repetitive questions or return to comfortable topics when anxious during conversations

- Become anxious in new situations or in response to unexpected changes

- Act out or have difficulty controlling behavior when highly frustrated, anxious, or tense

-Adapted from Charlton, et al. (2004)

There is a misunderstanding that therapy is not an effective approach for youth with cognitive delays because of these communication and comprehension challenges. While there is a shortage of literature describing new therapeutic models with this population, by making thoughtful adaptations to cognitive-based therapy or behavioral intervention approaches, clinicians can provide effective trauma-focused services. While these approaches do work, progress can be slow because greater repetition is needed to teach new concepts and skills.

To effectively communicate new ideas to youth with developmental disabilities, it is often necessary for clinicians to speak slowly, use visuals to reinforce ideas, and present information one item at a time (Charlton et al., 2004). Whenever possible, concrete ideas and actual events, rather than analogies or abstract concepts, should be used to communicate ideas and information. In addition, it is helpful to ask for feedback regularly to ensure the client understands all of the information being discussed.

Youth with developmental disabilities often have a modest vocabulary to express their feelings, limited to basic expressions of mad, sad, happy, and scared (Focht-New, et al., 2008). Helping youth expand their vocabulary and understand their emotions in context of a traumatic experience can help them develop ways to more accurately describe the intensity of their feelings. In instances where youth may not have the verbal skills to expand their vocabulary, youth may be able to express their feelings by drawing pictures or identifying colors that represent different feelings. Play therapy may also be a useful approach to help children define and clarify their feelings. Clinicians often need to take a patient approach to help youth with developmental disabilities assign words to explain feelings and emotions and make connections between their feelings and behavior. In addition, clinicians need to approach their work with a client with openness and an understanding that the child's comprehension of their conversations may be far greater than what the client can communicate verbally (Hollins & Sinason, 2000).

Finally, because abstract concepts are often difficult for youth with developmental disabilities to understand, therapeutic goals should focus on building coping skills, rather than insight (Charlton et al., 2004). Role playing responses to a variety of different scenarios, both real and imagined, can help youth generalize their use of specific coping skills. Rather than providing youth with a number of different skills to master at once, providing opportunities for repetition with a single skill during multiple sessions is likely to be a more effective approach.

Implementing developmentally-appropriate intervention strategies

While the models and approaches described in this report share common components, none offer a step-by-step recipe to provide developmentally-appropriate trauma-focused services. Instead, these models require individual clinicians to develop a variety of skills and approaches that can be used to work with clients at their current developmental stage. Wilder Research suggests clinicians consider the following next steps to further enhance the use of developmentally-appropriate therapeutic services:

- **Continue to provide clinicians with education and training about childhood development and developmentally-appropriate intervention strategies.** In order to provide developmentally-appropriate services, it is essential that all clinicians share a common understanding of childhood development and understand behaviors as responses that reflect the child's developmental stage. In addition, ongoing opportunities to build and practice new skills will be essential to helping individual clinicians develop a broad range of effective intervention strategies. It may be helpful for supervisors within the Children and Family Services division to review which training and consultation strategies have been most helpful in providing high-quality training in a cost-effective and efficient way to staff.

- **Develop procedures to regularly monitor the child's progress in treatment in order to intervene early to new stressors.** Child behaviors may stagnate or worsen when the child approaches new developmental stages, such as adolescence. Frequent reassessment of the child's functioning, whether formal or informal, may help clinical staff respond more quickly to new stressors in the child's life and help both the child and caregiver understand changes in behavior.

- **Document the use and effectiveness of various intervention strategies.** In many ways, the use of a developmental framework to understand and address trauma is in its earliest stages. Despite great interest in this approach, there is little information available identifying specific approaches that work well as interventions at different developmental stages. Documentation of the strategies being used by clinicians and their effectiveness could provide staff with a wealth of information about

developmentally-appropriate strategies internally, and would be of great interest to clinicians outside of the agency.

Culturally-competent intervention strategies

Across cultures, individuals share a number of common responses to trauma, including affect dysregulation, problems re-experiencing traumatic events, poor sleep, avoidance, and depression (Drozdek, 2007). However, within each culture, there are assumptions about the cause of the problem, essential requirements necessary for healing, appropriate behavioral and emotional responses to trauma, and the roles and responsibilities of the therapist/healer. When individuals from marginalized cultural groups experience trauma, feelings of avoidance and isolation may become more pronounced because the trauma-related symptoms are compounded by ongoing daily stressors (Gusman, et al., 1996). Further, when individuals are displaced after natural disasters, their cultural values and practices are carried to their new living environment and may become more heightened in unfamiliar surroundings. Therefore, it is important to not only recognize how trauma can be experienced differently across cultures, but to identify strategies to provide culturally-competent services.

