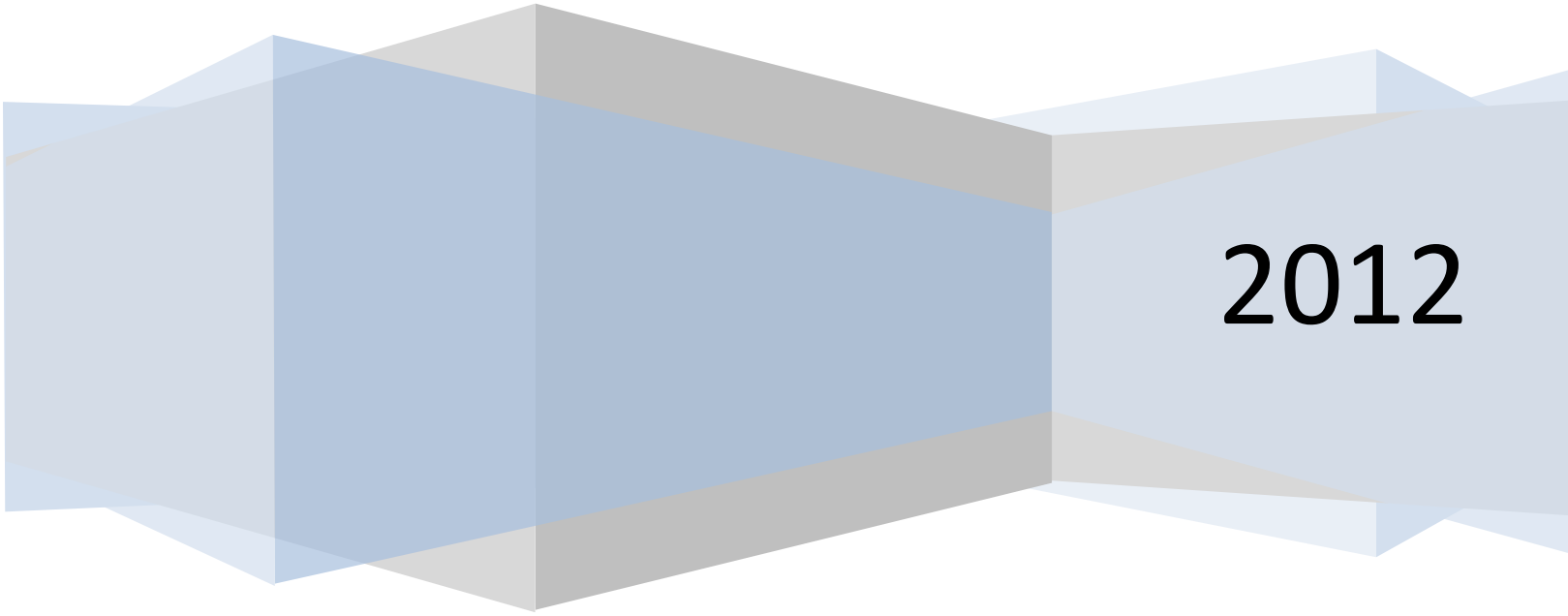
CYS Trauma Assessment and Treatment Practice Guidelines



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Overview

CYS recognizes the prevalence and significance of traumatic stress in the histories of clients treated in CYS and CYS-contract programs. Traumatic stress among children and adolescents can have a significant impact on the child/adolescent in several areas of functioning, such as home, school, community, occupational, social, and personal. The effects of traumatic stress can also negatively influence the normal adaptive developmental processes of children and adolescents and result in a variety of behavioral and emotional disorders. The purpose of the CYS Trauma Assessment and Treatment Practice Guidelines is to help CYS clinicians make informed decisions about treating their clients who are experiencing traumatic stress. These Guidelines will provide the clinician with information about evidence- based and clinically sound interventions which can be used to help minimize the potential deleterious effects of traumatic stress on their young clients.

This practice guideline was developed by a committee of clinician's, supervisors, and management and was based on a review of the literature and other popular research sources (e.g. internet websites) in the field.

CYS Trauma Assessment and Treatment Practice Guidelines should be referrenced across all CYS programs that provide mental health services to children, adolescents and their families. These guidelines will help assess and improve the care processes for CYS clients and achieve more positive outcomes for clients. Such guidelines should be utilized in conjunction with other important treatment considerations such the presence of co-occurring conditions (e.g. substance abuse) and legal status/circumstances. These guidelines are not intended to replace other interventions that would be considered to be consistent with the community standard of practice within a particular mental health profession. In addition, these guidelines should not be used by staff that does not possess the minimum qualifications required by county policy and/or state licensing laws and basic expertise needed to provide mental health treatment. Ultimately, the CYS clinician must use his or her clinical judgment in deciding when a particular intervention is indicated for the client.

