Trauma-Informed Care for Children & Adolescents

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Faculty Disclosure Information

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I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Learning Objectives

- To increase understanding of:
  - The impact of trauma on adolescents and their caregivers
  - Evidence-based treatment approaches to address trauma-related symptoms among adolescents.
  - The importance of coordinated care in service provision for traumatized adolescents and their families

News Flash: *Trauma Can Be Bad....*

RESILIENCE

- **Behavior Problems**
- **Suicide Risk**
- **Risky Sexual Behaviors, STDs, & HIV**
- **Substance use/abuse**
- **Delinquency and criminal behavior**
- **Violent behavior**
- **Revictimization**
- **Guilt, shame, low self-esteem**
- **Academic and relationship difficulties**
- **Posttraumatic Stress Disorder (PTSD)**
- **Depression**

What does *Traumatic Stress* look like in adolescents?

Traumatic Stress in Adolescents

- May fear they're 'going crazy' or that they are weak/different from everyone else
- Feel isolated – no-one understands what they went through
- May overly focus or seem fascinated by 'dark' topics
- May engage in extreme reckless/dangerous behaviors OR become extremely avoidant
  - Examples –alcohol/drug use; cutting
- May have thoughts of revenge because of belief that others failed to protect them or to prevent what happened
- Significant issues related to trust, safety, esteem

Severity and Duration

- *Objective* Details of the Event
  - More severe the trauma – the more severe the response
    - Examples: repeated, violent abuse by a caregiver
      - Witness severe DV and having to 'care' for the caregiver's injuries
      - Witnessing a loved one being shot and killed
- Child's *Subjective* Experience
  - Sense of helplessness, terror, horror
  - Fear of being seriously hurt or killed
  - Fear that loved one would be seriously hurt or killed
  - Feeling that he/she could've/should've done something to prevent the trauma

Myth or Fact? Youth who have experienced trauma will exhibit behavioral and/or emotional problems that will last a lifetime.

Facts:

- Not all youth will exhibit significant longterm problems as a result of abuse
- Children are resilient
- With a supportive response, protection and treatment (if indicated), the child can do well.

Impact of Trauma on Caregivers

- May not have known trauma occurred until after the fact
- May not know details of the trauma
- Possibility of anger/blame towards adolescent
- Can result in: “Super” monitoring
- Privacy/trust issues
- Need to restore appropriate balance

Intervening: How to Engage the Adolescent?

- Clearly explain your role and your decision making process
- Work together (e.g., to set goals for treatment)
- Set clear boundaries
- Provide options/choices that are reasonable (giving back some sense of control)
- To initiate treatment, may need to use motivational interviewing to motivate behavior change

Initiating Treatment with the Adolescent

- What is adolescent willing to share?
- Rationale for why caregiver inclusion is important
- Parenting issues – negotiating/setting clear limits and consequences
- Understanding connections between behavior/choices and consequences

Myth or Fact? The most important factor in how child victims manage their experiences is the quality of the treatment they receive.

Fact:

- The most important factor in how child victims manage their experiences is the presence of a believing, supportive and protective adult caregiver.

Assessment

- Importance of conducting a trauma screen which includes trauma history and psychosocial impact
- Evaluate environmental risk and safety
- Assess child/caregiver strengths and available support
- Assess caregiver's perception of youth's trauma experiences and symptoms
- Assess to identify potential barriers to treatment engagement

Myth or Fact? It is better to not talk about the abuse and just let the child forget what happened.

Facts:

- Not talking about abuse may be more comfortable for the adults, but may leave children feeling ashamed or believing that they have to keep all of their feelings inside.
- As with any problem, it is helpful to talk about what happened. Talk is also the most important tool in helping the children understand what has happened and to feel okay about themselves.

What is a Trauma-Informed Service System?

