

Trauma Care Pathway

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Section 1: Introduction

This trauma Care Pathway has been developed by a group of professionals with varying clinical expertise and backgrounds, all of whom have experience in working with young people who have experienced traumatic life events. During its development clinicians have been mindful of the NICE guidelines regarding approaches to treatment of Post-Traumatic Stress Disorder (PTSD), ensuring that these recommendations are carefully considered. This document acknowledges that NICE guidelines have been followed, and clearly highlights and justifies any deviations from these guidelines. However it must be noted that this Care Pathway has not been specifically developed for the care and treatment of individuals with a formal diagnosis of PTSD. Instead all individuals whose mental health has been significantly affected by a traumatic event are included in the Care Pathway.

This pathway aims to ensure that young people who have experienced trauma, and have been significantly affected by this event are responded to in a timely fashion by services and clinicians who have the skills and experience in assessing and treating individuals who have been effected by such trauma. The Care Pathway is presented in the form of a flow chart to ensure that it is user-friendly and that it can be used in clinical practice efficiently. This document also outlines the assessment schedule and screening tools that will be used to ensure that individuals who have experienced trauma are appropriately assessed upon arrival at the service. Moreover, details as to partnership agencies and local services that may also be involved in the treatment of the young person are included along with the appropriate referral forms and contact details.

The Care Pathway will be regularly reviewed to ensure that it remains in line with current research within the literature and good practice.

Section 2: Definition of trauma

- Psychological trauma can be defined as an adverse emotional response to a perceived negative life-event, or exposure to perceived on-going negative circumstances.
- Traumatic events that lead to psychological trauma often involve a threat to life or safety; however any situation that leaves a young person feeling overwhelmed can be traumatic, even if it does not involve physical harm. It's not the objective facts that determine whether an event is traumatic, but the individual's subjective emotional experience of the event.
- Exposure to traumatic life events can lead to Post Traumatic Stress Disorder (PTSD): an anxiety disorder characterised by recurring flashbacks, avoidance of memories of the event, and symptoms of hyperarousal and hypervigilance, that continue for more than one month after the event.
- This Care Pathway focuses on the treatment of young people who present symptomology typical to that of PTSD (see section 4 for full diagnostic criteria); however the pathway will not be confined to young people with a formal diagnosis of PTSD. Clinicians must also be mindful of other psychological reactions to traumatic life events, such as acute stress disorder, adjustment disorder, and reactive attachment disorder. Thus, despite a lack of a formal diagnosis of PTSD, these young people can be assessed and treated in line with the pathway.
- A further psychological reaction to trauma can include dissociation, which is a disconnection or lack of connection between things usually associated with each other. Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness. In severe forms of dissociation, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception. There are five main ways in which the dissociation of psychological processes changes the way a person experiences living: depersonalisation, derealisation, amnesia, identity confusion, and identity alteration.

Section 3: Key Points

- When assessing a young person who has experienced a traumatic event, the clinician must be mindful of the risk factors for developing PTSD. According to DSM-V the primary risk factors include:
 - Temperamental factors – such as prior psychiatric history (e.g. OCD, depression), ineffective coping strategies, greater perceived severity of the traumatic event
 - Environmental factors – such as childhood neglect, lack of social support, repeated exposure to reminders of the event
 - Biological factors – such as genetic predisposition, gender (females are twice as likely to develop PTSD), alterations in brain structure as a result of the traumatic event
- When assessing young people who have experienced trauma it is important that one does not solely rely on information provided by their parent or guardian. Instead it is recommended that the clinician asks the young person separately and directly about their symptoms.
- Psychological treatment should be regular and continuous (usually at least once a week), and delivered by the same clinician who is skilled in delivering trauma work.
- With the consent of the young person, provide their carer with psycho-education relating to trauma by informing them of common reactions to traumatic events, the symptoms of PTSD, and the typical course of treatment. Inform families and carers of self-help and support groups, and encourage their participation if assessed as appropriate. If appropriate to the individual case, consider and assess the impact of the trauma on the family as a whole, and provide appropriate support if necessary. Ensure treatment for different family members is coordinated if more than one family member presents with PTSD or other difficulties requiring formal support from services.