I. Introduction

What is traumatic stress? Traumatic stress is the psychological reaction to a sudden or unexpected event that is perceived to be dangerous. It may involve the threat of physical harm or actual physical harm to the victim or others close to the victim. The type of trauma experienced by a child or adolescent usually falls into two categories: Acute Trauma and Complex Trauma. Acute trauma is a single traumatic event that is limited in time. Complex trauma involves prolonged or multiple traumatic events usually occurring within a caregiving relationship and negatively impact the child's development in significant ways.

Traumatic stress in children and adolescents can linger long after the traumatic event has occurred. A variety of emotional, behavioral and physical responses can be manifested in different ways by children and adolescents who have been exposed to traumatic experiences. There are three general groups of responses that are observed as a result of trauma: one, recurring images or thoughts of the traumatic event, two, avoidance of things that trigger memories of the traumatic event, and three, physical or bodily reactions or changes that are abnormal.

The need to address the mental health issues associated with traumatic stress in children and adolescents is important because of the broad range of disruption such stress can have on the young person's level of functioning (e.g. family, school, social, academic, occupational). The following practice guidelines are intended to help the clinician make informed decisions about treating children and adolescents who may be experiencing psychological, emotional, and behavioral difficulties related to traumatic stress.

II. General Guidelines

1. *Guideline One: Gathering Information*

A. Interviewing the Child/Adolescent and Parent/Caregiver – Separately and Together

1) Client-focused interview – Interviewing the child or adolescent requires special attention to the developmental level/maturational stage of your client. It is important to "meet the child/adolescent at his or her level" in terms of language and interpersonal skill level.

- ✓ Discuss the importance and limits of confidentiality with the child/adolescent.
- ✓ Be aware that children and adolescents interpret their experiences differently than adults.
- ✓ Children do not associate feelings with traumatic events.
- ✓ Signs of trauma are manifested differently in children/adolescents compared to adults (e.g. developmental regression, somatic complaints, hyperactivity).
- ✓ Focus on listening to the child's own point of view.
- ✓ Provide the child/adolescent with a safe and non-judgmental environment.
- ✓ Encourage the child/adolescent to talk about his or her traumatic experience(s) by making reassuring statements. Provide non-verbal opportunities for expression of the traumatic experience when appropriate (e.g. drawings, play).

2) Parent-focused interview – Interviewing the parents of children and adolescents is important in order to obtain information about the child's developmental history, system of support and how the parent's reaction may influence the impact of trauma on the child or adolescent.

- ✓ Discuss the importance and limits of confidentiality with the parent.

- ✓ Obtain both a pre- and post-morbid history of the child/adolescent.
- ✓ Ask the parent direct and specific questions about the trauma his or her child experienced
- ✓ Ask what the parent has said or explained to the child about his or her traumatic experience(s).
- ✓ Allow the parent to share his or her feelings about what has happened to their child/adolescent.
- ✓ Take into consideration the family's cultural and religious values and beliefs.

2. *Guideline Two: Screening and Assessment*

A. Administration of the Pediatric Symptom Checklist and 40 Developmental Assets

1) The Pediatric Symptom Checklist (PSC) - obtains parents' reports of children's behavioral/ emotional problems. The PSC is a screening instrument and not a diagnostic tool. The PSC is designed to alert parents early to difficulties in functioning that may indicate current or potential psychosocial problems. A positive score on the PSC suggests the need for further evaluation.

http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_symptonchklst.pdf - English

http://psc.partners.org/psc_spanish.PDF - Spanish

- ✓ Can help differentiate normal behavior from maladaptive behavior.
- ✓ The PSC can be helpful in identifying behaviors that are associated with traumatic stress.
- ✓ The results of the PSC can lead to additional questions the CYS therapist might ask the parent or client.
- ✓ The PSC may encourage the client to talk about other aspects of his or her traumatic experience(s).

2) The 40 Developmental Assets – Developed by the Search Institute, the 40 Developmental Assets list is based on "…extensive research in youth development, resiliency, and prevention, the Developmental Assets represent the relationships, opportunities, and personal qualities that young people need to avoid risks and to thrive."

http://www.search-institute.org/developmental-assets/lists

- ✓ A simple tool to measure the "developmental" strengths of a child or adolescent (intended for ages 12-18).
- ✓ Children exposed to trauma are inherently at risk for developing maladaptive behaviors.
- ✓ Research shows that the more developmental assets one has the less likely they will engage in a wide variety of maladaptive behaviors.
- ✓ There are certain internal and external factors that can mitigate the negative impact of trauma on a child's or adolescent's life. Having a way to measure and identify these factors can be helpful in the treatment of these young individuals.