A shortcoming of the peer-reviewed mental health intervention research using randomized control trials is their focus on majority populations, rather than study populations more reflective of the diversity within the United States. While there is a growing amount of research describing 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 minority youth who have experienced other types of trauma.

One review of mental health interventions for minority youth found that, despite limited data, intervention strategies used to treat depression, anxiety, ADHD, and disruptive behaviors were likely to be effective for White, African-American, and Latino youth (Miranda, et al., 2005). However, they found there were not enough studies conducted to determine whether cultural adaptations to the interventions would lead to improved outcomes among minority youth. Similarly, a recent study focused on the identification of treatments effective for immigrant youth experiencing PSTD, found that Cognitive Behavioral Therapy (CBT), Narrative Exposure Therapy (NET), and Eye Movement Desensitation and Reprocessing (EMDR) all led to promising, though preliminary, outcomes (Ehntholt & Yule, 2006). There is also general consensus that cultural adaptations of evidence-based practices are necessary to improve outcomes and retain youth and families in trauma-focused treatment (Flores & Kaplan, 2009).

Many of the examples of culturally-specific adaptations identified in the literature have focused on interventions for Latino and American Indian populations. While the specific strategies used to adapt therapeutic interventions for these specific populations should not be assumed to be effective in all cultural communities, there are some important lessons learned that may help clinicians develop treatment approaches appropriate for other cultural communities. Some of these findings include:

■ White, middle class values of individualism and autonomy may lead to barriers in treatment. The traditional Western therapeutic approach that encourages detachment and objectivity may be perceived as distancing by cultural groups, particularly African-American clients (Dass-Brailsford, 2008).

■ The full understanding and incorporation of culturally-specific values and terms (such as *familismo* among many Spanish-speaking cultural groups) can help overcome communication barriers. However, it is essential that, in situations where the therapist and client do not share the same primary language, the clinician understands the feelings and meanings behind the words chosen by the client (Flores & Kaplan, 2009).

■ Some research suggests cultural self-identification can be a protective factor for alcohol and drug abuse. Therefore, incorporating cultural practices into intervention strategies can increase the relevance of the therapeutic approach and help the child build self-confidence and a stronger cultural identity. For example, among American Indian populations, elders and spiritual leaders have been incorporated into the treatment approach and traditional phrases and practices have been used to adapt the development of relaxation skills in the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) model to a more culturally-relevant approach (DeBruyn, et al., 2001; Bigfoot & Braden, 2007).

A number of broader recommendations have also been made, describing ways for clinicians to provide culturally-competent services:

■ Ensure all staff members who work with the child and family are warm and welcoming, especially during the intake process.

■ Consider the role acculturation may play in the client's perceptions of events and comfort seeking treatment.

■ Integrate meaningful cultural values into the therapeutic process.

■ Address the family's social needs early, as those concerns may become barriers to treatment.

■ Allow for flexibility in the treatment approach to accommodate the family's schedule and build rapport between the therapist and client.

- NCTSN, 2003; 2007

Implementing culturally-specific intervention strategies

Despite great interest in developing culturally-appropriate trauma-focused intervention strategies, the recommendations available to clinicians describe fairly general approaches, rather than specific activities. To continue enhancing efforts to provide culturally-specific trauma-focused services, Wilder Research encourages clinicians to consider the following recommendations:

■ **Use the lessons learned by staff implementing other treatment models to inform the development of culturally-specific trauma-focused services.** Although staff are developing the skills and approaches necessary to provide trauma-informed services, the strategies used by staff to provide culturally-specific services in a variety of programs can provide clinicians with key lessons learned. Documenting the approaches used by clinicians and the degree to which each was successful can help staff identify strategies that can be used more broadly by the agency.

Conclusions and next steps

While there is a growing research base describing effective trauma-focused intervention strategies, there is a need for more information describing ways to use or adapt evidence-based practices, such as TF-CBT, to work effectively with youth who are more difficult to engage in services. This report identifies a number of promising approaches that can be used to better engage families in services at an agency level, provide developmentally-appropriate services, and offer culturally-competent treatment adaptations that encourage ongoing treatment participation and maintain the integrity of the intervention.