NCTSN The National Child Traumatic Stress Network

- All involved parties recognize and respond to the impact of traumatic stress on children and families
- Trauma awareness, knowledge, and skills are integrated into an organization's culture, practice and policies
- Includes the following:
  - Routine screening for trauma exposure and related symptoms
  - Use of culturally appropriate, evidence-based assessment and treatment for trauma and its impact

Trauma-informed systems (cont'd)

- Makes resources on trauma exposure, impact and treatment available to children/families and providers
- Focuses on resilience and protective factors for children/families
- Addresses caregiver trauma and its impact on the family
- Emphasizes continuity of care and collaboration across child-service systems
- Maintains an environment to address, minimize, treat secondary traumatic stress/resilience among staff

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What is an Evidence-Supported Treatment

- Aka:
  - Evidence-based treatment
  - Empirically supported treatment
  - Evidence-based practice
  - Best Practice
  - Promising Practice
  - EBT/EST/EBP

What is an EST (cont'd)

- Tx or intervention with scientific, empirical research evidence supporting its efficacy
- How is this determined?
  - Multiple baseline, single case designs
  - Open trials, pre-post designs
  - Controlled studies without randomization
  - RCT –'gold standard'

Good News! 20 years of Research

Effective Treatments Have Been Developed, Tested, and Implemented

- **Abuse-Focused Cognitive Behavioral Therapy – AF-CBT**
- **Child-Parent Psychotherapy – CPP**
- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**
- **Cognitive Processing Therapy**
- **Eye Movement Desensitization and Reprocessing (EMDR)**
- **Multisystemic Therapy (MST)**
- **Parent Child Interaction Therapy – PCIT**
- **Project SafeCare**
- **Seeking Safety**
- **The Incredible Years (TIY) series**
- **Trauma-Focused Cognitive-Behavioral Therapy – TF-CBT**
- **Triple P – Positive Parenting Program**

**Not an exhaustive list

www.nrepp.samhsa.gov

Three Treatments Selected as "Best Practices" in Child Trauma Cases

- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) [www.musc.edu/tfcbt]
- Parent-Child Interaction Therapy (PCIT) [www.pcit.org]
- Alternatives for Families - Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT) [http://www.afcbt.org]

Key Points

- Trauma histories can be extensive and long lasting
- Cases often involve multiple agencies & providers
- ESTs exist but services must be ACCESSIBLE, AVAILABLE & COORDINATED
- PROBLEM:
  - inconsistent communication; uncoordinated treatment plans

insufficient care

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Caveats about ESTs

- ESTs do not work every time for everyone
  - Not everyone gets better
  - A few get worse
  - They do not work for every problem.
- ESTs do not exist yet for all the mental health problems and needs children and families might have.
- Evidence-based algorithms are not yet established for multi-problem children and families (e.g., best way to sequence ESTs)
- Not all problems are related to the trauma(s)

CURRENT SITUATION

- Not all children/families have ready access to trauma-informed, evidence-based services
- EBTs are not well-integrated into many communities
- Trauma-focused EBTs aren't the standard practice of care throughout mental health and public health systems.

Challenge: How do we do a better job of getting these EBTs into communities??

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Referral and Care Coordination

- Research[1] has demonstrated that the greater the collaboration and coordination between service professionals involved with cases of child abuse and victimization, the more likely the family is to engage in mental health services and, more important, the more positive the outcomes.

- [1]Bai, Y., Wells, R., Hillemeier, M.M. (2009). Coordination between child welfare agencies and mental health service providers, children's service use, and outcomes. *Child Abuse & Neglect*, *33*, 372-381.

Responsibilities of Providers

- Providers have a duty to:
  - Be familiar with available interventions and their supporting literature.
  - Be trained, knowledgeable, and skilled in the use of proven interventions. [if not, REFER]
  - use proven interventions with appropriate clients as their first-line practice.
  - refrain from using experimental or potentially dangerous interventions.

A clinical decision to use an alternative, unsupported approach when a empirically supported intervention exists must be considered an ethical issue.

Responsibilities of Referring Professionals

- To conduct an evidence-based, trauma-informed screening/assessment
- To be reasonably familiar with the evidence-based mental health interventions that are appropriate for the problems their clients often have.
- To refer clients to appropriate, evidence-based treatments from providers who are trained, knowledgeable, and skilled in their use.
- To know what types of treatment their clients are getting and to monitor client progress on treatment goals.

Any questions??

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Resources

- SAMHSA's National Center for Trauma-Informed Care
  - www.samhsa.gov/nctic
- SAMHSA's National Registry of Evidence-based Programs and Practices
  - http://www.nrepp.samhsa.gov/
- Association for Behavioral and Cognitive Therapies (ABCT) – Evidence-based mental health treatment for children and families
  - http://www.abct.org/sccap/

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