B. Consultation with CYS staff psychologist to discuss the need for psychological testing *(Note: All CYS outpatient contract providers that do not have psychological testing capabilities, can make referrals for psychological testing to CYS regional outpatient clinics).*

1) Psychological testing can improve the clinician's understanding of the client's problems and can also assist in developing a working diagnosis and generating appropriate treatment goals related to traumatic stress. Psychological testing should take into account the child/adolescent's culture, language, and physical disabilities.
   - ✓ There are a variety of psychological test that can help measure the presence and intensity of symptoms associated with traumatic stress in children and adolescents.

- ✓ Standardized tests designed to measure trauma allow the clinician to compare data with the client's particular peer/age group and the general population.
- ✓ Testing provides the clinician with an objective and quantifiable way of looking at the client's presenting symptoms.
- ✓ Testing can be helpful in developing a diagnosis of Posttraumatic Stress Disorder or Acute Stress Disorder and identifying any co-occurring diagnostic conditions.
- ✓ Testing should be part of an ongoing process of monitoring the course of recovery and identifying changes to treatment planning.
- ✓ Possible testing instruments include:
  - Trauma Symptom Checklist for Children (TSCC)
  - Trauma Symptom Checklist for Young Children (TSCYC)
  - Children's PTSD Inventory (CPTSD-I)
  - Child Stress Disorders Checklist (CSDI)
  - Trauma and Attachment Belief Scale (TABS)
  - The Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA)
  - UCLA PTSD Reaction Index (PTSD-RI)

3. *Guideline Three: Culturally Competent Trauma-Informed Treatment Principles* - *The National Child Traumatic Stress Network (NCTSN).*

   A. Engagement with the child, the family and the community. Issues of engagement may be problematic for some cultural groups. Making outreach and engagement strategies more culture-specific is an important treatment goal. For example, trust is a sensitive issue when working with refugees. Also, expanding engagement efforts to members of the child/family's immediate community can be key in providing treatment more effectively.

   B. Sensitivity to the family's cultural background when building a strong therapeutic relationship. When treating the trauma-exposed child/adolescent, developing a strong relationship is critical to a successful recovery. The therapist needs to appreciate the importance of asking questions about the client's and his/her family's culture.

C. **Consideration of the impact of culture on symptom expression**. Taking into account the child's or caregiver's cultural view is important in understanding how symptoms of trauma are expressed for certain cultural groups. Measurements of these trauma symptoms should also be sensitive to these differences.

D. **Careful use of interpreters when necessary**. Being able to communicate with caregivers during treatment is very important. Language barriers present challenges to the therapist employing treatment models that require caregiver participation. The use of interpreters should be examined carefully before using a particular treatment intervention.

E. **Understanding that differences in emotional expression exist among cultures**. Teaching children/adolescent and their caregivers how to effectively regulate emotional expression in the face of overwhelming feelings associated with their traumatic experiences, is vital to effective treatment. The therapist must learn how different cultures dictate the expression of these feelings and the appropriate level of emotional expression within a given culture's norms.

F. **Assessment of the impact of cultural views on cognitive processing or reframing.** Addressing cognitive distortions and misattributions is a core element in many treatments for traumatic stress in children and adolescents. The therapist should be aware of how culture may influence how children/adolescents and their families explain to themselves and others their traumatic experiences. For example, keeping feelings to oneself may be a result of a cultural function as opposed to a reaction to the traumatic experience.

G. **Construction of a coherent trauma narrative using culturally congruent methods.** Building the capacity of children and adolescents to talk about their traumatic experiences while using coping skills to deal with the emotional reminders that will emerge is critical to many treatment approaches. Including one's cultural view on how life experiences are shared is equally important. The use of storytelling or cultural traditions is examples of how some cultural groups relate their experiences to others.

H. **Highlighting ways in which culture may be a source of resiliency and strength.** Capitalizing on the strengths of the child can help foster feelings of empowerment and confidence that the traumatized child or adolescent can use in his/her treatment and post-treatment recovery. Identifying certain aspects of one's culture that provide support and a sense of competence in dealing with adversity can be valuable to any treatment approach.

4. Guideline Four: Diagnosis

A. Diagnostic Issues Related to Trauma in Children and Adolescents

1) Parent-Child Agreement – the accuracy of diagnosis improves when the child's report about his or her traumatic experience is consonant with what the parent is reporting about their child's traumatic experience.

2) Young children do not possess the necessary language or cognitive abilities required to describe their "internal states," which is needed in order to properly identify important criteria of Acute Stress disorder (ASD) and Posttaumatic Stress Disorder (PTSD) (e.g. evidence of dissociation).

3) Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) falls short of taking into account the unique developmental aspects of trauma experienced by children and adolescents.

4) Consider the number of DSM criteria met versus reporting criteria along a continuum of frequency. For example, children may experience long periods of re-experiencing that alternate with long periods of avoidance and numbing, rather than experiencing both in the same time period.