- If the young person presents with co-morbidities then the treatment path may be altered based on these:
 - If the individual is at high risk of suicide or harming others, then this risk must be managed in the first instance. The effects of trauma can be managed later.
 - If the young person has a significant substance abuse problem, then this must be treated prior to any trauma work.
 - For individuals who present an emerging personality disorder, then the clinician should consider extending the duration of the trauma-focused intervention.
 - However, if there is co-morbid depression, the symptoms of trauma should be tackled initially followed by the depression, unless the depression is so severe that it makes psychological treatment difficult.
- Psychopharmacological interventions, such as anti-depressant medication, should not be routinely prescribed to treat symptoms of PTSD within young people. If, however, the young person is already taking medication before the therapeutic intervention begins, then this medication should not be discontinued.
- The clinician should take into consideration the cultural and ethnic background of the young person with PTSD, particularly if the trauma is directly related to their ethnic origin. The clinician may consider using interpreters if language or cultural differences present a challenge for trauma-focused psychological interventions.
- Consider and assess any on-going risk or threat associated with the traumatic event and what practical support may need to be put in place to remove or alleviate this (i.e. support family to move house).
- Do not withhold or delay treatment because of court proceedings or applications for compensation

- Avoidance or ambivalence about treatment may be present. Ensure the client/family are in control and only proceed if they agree to do so. Be proactive in engaging clients if avoidance is present.
- Do not routinely offer non-trauma focused interventions that are not aimed address traumatic memories. This does not include preparatory work, such as family work that does not specifically address the trauma, as although such work does not focus on the trauma it is necessary for establishing the conditions in which therapy can occur.
- Do not debrief the young person as to the details of the traumatic event on a one-to-one basis as this may lead to re-traumatisation.
- If the young person is referred at age 17 ½ then it is suggested that they do not receive treatment as it is likely that it will take longer than 6 months for therapeutic outcomes to be achieved. If treatment was stopped when the young person turns 18 then it is likely that this will affect their emotional wellbeing. Thus, it is suggested that the transition protocol to adult services is adopted for these individuals.
- Consider the possibility that the young person may disassociate during the trauma-focused therapeutic intervention, and ensure that clinicians have the necessary tools to deal with this.

Section 4: Diagnostic Criteria

The DSM-5 criteria for Post-Traumatic Stress Disorder (PTSD) is as follows:

A1. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to close family member or close friend.
In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (eg. First responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

- B1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
- B2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
- B3. Dissociative reactions (eg. Flashbacks) in which the individual feels or acts as if the traumatic event(s) were reoccurring (such reactions may occur on a continuum with the most extreme expression being a complete loss of awareness of present surroundings).
- B4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidence by one or both of the following:

C1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

C2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood that are associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:

D1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs).

D2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (eg. "I am bad" "No one can be trusted" "The world is completely dangerous" "My whole nervous system is permanently ruined").

D3. Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

D4. Persistent negative emotional state (eg. Fear, horror, anger, guilt, or shame).

D5. Markedly diminished interest or participation in significant activities.

D6. Feeling of detachment or estrangement from others.

D7. Persistent inability to experience positive emotions (eg. Inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidence by two (or more) of the following:

E1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

E2. Reckless or self-destructive behaviour.

E3. Hypervigilance

E4. Exaggerated startle response.

E5. Problems with concentration.

E6. Sleep disturbance (eg. Difficulty falling or staying asleep or restless sleep)

F. Duration of the disturbance (criteria B, C, D and E) is more than one month.

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

H. The disturbance is not attributable to the physiological effects of a substance (eg. medication, alcohol) or another medical condition.

