|  |  |
| --- | --- |
| **Module Details: Trauma Specific Interventions - Supplementary Information** | |
| **Title** | **Module 4 – Trauma informed interventions for working with children and adolescents who engage in behaviours that challenge (Lead: Hamburg with Cork)- Trauma Informed Interventions supplementary information.** |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | This section provides information about evidence-based Trauma specific Interventions and presents an overview regarding the following interventions:   1. Attachment, Regulation and Competency (ARC) 2. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) 3. Eye Movement Desensitization and Reprocessing (EMDR) 4. Parent-Child Interaction Therapy 5. Child Parent Psychotherapy 6. Play Therapy 7. Yoga |  | **Notes or comments** |
|  | **Evidence-based Trauma Specific Interventions for children and adolescents who have experience childhood and intergenerational trauma – Supplementary Information**  Evidence-based interventions aim to address the emotional, psychological, and social consequences of trauma. In the following, we will outline some evidence-based interventions for children and adolescents who have experienced childhood and intergenerational trauma. It's important to note that the choice of intervention should be based on the individual's needs, the severity of their trauma, and their cultural background. Additionally, interventions should ideally be delivered by trained and licensed mental health professionals who have experience working with trauma-affected children and adolescents.  1. Attachment, Regulation and Competency (ARC)  Attachment, Regulation, and Competency (ARC) is a framework and therapeutic approach developed by Dr. Margaret Blaustein and Dr. Kristine Kinniburgh. It is designed to support individuals, particularly children and adolescents, who have experienced complex trauma or have attachment-related difficulties. Complex trauma typically involves exposure to prolonged, multiple, and interpersonal traumas, such as abuse, neglect, or disrupted attachment relationships.  The ARC framework focuses on three key areas (Arvidson et al., 2011):   1. Attachment: This aspect of ARC recognizes the significance of secure and healthy attachment relationships in a person's development. It addresses how trauma and disrupted attachments can impact an individual's ability to form secure connections and relationships. The goal is to help individuals build more secure and healthy attachments with caregivers and peers. 2. Regulation: ARC emphasizes the importance of emotional and physiological regulation. Trauma can lead to difficulties in managing emotions and physical responses to stress. The framework helps individuals learn strategies to regulate their emotions and manage stress, contributing to greater emotional stability and well-being. 3. Competency: The competency component focuses on enhancing an individual's adaptive coping skills, resilience, and personal strengths. It aims to empower individuals with the ability to cope with life's challenges and build a sense of self-efficacy.     ARC interventions are typically implemented by mental health professionals, therapists, and caregivers, with a particular emphasis on those working with children and adolescents who have experienced complex trauma. The framework incorporates a range of therapeutic strategies and interventions to address the unique needs of each individual, taking into account their trauma history and attachment patterns. Overall, ARC is a trauma-informed and attachment-focused approach that seeks to promote healing, resilience, and healthy development in individuals who have experienced complex trauma or attachment disruptions. It emphasizes the importance of creating a safe and nurturing environment in which individuals can develop secure attachments, improve emotional regulation, and enhance their coping and problem-solving skills.  2 Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):  Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a widely recognized and evidence-based therapeutic approach designed to help individuals, particularly children and adolescents, who have experienced trauma. It combines elements of cognitive-behavioral therapy (CBT) with techniques and strategies specifically tailored to address the emotional and psychological aftermath of trauma. TF-CBT is primarily used to treat individuals who have experienced various types of trauma, including physical abuse, sexual abuse, neglect, domestic violence, natural disasters, and other traumatic events.  