5) Recurrent and intrusive thoughts about the traumatic experience are more likely to be observed in the play and dreams of children than in their verbalizations.

6) Young children may become increasingly hyperactive or distractible in response to trauma making it look like Attention Deficit Hyperactivity Disorder (ADHD) and correct diagnosis confusing.

7) Recent findings suggest that it is more important when diagnosing children with PTSD to look at the intensity of symptoms and the relationship with functional impairments rather than the threshold number of criteria.

8) Differential diagnosis: trauma-related symptoms may mimic other disorders such as ADHD, depression, generalized anxiety, conduct disorder, Oppositional Defiant Disorder (ODD), etc. These disorders could also exist alongside ASD or PTSD and represent a co-occurring condition.

B. Acute Stress Disorder (DSM IV-R Code 308.3)

1) The person has been exposed to a traumatic event in which both of the following were present:

   a. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
   b. The person's response involved intense fear, helplessness, or horror.

2) Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following symptoms:

   a. A subjective sense of numbing, detachment, or absence of emotional responsiveness
   b. A reduction in awareness of his or her surroundings (e.g., being in a daze)
   c. Derealization
   d. Depersonalization
   e. Dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

3) The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

4) Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

5) Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hyper-vigilance, exaggerated startle response, motor restlessness).

6) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the

individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

7) The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

8) The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

C. Posttraumatic Stress Disorder (DSM IV – R Code 309.81)

1) The person has been exposed to a traumatic event in which both of the following have been present:

   a. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
   b. The person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.

2) For the person suffering from Post Traumatic Stress Disorder, the traumatic event is persistently re-experienced in one (or more) of the following ways:

   a. Recurrent and intrusive distressing recollections of the event, Including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

   b. Recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

   c. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and

dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

d. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

e. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

3) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

a. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
b. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
c. Inability to recall an important aspect of the trauma.
d. Markedly diminished interest or participation in significant activities.
e. Feeling of detachment or estrangement from others.
f. Restricted range of affect (e.g., unable to have loving feelings).
g. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

4) Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

a. difficulty falling or staying asleep
b. irritability or outbursts of anger
c. difficulty concentrating
d. hypervigilance
e. exaggerated startle response

5) Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

6) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

5. *Guideline Five: Conceptualizing the Effects of Trauma*

A. Twelve Core Concepts for Understanding Traumatic Stress Responses in Children – The National Child Traumatic Stress Network (NCTSN).

1) Traumatic experiences are inherently complex.
2) Trauma occurs within a broad context that includes children's personal characteristics, life experiences and current circumstances.
3) Traumatic events often generate secondary adversities, life changes and distressing reminders in children's daily lives.
4) Children can exhibit a wide range of reactions to trauma and loss.
5) Danger and safety are core concerns in the lives of traumatized children.
6) Traumatic experiences affect the family and broader caregiving systems.
7) Protective and promotive factors can reduce the adverse impact of trauma.
8) Trauma and posttrauma adversities can strongly influence development.
9) Developmental neurobiology underlies children's reactions to traumatic experiences.
10) Culture is closely interwoven with traumatic experiences, response and recovery.
11) Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.
12) Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care.

B. Age-Related Impact of Trauma – Trauma can be conceptualized in terms of how it influences the developmental tasks and activities of the child or adolescent. Mastery over certain developmental challenges can be delayed, fixated, or regressed due to the negative effects of traumatic stress. This impact can be manifested in a variety of behavioral, emotional, and social changes.

1) Pre-school and young school-aged children
   - ✓ (0-5 years)

     - Sleep disturbances

- ☐ Eating problems
- ☐ Regressive behaviors (e.g. baby talk, bedwetting)
- ☐ Regressive cognition (e.g. poor impulse control or problem-solving)
- ☐ Feelings of helplessness
- ☐ Feelings of general anxiety
- ☐ Separation problems
- ☐ Increased temper tantrums
- ☐ Oppositional behavior

2) School-aged children
   - ✓ (6-12 years)
     - ☐ Sleep disturbance, nightmares
     - ☐ Eating problems
     - ☐ Somatic complaints
     - ☐ Poor concentration and learning disturbances
     - ☐ Guilty feelings
     - ☐ Irritability, mood swings
     - ☐ Intense anxiety reactions
     - ☐ Aggressive, withdrawn, disorganized
     - ☐ Regressive behaviors

3) Adolescents
   - ✓ (13-18 years)
     - ☐ Feelings of self-consciousness about their emotions
     - ☐ Fear or concern about being labeled “abnormal”
     - ☐ Shame and guilt about their traumatic experience
     - ☐ Engage in fantasies about how they would respond differently to the traumatic event
     - ☐ Changes in the way they view the world
     - ☐ Engage in self-destructive or accident prone behaviors
     - ☐

C. "**The Threatened Child: How Fear Changes Thinking, Feeling, and Behaving" – Bruce Perry, M.D., Ph.D. –** The work and research by Dr. Perry offers the clinician another way of understanding the impact of trauma on children and adolescents. Dr. Perry's model of "The Threatened Child" focuses on the relationships between trauma and the physiological, cognitive, and behavioral responses of the child or adolescent who experience traumatic stress.

