Evidence-Based Treatment Addressing Trauma

Over the past 10–15 years, spurred by the federally funded National Child Traumatic Stress Network, there have considerable advances in the development and availability of trauma-specific treatments that can be used in a variety of settings, such as a clinic, home, or school. Significant empirical research supports the efficacy and safety of many of these treatments, establishing them as evidence based. Other trauma-specific treatments have some scientific research or data showing positive outcomes but not enough evidence yet to support generalizable conclusions, making them promising treatments. Given the breadth and robustness of available evidence-based treatments (EBTs) for child trauma, it is recommended that agencies and organizations implement these treatments to provide children and caregivers who have experienced trauma the best care possible to help them heal and build resilience. Implementing trauma-specific EBTs requires a commitment from agencies to train clinicians, provide ongoing supervision and support, make environmental accommodations in the treatment setting, and actively address barriers to treatment participation and caregiver engagement.

What Are EBTs for Trauma?

Children who experience traumatic events may develop debilitating symptoms or challenges that affect their ability to function and put them at risk for long-term problems. As shown by the results of the Adverse Childhood Experiences (ACE) study, there is a strong relationship between trauma experiences in childhood and poor physical, mental, and behavioral outcomes later in life.[1] It is crucial that treatments to address trauma be trauma specific, in that they explicitly address the traumatic experience(s) and the impact of the experience(s) on the child's and caregiver's lives. In addition, the treatments should be sensitive to the child's and family's cultural beliefs and values. Trauma-specific treatments are delivered by specialized mental health professionals and are generally designed to "help children regain a sense of control over the trauma, destigmatize the potential shame the trauma has engendered, [and] normalize symptoms as common and understandable responses to the traumatic event".[2] Typically, these interventions include the use of specific strategies such as trauma narratives, cognitive reframing, and emotion regulation skills. In addition, trauma-specific treatments often require active participation of parents or caregivers.

EBTs are safe and effective interventions for specific populations. They become evidence based through well-designed, randomized clinical trials using outcomes that are tied to specific treatment goals.[3] In addition, EBTs typically have well-developed treatment manuals, training protocols for clinicians, and ongoing assessment of clinician fidelity to the treatment model. By using EBTs, therapists can provide quality care that is empirically grounded.

Example of Trauma-Specific Evidence-Based and Promising Treatments

Trauma-specific treatments have been developed for a variety of settings and employing a range of approaches.

- **Trauma-focused cognitive-behavioral therapy (TF-CBT)** is a cognitive-behavioral intervention used primarily to treat traumatized children ages 3 to 17. It is based on a conjoint child and parent psychotherapy model. TF-CBT consists of several core treatment components including psycho-education about trauma; strategies for managing distressing feelings, thoughts, and behavior; exposure to and processing of trauma-related memories through development of a trauma narrative; and enhancing parenting skills and child safety.[3] Children and non-offending caregivers are initially seen individually. When both are ready, they can come together, so the child may share the trauma narrative with his or her caregiver.
- **Parent–child interaction therapy (PCIT)** is a behavioral intervention for children and their parents. The focus is on enhancing the quality of the parent–child relationship through a combination of didactic training and coaching of parent–child interaction skills and positive behavior management.[4]
- **Child–parent psychotherapy (CPP)** also focuses on relationship enhancement by helping children and parents develop secure attachments, a sense of safety and trust within the parent–child relationship. It also addresses the meaning of the event or trauma. Sessions emphasize parent–child interactions to support and foster coping, affect regulation, and appropriate reciprocity between parent and child.[3]
- **Cognitive-behavioral intervention for trauma in schools (CBITS)** is a group and individual trauma-specific approach designed for delivery in school settings by mental health professionals working in close collaboration with school personnel. CBITS is based on cognitive-behavioral techniques, including psycho-education, relaxation, cognitive restructuring, exposure, and development of a trauma narrative to reduce symptoms, improve peer and parent support, and enhance coping skills.[5]
- Other trauma-specific treatments include **Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT); Attachment, Self-Regulation and Competency (ARC); Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS); and Trauma Adapted Family Connections (TA-FC).**

These and other trauma-specific treatments have different levels of empirical support. TF-CBT currently has the highest level of evidence, while others are in early stages of conducting research and replicating results. Databases, such as the California Evidence-Based Clearinghouse for Child Welfare[6] and SAMHSA's National Registry of Evidence-based Programs and Practices[7] provide the most recent findings for available treatments. Users can consult these databases when thinking about adopting a trauma-specific treatment.

Choosing a Treatment

When choosing a treatment for a child it is important to ensure the treatment is safe, has the potential to improve outcomes, and is appropriate for the child's symptoms. It is also important to consider other factors, such as the child's culture, age, family environment, and memory of the traumatic event to choose the treatment that best meets the needs and preferences of the child and family. Clinicians should conduct a comprehensive assessment as the first step to determine which treatment may be most appropriate for the child.

It is important to recognize there are also a number of treatments available that are promising but have not been fully empirically tested to become evidence based. Some of these promising treatments include components that are similar to those in EBTs but have been adapted for specific settings or to better address diversity in trauma type, client characteristics, and needs. For instance, developers/researchers may adapt existing EBTs to include a spiritual component or cultural practices to foster healing. The fact that a treatment is not evidence based does not mean the treatment will not be effective for the child. There are other important factors that can lead to successful outcomes but that are difficult to evaluate, such as the therapeutic relationship between client and clinician and cultural competence of the provider. It is important that clinicians continue to explore the use of promising treatments and use flexibility when using EBTs.

Adopting and Implementing EBTs

For EBTs to be available to the children and families who need them, qualified clinicians need to be trained in a specific treatment model. Even though EBTs are available to address trauma, awareness of their availability and commitment to adopt them is still limited. As with any other intervention, adopting and implementing trauma-specific EBTs requires commitment, financial support, a strong, supportive organizational context for delivery of the treatment, and supervision and guidance for clinicians administering the treatments. To become proficient in using the treatments, clinicians and supervisors need to participate in intensive clinical training, which is often supplemented with training materials, such as printed manuals and other self-study materials. Environmental accommodations to the treatment setting (i.e., private rooms for treatment and comfortable waiting rooms) may also be needed. Delivering EBTs also requires ongoing, regular supervision and case consultation by clinical supervisors skilled in the

use of the treatment and continuous monitoring. This is essential not only to support clinicians but also to ensure treatment fidelity (i.e., the extent to which the techniques implemented in treatment sessions match the EBT model and the structural elements of fidelity, such as dosage of treatment and frequency of supervision). [8] Treatment fidelity is critical to the success of administering an EBT. At the same time, it is important to recognize that treatment components may have to be adapted to better serve children and families whose cultures, values, needs and preferences were not represented in the original research to develop the intervention.

When implementing EBTs it is also important that agencies and organizations assess and address potential barriers that may affect treatment participation and caregiver engagement, such as low treatment expectations, cultural norms, or stigma. Providers need to take active steps to help overcome these barriers, which may include taking extra time at intake to talk with the child and caregiver about the treatment and its effectiveness, maintaining ongoing contact, and validating the child's and caregiver's attitudes and beliefs regarding trauma and treatment.

Conclusion

Children who suffer the consequences of acute or chronic trauma need access to treatments that directly address their trauma and its impact and help them heal and build resilience. Trauma-specific treatments are now available that can be used in a variety of settings and that have robust evidence for their safety and effectiveness. Agencies and organizations need to take active steps in implementing and disseminating the available treatments by training qualified clinicians and providing financial and organizational support.

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