Specify if:

With dissociative symptoms: with either depersonalisation or derealisation.

With delayed expression: if the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Posttraumatic Stress Disorder in preschool children (age 6 and younger)

What types of trauma do young children experience?

Young children are exposed to many types of traumatic experiences, placing them at risk for PTSD. These include:

- Abuse
- Witnessing interpersonal violence
- Motor vehicle accidents
- Experiences of natural disasters
- Conditions of war
- Dog bites
- Invasive medical procedures

How is the diagnosis different in preschool PTSD?

Because young children have emerging abstract cognitive and verbal expression capacities, research has shown that the criteria need to be more behaviorally anchored and developmentally sensitive to detect PTSD in preschool children.

Immediate reaction to traumatic event criterion

The criterion that the children's reactions at the time of the traumatic events showed extreme distress should be deleted. If children were too young to verbalize their acute reactions to traumatic experiences, and there were no adults present to witness their reactions, there was no feasible way to know about these reactions.

Intrusion symptoms

The change to the re-experiencing symptoms is a relatively minor change in wording to increase face validity and, thereby, lower the symptom detection threshold. The symptom of "recurrent and intrusive distressing recollections of the event ..." requires three conditions: (1) recurrent, (2) intrusive, and (3) distressing. Research has shown empirically that preschool children do not always manifest overt distress with their intrusive, unwanted thoughts. Some children were neutral or "over bright". While distressed reactions are common, parents also commonly report no affect or what appeared to be excitement.

Avoidance symptoms and negative alterations in cognitions and mood

Because many of the avoidance and negative cognition symptoms are highly internalized phenomena, the most significant changes in the criteria for preschool children are in this section.

The major change is to require only one symptom in either the avoidance symptoms or negative alterations in cognitions and mood. The number of these symptoms that are possible to detect is simply fewer compared to adults. The symptoms of "loss of interests," "restricted range of affect," "detachment from loved ones," and "avoidance of thoughts or feelings related to the trauma" manifest in young children but are consistently ranked as some of the least frequent among the PTSD symptoms. The symptoms of "sense of a foreshortened future" and "inability to recall an important aspect of the event" are deleted because of the developmental challenges in manifesting and/or detecting them.