Hyperarousal Continuum	Rest	Vigilance	Resistance (Crying)	Defiance (Tantrums)	Aggression
Dissociative Continuum	Rest	Avoidance	Compliance (Robotic/Detached)	Dissociation (Fetal Rocking)	Fainting
Regulating Brain Region	Neo Cortex (Cortex)	Cortex (Limbic)	Limbic (Midbrain)	Midbrain (Brainstem)	Brainstem (Autonomic)
Cognitive Style	Abstract	Concrete	Emotional	Reactive	Reflexive
Internal State	Calm	Arousal	Alarm	Fear	Terror

"Different children have different styles of adaptation to threat. Some children use a primary hyperarousal response some a primary dissociative response. Most use some combination of these two adaptive styles. In the fearful child, a defiant stance is often seen. This is typically interpreted as a willful and controlling child. Rather than understanding the behavior as related to fear, adults often respond to the 'oppositional' behavior by becoming more angry, more demanding. The child, over-reading the non-verbal cues of the frustrated and angry adult, feels more threatened and moves from alarm to fear to terror. These children may end up in a primitive "mini-psychotic" regression or in a very combative state. The behavior of the child reflects their attempts to adapt and respond to a perceived (or misperceived) threat."

6. Guideline Six: Treatment

A. Core Components of Empirically Supported Intervention - The National Child Traumatic Stress Network (NCTSN) website maintains detailed information about numerous evidence-based and promising practice trauma treatment models. The breadth of treatment models covered allows clinicians flexibility to pick a model appropriate to a variety of clients and clinical situations. These "core components" represent the overlap among these treatment models in terms of both their content and approach. To the extent that it is clinically, developmentally and culturally appropriate, these components should be incorporated into the treatment of children and adolescents who have experienced traumatic stress.

1) *Screening and Triage* - This is covered in Guidelines 1 and 2 of this Practice Guideline. Treatment begins with obtaining information and identifying areas of dysfunction/impairment to be used as focal points in treatment.
2) *Systematic Assessment, Case Conceptualization, and Treatment Planning* - This is covered in Guidelines 2, 5, and 6 of this Practice Guideline. There are a variety of standardized measures of traumatic stress for children and adolescents that can be used in the treatment process, including monitoring progress. Using a theoretical framework can help organize one's understanding of a client's treatment issues and will help guide treatment planning. Treatment planning can also be used in forming a working alliance with the child/adolescent clients and their families.
3) *Psycho-education* – Increasing a client's or parent's knowledge of and awareness of the important aspects of traumatic stress can facilitate the recovery process. Providing information that is both practical and meaningful can serve as a foundation for building a healthier child and a more supportive family.
4) *Addressing Children and Families' Traumatic Stress Reactions and Experiences* – Becoming familiar with both the child's and family's response to the traumatic event(s) is critical when providing treatment. Every child or adolescent has a different view of their world and the environment in which the trauma was experienced. The family's interaction with the child/adolescent after and during the traumatic

event(s) can form a certain family dynamic that can also influence the course of recovery.

5) *Trauma Narration and Organization* – Allowing the child or adolescent to tell their story of the traumatic experience is central to most effective models of treatment. Such "story-telling" can occur spontaneously or during the structure of the therapy session. The clinician helps the child or adolescent develop his/her trauma narrative via verbal conversation, drawings or artwork, play or by other creative methods of communication and sharing. Both processes of telling one's story and developing coherence in the narrative have important therapeutic value.
6) *Enhancing Emotional Regulation and Anxiety Management Skills* – Helping the child/adolescent identify and express internal states related to their traumatic experience is a key element in effective treatment. The young client must be able to interpret their traumatic experiences by recognizing and sharing his or her emotions in a coherent and unrestricted manner. An important task for the clinician is to help the client learn ways to manage the experiencing and re-experiencing of the anxiety associated with the traumatic event(s).
7) *Facilitating Adaptive Coping and Maintaining Adaptive Routines* - Promoting the development of coping skills to reduce the disturbing thoughts and feelings associated with traumatic stress is another key element in effective treatment and is important in avoiding issues of relapse or regression. Building the practice of such coping skills into the child or adolescents daily life can help the client feel more confident and empowered when dealing with the negative feelings of trauma.
8) *Parent Skills and Behavior Management* – The traumatized child or adolescent can develop a variety of behavioral problems and such behaviors are often first observed at home. Effective treatment involves working with parents by teaching them how to respond positively to their child's behavior. The goal is to support the child by increasing the parents' level of competence in dealing with the behavioral sequelae of traumatic stress.
9) *Promoting Adaptive Developmental Progression* – The clinician can help insure the forward movement of recovery of the traumatized child/adolescent by reinforcing both positive internal and external

characteristics of the child and his/her environment. Identifying pre-existing strengths, such as self-confidence, social competence, and intelligence, as well as supportive factors, such as positive parent-child attachments, intact family structure, and community involvement can be used by the clinician to promote healthy development in the child or adolescent.