Key components and principles of TF-CBT include (Cohen et al., 2017; Pollio & Deblinger, 2018):   1. **Psychoeducation**: Clients are provided with information about the nature of trauma, how it affects the brain and body, and the common reactions to traumatic events. This helps individuals understand that their responses are normal reactions to abnormal circumstances. 2. **Trauma Narrative**: Clients are encouraged to discuss and process their traumatic experiences within a structured and safe therapeutic environment. This narrative helps them gain a sense of control over their memories and emotions related to the trauma. 3. **Cognitive Restructuring**: Like traditional CBT, TF-CBT focuses on identifying and challenging negative thought patterns and beliefs related to the trauma. Clients learn to reframe these thoughts and develop healthier coping strategies. 4. **Relaxation and Stress Management Techniques**: Clients are taught relaxation and grounding techniques to manage the physical and emotional symptoms of trauma, such as anxiety and flashbacks. 5. **Emotional Regulation**: TF-CBT helps individuals learn to recognize and manage their emotions in a healthier way, reducing emotional reactivity and impulsivity. 6. **Parent/Caregiver Involvement**: TF-CBT often involves parents or caregivers, as children and adolescents require support from their primary caregivers. Parenting skills, communication, and strategies to create a safe and supportive environment for the child are addressed. 7. **Gradual Exposure**: Over time, clients may engage in controlled and gradual exposure to traumatic memories and triggers. This process is done under the guidance of a therapist to desensitize the individual to their trauma-related distress. 8. **Safety and Trust**: Establishing a safe and trusting therapeutic relationship is a fundamental aspect of TF-CBT. Therapists work to build rapport with their clients, creating a secure space for them to share their experiences and emotions. 9. **Grief and Loss**: Clients are encouraged to process any feelings of grief or loss associated with the traumatic event. This can include mourning the loss of a sense of safety or trust.   TF-CBT is typically delivered by licensed mental health professionals, including clinical psychologists, social workers, and counselors. It is often delivered over a course of 12-16 sessions, but the duration can vary depending on the individual's needs and the severity of the trauma. The goal of TF-CBT is to help individuals process their trauma, reduce symptoms of post-traumatic stress, and promote healing and recovery.  3 Eye Movement Desensitization and Reprocessing (EMDR):  Eye Movement Desensitization and Reprocessing (EMDR) is a therapy approach that uses bilateral stimulation (often in the form of eye movements) to help individuals reprocess traumatic memories. It has been shown to be effective in reducing the emotional charge associated with traumatic events. was introduced in 1987 as a therapy treatment for PTSD (Watts et al. 2013). EMDR represents a paradigm shift form psychological theory towards neuroscience (Lanius & Bergman 2014). EMDR is a comprehensive model of psychotherapy informed by the adaptive information processing model (AIP). The AIP model assises that the human brain can usually process stressful information to complete integration. However, if this processing system is impaired, the memory will be stored in a raw unprocessed and maladaptive form. A traumatic experience may become stored in a state specific form (Hase et al. 2017). EMDR therapy facilitates the effective processing of traumatic or disturbing life experiences and as a result of effective EMDR treatment previously impaired linkage or binding mechanisms in the information processing system are repaired (Bergmann 2020).  **How does EMDR Work**  EMDRs bilateral sensory stimulation (BLS) is found to facilitate parasympathetic and information processing mechanisms. Repetitive BLS is found to facilitate activation of Rapid Eye Movement (REM) systems which facilitate reduction in both the strength of episodic memories, as well as the negative effects of PTSD (Romero et al. 2018).  **Effects of Bilateral Eye Movements (BLS)**   * Decreased vividness of emotionally disturbing memories. * Enhanced memory processing * Enhances memory retrieval * Increased accuracy of memory * Induced cognitive and semantic flexibility and facilitate attentional orienting. * Enhanced executive control processes and increased metacognitive awareness.   (Leeds 2016).  **8 Phases of EMDR**  Table 1 from The role of eye movement desensitization and reprocessing (EMDR)  therapy in medicine: addressing the psychological and physical symptoms  stemming from adverse life experiences. | Semantic Scholar  (Shapiro 2014)  4 Parent-Child Interaction Therapy  Parent-Child Interaction Therapy (PCIT) is an evidence-based behavioral intervention designed to help parents improve their relationship with their child and manage behavioral problems in young children. PCIT is typically used with children between the ages of 2 and 7 years who display challenging behaviors, such as defiance, aggression, temper tantrums, or difficulty following rules. It was developed by Dr. Sheila Eyberg in the 1970s and has since been widely used in clinical settings to address a variety of child behavior issues.  PCIT is based on a two-phase approach (Eyberg and Funderburk, 2011):   1. **Child-Directed Interaction (CDI):** In the first phase, the therapist teaches parents how to engage in positive interactions with their child. This involves using techniques like praise, reflection, and imitating the child's play. The goal is to enhance the parent-child bond and create a more positive and supportive relationship. 2. **Parent-Directed Interaction (PDI):** In the second phase, parents learn to set clear and consistent limits for their child's behavior. They are taught effective discipline and communication strategies to manage challenging behaviors. The parent takes on a more authoritative role while maintaining a nurturing and supportive environment.   PCIT sessions typically involve live coaching, where a therapist observes the parent and child during interactions and provides real-time feedback and guidance. This helps parents practice and refine their skills.  The key principles of PCIT are:   * **Positive Reinforcement:** Emphasizing the use of positive reinforcement to encourage desired behaviors in children. This includes praise, rewards, and other forms of acknowledgment for good behavior. * **Consistency:** Encouraging consistent parenting techniques and boundaries to provide stability and predictability for the child. * **Effective Communication:** Teaching parents effective communication strategies to improve their relationship with their child and help the child understand expectations. * **Problem-Solving:** Providing parents with problem-solving skills to address challenging behaviors and find constructive solutions.   PCIT has been found to be effective in reducing behavior problems in young children, improving the parent-child relationship, and enhancing parenting skills. It can be particularly useful for families struggling with disruptive behaviors and conflicts. It is usually delivered by trained therapists, and the length of treatment can vary depending on the specific needs of the family.  5 Child Parent Psychotherapy  Child-Parent Psychotherapy (CPP) is a specialized therapeutic approach designed to support young children (typically aged 0 to 5) who have experienced trauma, emotional difficulties, or relationship disruptions, and their caregivers, usually parents. It is a form of evidence-based psychotherapy that places a strong emphasis on the parent-child relationship and its role in promoting healthy emotional development in children. Child-Parent Psychotherapy is typically conducted by licensed mental health professionals, such as clinical psychologists, social workers, or licensed professional counselors, who have received specialized training in this approach.  Here are some key features and concepts associated with Child-Parent Psychotherapy (Vanderzee et al., 2019; Lieberman et al. 2015):   1. **Focus on the Parent-Child Relationship**: CPP recognizes the significance of the parent-child bond in a child's emotional development. The therapy seeks to strengthen this relationship as a means of promoting resilience and healing in the child and actively involves parents or caregivers in the therapy process. 2. **Trauma-Informed**: CPP is often used to address the effects of trauma in young children. This trauma can result from various experiences, such as abuse, neglect, domestic violence, or other adverse events. The therapy is trauma-informed, meaning it acknowledges and addresses the impact of trauma on the child and their caregiver. 