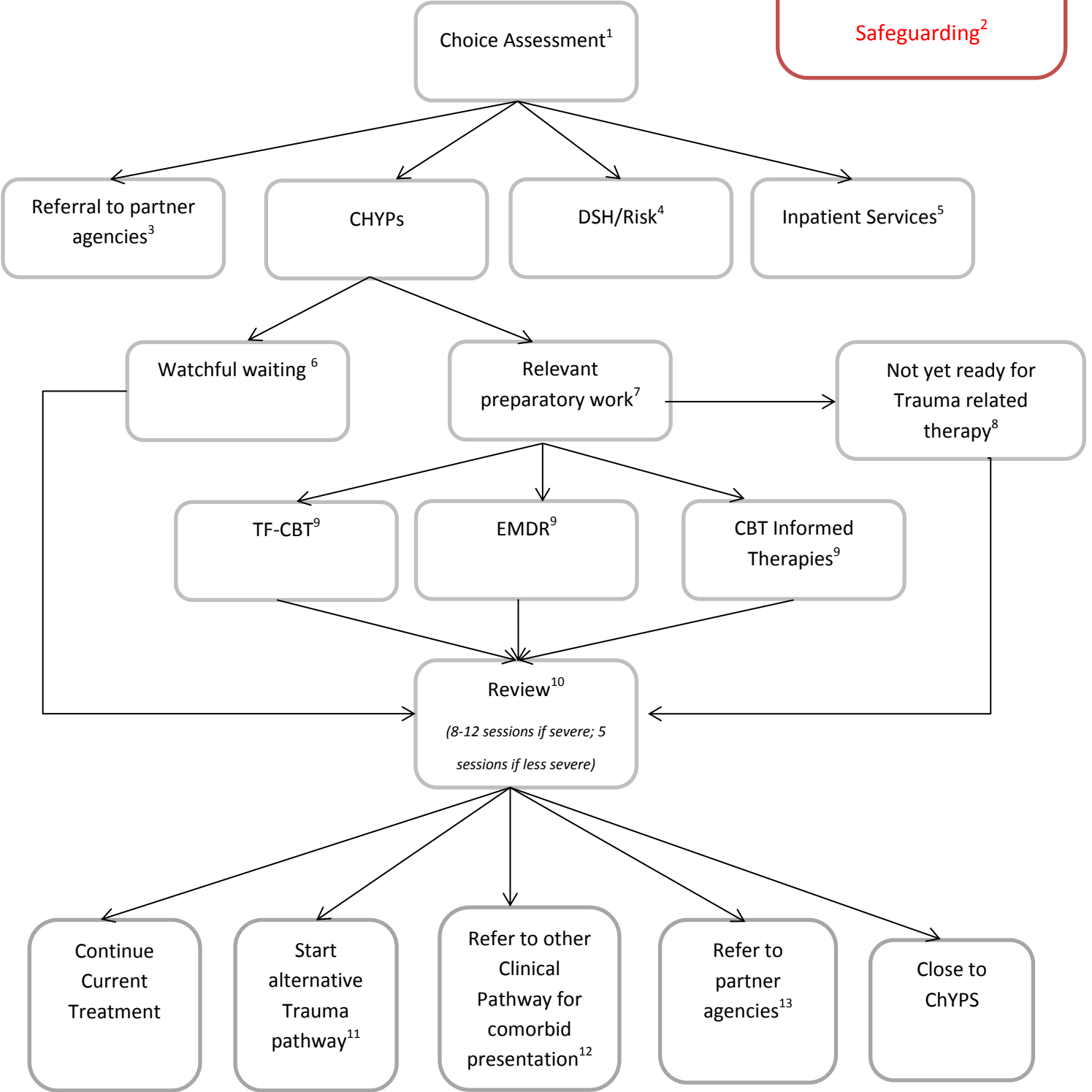
Diminished interest in significant activities may manifest as constricted play. Feelings of detachment or estrangement may be manifest more behaviorally as social withdrawal.

Increased arousal symptoms

Being the most behavioral and observable types of symptoms, few changes seem to be needed for these problems. The symptoms "irritability or outbursts of anger" is modified to include "extreme temper tantrums" to enhance face validity.

Section 5: Flow Charts

Consideration of Risk
&
Safeguarding²



Flow chart notes

¹Choice assessment – This includes DSH assessments, inpatient assessment etc. Following the Choice assessment a multi-disciplinary discussion should take place regarding whether the young person should follow the Trauma Pathway

²Given the nature of Trauma related therapy, risk should be assessed on sessional basis. Please see Section 7 & 8 for appropriate risk screening tools. If the young person presents as a high risk and/or unable to keep themselves safe then please refer to the Home Treatment Team immediately. There should also be a continual assessment of the child's safety, and if any safeguarding issues arise then a safeguarding referral should be made.

³This includes tier 2 services, 3rd sector providers, social services etc. Please see the 'Partnership Agencies' section for national and local organisation.

⁴When the young person is self-harming and/or presents an immediate risk that does not warrant inpatient admission please refer to the Home Treatment Team

⁵Inpatient service may be considered in a small number of cases where there is a risk to life, severe self-neglect, extreme distress or functional impairment. In such cases consider a referral to inpatient services via the Home Treatment Team, who will carry out the relevant assessment

⁶NICE guidelines recommend that when symptoms are mild and have been present for less than four weeks, then watchful waiting should be adopted in which symptoms are monitored to see whether they improve or worsen without an intervention. If watchful waiting is required, a follow-up appointment should take place four weeks after the initial assessment to review the young person's symptoms, and determine whether an intervention is necessary.