10) *Addressing Grief and Loss* – After experiencing the traumatic loss of a parent or loved one, children are challenged by three sets of reminders of the loss: (1) trauma reminders of the manner of death; (2) loss reminders, especially situations or times when the child misses the lost loved one; and (3) loss reminders of how life has changed because of the traumatic death. Helping the child process and deal with these aspects of traumatic loss should be incorporated into the clinician's treatment plan.
11) *Promoting Safety Skills* – Developing the ability to recognize and avoid potentially dangerous/harmful situations is an important skill that should be taught or enhanced when treating traumatized children or adolescents. Knowing one's "personal space" or learning to be vigilant without being hypervigilant are examples of skills the clinician can teach their young clients so they can be more assertive in protecting themselves from future traumatic experiences.
12) *Relapse Prevention* - The key to relapse prevention is for the child/adolescent to continue using the cognitive and behavioral skills learned in treatment and to recognize the early signs of returning traumatic stress symptoms.
13) *Evaluation of Treatment Responses and Effectiveness* – Monitoring the course and outcome of treatment responses can help in determining the need for changes in treatment planning. Post-treatment assessment can also be used to examine the effectiveness of the therapist's clinical interventions.
14) *Engagement/Addressing Barriers to Service-Seeking* – The therapist should be aware of and be prepared to address the potential/existing obstacles that clients have to deal with when accessing treatment. Examples may include language barriers, transportation issues, cultural differences, financial difficulties, and scheduling conflicts.

B. List of Popular Evidence-Based Treatment Interventions – The following is a list of specific treatment intervention models that have been widely used to address traumatic stress in children and adolescents. These treatment models are supported by research/clinical studies and have been evaluated for effectiveness in the treatment of traumatized children and adolescents. Each treatment model is given a "classification score" which was developed by Benjamin E. Saunders, Ph.D. from the National Crime Victims Research and Treatment Center.

The classification system, developed by B.E Saunders, Ph.D., uses criteria regarding a treatment model's theoretical soundness, clinical support, acceptance within the field, potential for harm, documentation, and empirical support to assign a "classification score." A lower score indicates greater level of support for the treatment protocol. The classification scores are summarized below:

1 = Well-supported, efficacious treatment
2 = Supported and probably efficacious treatment
3 = Supported and acceptable treatment
4 = Promising and acceptable of treatment
5 = Innovative or novel treatment
6 = Concerning treatment

1) Child Focused Interventions

a. *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)* – Trauma-focused cognitive behavioral therapy, an intervention based on learning and cognitive theories, is designed to reduce children's negative emotional and behavioral responses and correct maladaptive beliefs and attributions related to the traumatic experiences. It also aims to provide support and skills to help parents cope effectively with their own emotional distress and optimally respond to their children. Classification Score = 1.

b. *Cognitive-Processing Therapy (CPT)* – Cognitive Processing Therapy (CPT) is a brief, structured, cognitive-behavioral treatment designed to treat posttraumatic stress disorder (PTSD) and associated features such as depression. CPT is a therapy consisting of exposure to the traumatic memory, training in cognitive restructuring, and modules on various topics most likely to be affected by traumatic events. Classification Score = 3.

c. *Eye Movement Desensitization and Reprocessing (EMDR)* – EMDR is a multi-component therapeutic procedure for traumatic memories and for posttraumatic stress disorder (PTSD) that purports to restart and facilitate blocked processing of the alternate positive cognitions, coping strategies, and adaptive behaviors. Classification Rating = 3.

d. *Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST)* - is a two-module treatment focused on reducing symptoms of PTSD and other trauma-related symptoms (including depression and dissociation) and on building and enhancing specific social and emotional competencies that are frequently disturbed in youths who have experienced multiple traumas and/or sustained trauma. Classification Score = N/A.