3. **Attachment-Based**: It draws heavily from attachment theory, which suggests that secure and healthy attachments with caregivers are crucial for a child's emotional well-being. CPP aims to promote secure attachment between the child and caregiver. 4. **Play-Based Interventions**: Given the age of the children involved, CPP often employs play and other developmentally appropriate activities as part of the therapeutic process. Play is a way for young children to express their emotions and experiences. 5. **Emotional Regulation**: CPP helps both the child and the caregiver develop skills for emotional regulation. Children learn how to express their feelings, while caregivers learn how to respond to their child's emotions in a supportive and nurturing manner.   6 Play Therapy  Child-centered play therapy is a therapeutic approach primarily used to help children, though it can also benefit adolescents and adults, especially those who have difficulty expressing themselves verbally or have experienced trauma. This approach uses play and various creative activities as a means to understand and communicate emotional and psychological issues which can help children process trauma in a safe and supportive environment (Parker et al. 2021).  7 Yoga  Mindfulness-based interventions and yoga can help children and adolescents regulate their emotions and reduce the symptoms of trauma. These practices teach relaxation techniques and emotional awareness. Bessel van der Kolk MD has spent his professional life studying how children and adults adapt to traumatic experiences. Van der Kolk et al. (2014) were able to prove that yoga can be an important component of evidence-based treatment of PTSD. |  |  |
|  | **Reference/Reading List**  Akin, B. A., Dunkerley, S., Brook, J., & Bruns, K. (2021). Driving organization and systems change toward trauma-responsive services in child welfare: Supervisor and administrator perspectives on initial implementation. Journal of Public Child Welfare, 15(2), 133-153. <https://doi.org/10.1080/15548732.2019.1652720>  Alvarado, G., McBain, R., Chen, P., Estrada-Darley, I., Engel, C., Malika, N., Machtinger, E., McCaw, B., Thyne, S., Thompson, N., Shekarchi, A., Lightfoot, M., Kuo, A., Benedict, D., Gantz, L., Perry, R., Kannan, I., Yap, N., & Eberhart, N. (2023). Clinician and staff perspectives on implementing adverse childhood experience (ACE) screening in los angeles county pediatric clinics. Annals of Family Medicine, 21(5), 416-423. <https://doi.org/10.1370/afm.3014>  Amstadter B., Aggen H., Knudsen P., Reichborn-Kjennerud T., Kendler S. (2013) Potentially traumatic event exposure, posttraumatic stress disorder, and Axis I and II comorbidity in a population-based study of Norwegian young adults. *Social Psychiatry and Psychiatric Epidemiology* 48(2), 215–23.  Asnaani, A., Narine, K., Suzuki, N., Yeh, R., Zang, Y., Schwartz, B., Mannarino, A., Cohen, J., & Foa, E. B. (2021). An innovative mobile game for screening of pediatric PTSD: A study in primary care settings. Journal of Child & Adolescent Trauma, 14(3), 357-366. <https://doi.org/10.1007/s40653-020-00300-6>  Bair-Merritt, M. H., & Zuckerman, B. (2016). Exploring parents’ adversities in pediatric primary care. JAMA Pediatrics, 170(4), 313-314. https://doi.org/10.1001/jamapediatrics.2015.4459  Bergmann U. ( 2020) Neurobiological Foundations for EMDR Practice Springer:Germany.  Breakwell, G. (1997) Coping with Aggressive Behaviour. Leicester, British Psychological Society  Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). Treating trauma and traumatic grief in children and adolescents (2nd ed.). NewYork: Guilford.  Eyberg, S. M., & Funderburk, B. (2011). Parent-Child Interaction  Therapy protocol. Gainesville, FL: PCIT International, Inc.  Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss. M. P. & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245–258.  Finkelhor, D. (2018). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. Child Abuse & Neglect, 85, 174-179. <https://doi.org/10.1016/j.chiabu.2017.07.016>  Hase M., Balmaceda M., Ostacoli L., Liebermann P. &Hofmann A. (2017) The AIP Model of EMDR Therapy and Pathogenic Memories. *Frontiers in Psychology* 8(1).  