⁷This could include family work, resilience building, more general stabilisation etc. NICE guidelines recommend devoting sessions to establishing a trusting therapeutic relationship. It may also include treating co-morbid disorders before starting trauma related treatment. For more information please see 'Section 3: Key Points'

⁸If the young person presents as unable to currently engage in trauma related therapy then consider alternative therapeutic input, such as Systemic Family Therapy (particularly if the whole family was affected by the trauma). Also consider offering support to parents/caregivers if they were affected by the trauma or attachment was disrupted as a result

of the trauma. Consider referring parents/caregivers or other members of the family to appropriate services if it is considered that they need support in their own right. Ensure interventions to different family members are coordinated.

⁹Trauma Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) are both NICE recommended treatments for trauma related disorders. CBT informed therapies include treatments such as Children's Accelerated Trauma Treatment (CATT), which may be more suitable for younger children and non-verbal young people. NICE guidelines recommend that psychological treatment should be regular and continuous (usually at least once a week), and delivered by the same clinician. When the trauma exposure work is being engaged in, the sessions should be extended and should last approximately 90 minutes.

¹⁰For severe trauma review after 8-12 sessions for less severe trauma review after 5 sessions. These reviews can take place with the young person and their family, or within the clinical team without the presence of the young person. NICE guidelines suggest that clinicians should consider extending trauma-focused psychological treatment beyond 12 sessions and integrating it into an overall care plan if several problems need to be addressed, particularly:

- After multiple traumatic events
- After traumatic bereavement
- Where chronic disability results from trauma
- When significant comorbid disorders or social problems are present

¹¹Consider whether an alternative Trauma intervention as outlined in Point 6 (above) is required. If the young person or their family request an intervention that is not specifically targeted at the management of PTSD, such as family therapy or art therapy, then they should be informed of their limited evidence base.

¹²In particular consider the Emerging Personality Disorder Pathway, given the evidence linking early trauma and later emotional dysregulation.

¹³Involvement of other agencies such as Social Services may also be required in some cases. Also, for young people who have not responded to the treatment programme, identify any need for continuing support and appropriate services to address these needs.

Finally, consider referring onto partner agencies if a stepped-down approach is appropriate in situations when the young person no longer meets criteria for a ChYPS intervention but still requires some emotional support, possibly for a co-existing concern (e.g. grief counselling through charity organisations such as Dandelion Time).

Section 6: Acknowledgement that the pathway has been created in line with NICE Guidelines

This Trauma Care Pathway has been developed in adherence to the NICE guidelines for the assessment and management of PTSD (NICE, 2005):

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)

- In adherence to the NICE guidelines for the management of PTSD for children and young people, a key intervention within the Trauma Care Pathway includes Trauma-Focused Cognitive Behavioural Therapy (TF-CBT). Section 1.9.5.2 of NICE guidelines clearly states that young people with post-traumatic symptoms should be offered a course of TF-CBT adapted appropriately to suit their age, circumstances, and level of development.
- The use of TF-CBT is further supported by current research within the literature, such as Lenz and Hollenbaugh (2015) whose meta-analysis illustrated that TF-CBT significantly alleviated post-traumatic symptoms when compared to a waiting list condition, and alternative treatments.
- Within the care pathway, Children's Accelerated Trauma Treatment (CATT) has been incorporated despite this not being a specific recommendation for this intervention within NICE guidelines. CATT is a CBT informed intervention that incorporates play and art therapy, meaning that it may be more suitable for younger children than traditional TF-CBT. Evidence for these types of intervention is minimal however and this should be taken into consideration when choosing this intervention and families should be informed.