These strategies provide clinicians, supervisors, and support staff with some options to further enhance the trauma-focused services being provided. However, because much of the research focused on trauma-focused services is in its infancy, there is not a base of information available that provides clear recommendations to provide services to specific populations, such as Hmong families. Instead, clinicians need to thoughtfully consider how lessons learned from various studies may apply to the populations they serve.

The following next steps may be helpful for supervisors, administrators, and clinicians to consider in order to further enhance efforts to engage youth and families in trauma-focused services:

■ **Continue to provide formal and informal training opportunities to clinicians.** As stated throughout this report, in order for clinicians to offer effective trauma-informed services, they need to have a clear foundation of child development, an understanding of ways culture can impact a family's understanding of trauma and their response, and a growing toolkit of intervention approaches that can effectively meet the needs of youth and families, regardless of where they are in the therapeutic process. Clinicians at Wilder have already begun to develop a set of promising approaches through ongoing training. To continue to move these efforts forward, it is important for supervisors to provide additional training to staff when appropriate and encourage the use of new strategies.

■ **Consider ways to simplify the intake process and provide families with individualized attention throughout their involvement in treatment.** As described in the report, the first contact families have with an agency has a large impact on the family's initial perception of treatment. Similarly, small efforts made throughout treatment, such as making reminder phone calls to families and taking time to explain the rationale behind the next stages of therapy to parents can help reduce early dropout.

■ **Capture and share lessons learned.** While there is growing evidence describing evidence-based trauma-informed interventions, there is a need for clinicians to also inform the research base by sharing lessons learned from the field. Documenting strategies clinicians use to integrate supplemental therapeutic approaches into the TF-CBT, approaches used to engage families from specific populations in services, and steps the agency makes to changes to the way staff engage families, and their outcomes, can help agency staff develop a shared approach to effective treatment. Sharing this information outside of the agency can further build the research base and provide insight to working with youth who are not always successful in traditional types of therapy.

References

Charlton, M., Kliethermes, M., Tallant, B., Taverne, A., & Tishelman, A. (2004). *Facts on traumatic stress and children with developmental disabilities.* National Children Traumatic Stress Network: Los Angeles, CA. Retrieved April 8, 2009, from www.NCTSNet.org/nctsn_assets/pdfs/reports/traumatic_stress_developmental_ disabilities_final.pdf.

Chasson, G., Vincent, J., & Harris, G. (2008). The use of symptom severity measured just before termination to predict child treatment dropout. *Journal of Clinical Psychology*, 64(7): 891-904.

Drozdek, B. (2007). The rebirth of contextual thinking in psychotramatology. In Drozdek, B. & Wilson, J. (Eds.), Voices of Trauma: Treating Psychological Trauma across Cultures (1-25). Springer Science: New York.

Focht-New, G., Barol, B., Clements, P., & Milliken, T. (2008). Persons with developmental disability exposed to interpersonal violence and crime: Approaches for intervention. *Perspectives in Psychiatric Care*, 44(2):89-98.

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

Gusman, F., Stewart J., Young, B., Riney, S., Abueg, F., & Blacke, D. (1996). A multicultural developmental approach for treating trauma. In Marsella, A., Friedman, M., Gerrity, E., Scurfield, R., (Eds.), *Ethnocultural Aspects of Post-Traumatic Stress Disorder: Issues, Research, and Clinical Applications* (439-457). American Psychological Association: Washington, DC.

Hollins, S. & Sinason, V. (2000). Psychotherapy, learning disabilities, and trauma: New perspectives. *The British Journal of Psychiatry*, 176: 32-36.

McCabe, K., Yeh, M., Hough, R., Landsverk, J., Huriburt, M., Culver, S. (1999). Racial/ethnic representation across five public sectors of care for youth. *Journal of Emotional and Behavioral Disorders*, 7: 72-82.

McKay, M., Nudelman, R., & McCadam, K. (1996). Involving inner-city families in mental health services: First interview engagement skills. *Research on Social Work Practice*, 6: 462-472.

McKay, M., Stoewe, J., McCadam, K., & Gonzalez, J. (1998). Increasing access to child mental health services for urban children and their caregivers. *Health and Social Work*, 23: 9-15.

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.

National Child Traumatic Stress Network (2003). *Complex trauma in children and adolescents.* Retrieved November 15, 2009 at http://www.nctsnet.org.

National Child Traumatic Stress Network (2008). *Pathways to partnerships with youth and families in the National Child Traumatic Stress Network.* Retrieved November 15, 2009 at http://www.nctsnet.org.

Nock, M. & Kazdin, A. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child & Family Studies*, 10: 155-180.

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.