2) Family, Parent-Child, and Parent Focused Interventions

a. *Parent-Child Interaction Therapy (PCIT)* – This intervention is a behavioral and interpersonal dyadic intervention for children (ages 2-8 years) and their parents or caregivers that is focused on decreasing externalized child behavior problems (i.e. defiance, aggression), increasing positive parent behaviors, and improving the quality of the parent-child relationship. Classification Score = 3.

b. *Child-Parent Psychotherapy (CPP)* – Treatment focuses on safety, affect regulation, improving the child-caregiver relationship, normalization of trauma related response, joint construction of a trauma narrative, with the goal of returning the child to a normal developmental trajectory. Primarily base in attachment theory. Classification Score = N/A.

c. *Alternatives for Families- A Cognitive Behavioral Therapy (AF-CBT)* - is an evidence-based treatment (EBT) designed to improve the relationships between children and parents/caregivers in families involved in physical coercion/force and chronic conflict/hostility. AF-CBT emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, promote positive family relations, and reduce violent behavior. Classification Score = N/A.

III. Special Guidelines

1. *Special Guideline One: Co-occurring Traumatic Stress and Substance Abuse - The National Child Traumatic Stress Network (NCTSN).*

A. Treatment considerations when working with adolescents.

1) Include assessments of substance abuse problems and traumatic stress as part of routine screening and assessment procedures.
2) Provide youth and families with more intense treatment options to address the magnitude of difficulties often experienced by this population.
3) Emphasize management and reduction of both substance use and PTSD symptoms early in the recovery process.
4) Start relapse prevention efforts – targeting both substance and trauma-related cues – early in treatment (e.g., problem solving, drug refusal, and safety skills and desensitization to trauma reminders).
5) Establish a therapeutic relationship that is consistent, trusting, and collaborative.
6) Focus on stress management skills such as relaxation and positive self-talk.
7) Help clients develop emotional regulation skills such as the identification, and modulation of negative affect.
8) Incorporate cognitive restructuring techniques such as recognizing, challenging, and correcting negative cognitions.
9) Provide social skills training and consider referral to adolescent self-help groups as needed.

10) Provide psycho-education for both youth and their families about trauma and substance abuse problems, and encourage parental involvement in treatment with the goal of increasing parenting skills, communication, and conflict resolution.

11) Make use of school-based treatment programs to reach at-risk youth.

B. Specific evidenced-based treatment for adolescents.

1) *Seeking Safety* – is a manualized treatment for co-occurring substance abuse disorders and PTSD. When used with adolescents the following modifications should be made: providing information verbally if adolescent refuses to read handouts, use hypothetical third-person vignettes for discussion, limit parent involvement, discuss details of trauma if okay with adolescent.
2) *Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)* – is a group intervention focused on addressing the needs of chronically traumatized adolescents who are still living with ongoing stress. Treatment focuses on three components: mindfulness/interpersonal/emotional regulation skills, problem-solving skills, and social support skills.
3) *Risk Reduction through Family Therapy (RRFT)* – is an intervention used to reduce the risk of substance abuse and trauma-related psychopathology. RRFT integrates several existing empirically-supported treatments which addresses the heterogeneous nature of symptom expression among adolescents.

2. *Special Guideline Two: Trauma-Focused Intervention for Youth in the Juvenile Justice System* - The National Child Traumatic Stress Network (NCTSN).

A. Assessment considerations

1) Evaluating the environmental and contextual risks and safety of youths in the juvenile justice system is important because of the potential dangers

associated with the typical environments of this population. For example, youths in detention settings are often exposed to additional traumatic events from other offenders and staff. Additionally, explaining to the juvenile and his or her family the issue of confidentiality is important because of the legal implications of disclosing information about the juvenile's situation.

2) Use multi-perspective assessments in order to evaluate information more accurately. Parents, caretakers, and other individuals working with the juvenile are more inclined to focus on information related to managing the youth's behavior. This information will be primarily focused on the external symptoms of the trauma, rather than on the more subjective, internal symptoms of the youth. Obtaining information from multiple informants is a good way to build a more complete picture of the impact trauma has had on the youth.
3) Determining the format of the assessment can be important when evaluating juvenile youths. Some assessments require being able to read at a certain level, but studies have shown that youths in the juvenile justice system are reading or learning below grade level which could inhibit their ability to comprehend question from written assessment instruments.
4) Taking into account the youth's developmental level and ethnocultural background is especially important when assessing youth in the juvenile justice system. Wording of certain questions may mean something different to a youth from a certain minority ethnic group. Certain non-verbal actions can also be misinterpreted by the assessor who is not familiar with a particular minority culture (i.e. averting eye contact). These considerations are all the more important since many studies have shown that ethnic minorities are overrepresented in this country's correctional/detention programs for youth.

B. Treatment considerations

1) Research over the past ten years have indicated the most effective treatments for traumatic stress for youth in the juvenile justice system are highly structured, focus on the development of basic skills, provide individual counseling that addresses behaviors, attitudes and perceptions.