Keeshin, B., Byrne, K., Thorn, B., & Shepard, L. (2020). Screening for trauma in pediatric primary care. Current Psychiatry Reports, 22(11), 60-60. <https://doi.org/10.1007/s11920-020-01183-y>  Lang, J. M., Connell, C. M., & Macary, S. (2021). Validating the child trauma screen among a cross-sectional sample of youth and caregivers in pediatric primary care. Clinical Pediatrics, 60(4-5), 252-258. <https://doi.org/10.1177/00099228211005302>  Lanius F. & Bergmann U. (2014) *Dissociation, EMDR, and adaptive information processing: The role of sensory stimulation and sensory awareness*. Springer : Germany.  Lieberman, A. F., Gosh Ippen, C., & Van Horn, P. (2015). Don’t hit my mommy: A manual for child-parent psychotherapy with young children exposed to violence and other trauma (2nd ed.). Washington, D.  C.: Zero To Three.  Leeds A. (2016) A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants. Springer: Germany.  Lotzin, A., Buth, S., Sehner, S., Hiller, P., Martens, M., Pawils, S., Metzner, F., Read, J., Härter, M., Schäfer, I., & CANSAS Study Group. (2018). "learning how to ask": Effectiveness of a training for trauma inquiry and response in substance use disorder healthcare professionals. Psychological Trauma, 10(2), 229-238. <https://doi.org/10.1037/tra0000269>  Mavandadi, V., Bieling, P.J., Madsen, V. (2016). Effective ingredients of verbal de-escalation: validating an English modified version of the 'De-Escalating Aggressive Behaviour Scale'. J Psychiatr Ment Health, 23(6-7):357-68. doi: 10.1111/jpm.12310.  National Child Traumatic Stress Network (NCTSN). [Trauma Screening | The National Child Traumatic Stress Network (nctsn.org)](https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening) (retrieved 06/11/2023)  Nelson, C. A., Bhutta, Z. A., Burke Harris, N., Danese, A., & Samara, M. (2020). Adversity in childhood is linked to mental and physical health throughout life. BMJ (Online), 371, m3048-m3048. <https://doi.org/10.1136/bmj.m3048>  Parker, M. M., Hergenrather, K., Smelser, Q., & Kelly, C. T. (2021). Exploring child-centered play therapy and trauma: A systematic review of literature. International Journal of Play Therapy, 30(1), 2-13. <https://doi.org/10.1037/pla0000136>  Pollio E, Deblinger E. (2018). Trauma-focused cognitive behavioural therapy for young children: clinical considerations. Eur J Psychotraumatol, 7:1433929. doi: 10.1080/20008198.2018.1433929.  Purewal, S. K., MPH, Marques, S. S., DrPH, Koita, K., MS, & Bucci, M., MD. (2016). Assessing the integration of the center for youth wellness adverse childhood experiences questionnaire (CYW ACE-Q) in a pediatric primary care setting. Journal of Adolescent Health, 58(2), S47-S47. <https://doi.org/10.1016/j.jadohealth.2015.10.106>  Romero R., Alcazar A., Pagani M. & Amann B. (2018) How does eye movement desentization and reprocessing therapy work? A systematic review on suggested mechanism of action. *Frontiers in Psychology* 9(1).  Shapiro F. (2002) *EMDR as an integrative approach: experts of diverse orientations explore the paradigm prism.* American Psychological Association, Washington.  Shapiro F. (2014) The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: addressing the psychological and physical symptoms stemming from adverse life experiences. *The Permanente Journal* 18(1), 71-77.  Sweeney A., Filson B., Kennedy A., Collinson L. & Gillard S. (2018) A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Advances* 24(5), 319-333.  Thakur, N., Koita, K., Ye, M., Harris, N. B., Ford, D., Long, D., Hessler, D., Benson, M., & Bucci, M. (2023). Pediatric ACEs and related life event screener. BMC Pediatrics, 23(1) <https://www.proquest.com/scholarly-journals/pediatric-aces-related-life-event-screener-pearls/docview/2838781055/se-2?accountid=14504>  Therapeutic Crisis Intervention System, Edition 7, Information Bulletin (2022). Residential Child Care Project Bronfenbrenner Center for Translational Research. College of Human Ecology. Cornell University, Ithaca, NY USA, ©Residential Child Care Project.  van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. *Viking.*  van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. The Journal of Clinical Psychiatry, 75, e559 – e565. http://dx.doi.org/10.4088/JCP .13m08561  Vanderzee KL, Sigel BA, Pemberton JR, John SG. Treatments for Early Childhood Trauma: Decision Considerations for Clinicians. J Child Adolesc Trauma. 2018 Dec 15;12(4):515-528. doi: 10.1007/s40653-018-0244-6. PMID: 32318220; PMCID: PMC7163896.  Watts B., Schnurr P., Mayo L., Young Xu Y., Weeks B. & Friedman J. (2013) Meta- analysis of the efficacy of treatments for posttraumatic stress disorder. *The Journal of Clinical Psychiatry* 74(1), 541-550. |  |  |