2) Teaching juvenile youth to manage/reduce symptoms of hypervigilance, hyperarousal and intrusive re-experiencing may not be appropriate since these characteristics may actually serve an adaptive function for juvenile youth in high risk, dangerous environments.
3) There is very little research on the use of treatment interventions for traumatized youth in the juvenile justice system.
4) Trauma-focused cognitive behavioral therapy (TF-CBT) has the highest ranking, in terms of its theoretical bases, clinical-anecdotal literature, acceptance among practitioners, and having the lowest risk of causing harm.
5) Treatments that also address substance abuse issues are especially relevant due to the fact that a large percentage of youth in the juvenile justice system struggle with drug use problems.
6) Including the juvenile youth's family in treatment is important but is often problematic to implement due to limited access and separation from his or her family during incarceration.
7) Studies on the effectiveness of group therapy with traumatized juveniles have shown adverse effects (e.g. increase in anti-social behavior); however, such effects can be minimized if certain factors are addressed (e.g. involving parents, mixing group with pro-social and maladjusted youth).

IV. Resources

www.NCTSN.org

The website of the **National Child Traumatic Stress Network** was developed to serve as a national resource for information on childhood traumatic stress.

www.childtrauma.org

This is the website for the **Child Trauma Academy**, whose primary founder is **Bruce Perry**. "CTA is a not-for-profit organization based in Houston, Texas working to improve the lives of high-risk children through direct service, research and education. We recognize the crucial importance of childhood experience in shaping the health of the individual, and ultimately, society. By creating biologically-informed child and family respectful practice, programs and policy, CTA seeks to help maltreated and traumatized children. A major activity of the CTA is to translate emerging findings about the human brain and child development into practical implications for the ways we nurture, protect, enrich, educate and heal children. The "translational neuroscience" work of the CTA has resulted in a range of innovative programs in therapeutic, child protection and educational systems."

www.traumacenter.org

"**The Trauma Center** is a program of Justice Resource Institute (JRI), a large nonprofit organization dedicated to social justice by offering hope and promise of fulfillment to children, adults, and families who are at risk of not receiving effective services essential to their safety, progress, and/or survival. The Executive Director of the Trauma Center is Joseph Spinazzola, Ph.D., and the Medical Director and Founder of the Trauma Center is **Bessel van der Kolk**, MD, who is an internationally recognized leader in the field of psychological trauma.The Trauma Center provides comprehensive services to traumatized children and adults and their families at the main office in Brookline.

In addition to clinical services, The Trauma Center offers training, consultation, and educational programming for post-graduate mental health professionals. Our Certificate Program in Traumatic Stress Studies has state-of-the-art seminars, lectures and supervision groups. Our monthly Lecture Series is open to all mental health professionals.

The Trauma Center Research Department is housed at our Brookline location and is also directed by Dr. van der Kolk. The Research Department conducts studies on traumatic memory and how treatment effects trauma survivors' minds, bodies, and brains."

www.ptsd.va.gov/index.asp

The National Center for PTSD is a special center within the **Department of Veterans Affairs**. It provides fact sheets, videos and other tools with information on PTSD as well as providing materials on assessment and treatment of trauma for providers and researchers.

www.developingchild.harvard.edu

This website has a wealth of information on the science of early childhood, with an emphasis on how early experiences affect brain development. The website has working papers, reports, educational videos and newsletters on topics like the effect of toxic stress (i.e. abuse, neglect and exposure to violence) on early brain development.

www.childwelfare.gov/

The "Child Welfare Information Gateway connects child welfare and related professionals to comprehensive information and resources to help protect children and strengthen families. We feature the latest on topics from prevention to permanency, including child abuse and neglect, foster care, and adoption" The website provides information on "the identification and assessment of the impact of maltreatment and trauma on brain development; how to work effectively with children, youth, and families to support healthy brain development; and how to improve services through cross-system collaboration and trauma-informed practice."

www.istss.org/Home.htm

The website of **The International Society for Traumatic Stress Studies** contains information on trauma assessment, treatment and research. They have been involved in the development of practice guidelines which are described in the book by Foa et.al.(2009) in the reference section of this document. The section of the website on treating trauma provides a description of the Foa book and 18 downloadable pdf files each covering a distinct guideline related to PTSD treatment. Six of the Guidelines address aspects of trauma treatment with children and adolescents. The following is the link to the page with these pdf downloads: http://www.istss.org/TreatmentGuidelines/3491.htm

www.apa.org/pi/families/resources/task-force/child-trauma.aspx

This website has information regarding the American Psychological Association Presidential Task Force on Post-traumatic Stress Disorder and Trauma on Children and Adolescents. The web page has additional references to updates and tips for mental health professionals regarding the treatment of trauma amongst children and adolescents.

www.mentalhealthconnection.org/pdfs/perry-handout-effects-of-trauma.pdf

This is a pdf by Bruce Perry, M.D., Ph.D. called "Effects of Traumatic Events on Children: An Introduction." In this document Dr. Perry provides a description of his model for how traumatic events impact the child in significant areas of functioning such as physiological, cognitive and behavioral.