Drug treatments

- In line with section 1.9.5.4 the Pathway ensures that drug treatments are not routinely prescribed for children and young people with post-traumatic symptoms

Eye movement desensitisation and reprocessing (EMDR)

- Within the Trauma Care Pathway EMDR is included as a potential intervention for young people with post-traumatic symptoms; however, despite suggesting EMDR for the treatment of adults, the NICE guidelines do not specifically recommend EMDR for children and young people.
- This deviation from NICE guidelines can be supported by research within the literature, such as a meta-analysis by Rodenburg and colleagues (2009), which revealed that a course of EMDR significantly improved post-traumatic symptoms within young people under 18 when compared to control conditions.
- It must, however, be highlighted that EMDR literature mainly centres on interventions for single-event trauma (such as a motor-vehicle accident) as opposed to on-going trauma (such as sexual abuse). Thus, when using EMDR as an intervention for on-going trauma clinicians must be mindful of this limited evidence base.

Section 7: Assessment Schedules

This assessment schedule refers to the assessment that would be carried out by a clinician who specialises in trauma after the need for trauma work has been identified during choice. The schedule includes suggested areas to investigate during the assessment period, which does not necessarily have to be gathered via direct questioning of the young person; instead caregiver accounts and reports from other professionals can be used if deemed more appropriate.

Trauma

Ask the young person or their caregiver details of the trauma. Please be cautious of the potential risk of re-traumatising the young person. If necessary, details of the trauma can be obtained from the reports of other professionals or via consultations with these individuals.

- What was the trauma?
- Was it multiple trauma or a single event?
- How old was the young person when the trauma occurred?
- If it was an on-going trauma, what was the duration?
- Is there any current threat?
 - E.g. if sexual abuse, is the perpetrator still around? If a health condition, is it on-going or has the young person recovered?
- What is the legal status of the trauma?
 - Are there any court proceedings/compensation claims?
- Was there anyone else involved in the trauma? (e.g. if a motor vehicle accident, were other family members involved?)
- What has happened since the trauma?
 - Any further life events, such as a bereavement?
- When the trauma was disclosed, was the young person believed?
- Is there a history of neglect?

Symptoms

Explore:

- Flashbacks of the trauma or nightmares?
 - If so, how often do these occur?
- Triggers
- Cognitive difficulties, such as:
 - Maladaptive thinking patterns regarding themselves, others, and situations
 - Distortions or inaccurate beliefs (e.g. self-blame for traumatic event)
 - Unhelpful beliefs (e.g. dwelling on the worst possibilities)

- Affective problems, such as:
 - Guilt, shame, anger, sadness, anxiety, fear etc.
- Somatic problems, such as:
 - Sleep difficulties
 - Hyperarousal and hypervigilance
 - Somatic symptoms (e.g. headaches and stomach-aches)
 - Changes in eating habits
 - Any physical injury that has occurred as a result of the trauma, such as brain injury
- Behaviours, such as:
 - Avoidance of trauma reminders
 - Unsafe behaviours: sexualised, aggressive, or oppositional behaviours, and substance abuse
 - Academic progress
 - Pre and post trauma – has the trauma affected achievement?
 - Can the young person concentrate at school?
 - Extra-curricular activities and interests
 - Has engagement in activities changed since the trauma?
- Assess possible symptoms of dissociation
- Existing coping strategies
 - What are these?
 - Are these adaptive/maladaptive?

Following this exploration of symptomology, please administer the screening tools, such as the CRIES-8 (See section 8)

Relationships

- Explore family relationships
 - Have these been affected by the trauma?
 - Does the young person have support from family members?
 - Do the family as a whole have a support network?
 - What are the coping strategies adopted by the family?
 - Are these adaptive/maladaptive?
 - How did the family cope with stress pre and post trauma?
 - Explore protective factors within the family?
 - Is there financial hardship/social disadvantage?
- Explore peer relationships
 - Have these been affected by the trauma?
 - Difference pre and post trauma
 - Is there a supportive peer network?
 - Or is the peer group maladaptive?
 - Has the young person been bullied?

Involvement of other services

- E.g. social services, forensic services, other counselling services

Cultural and spiritual needs

- Language considerations
 - Is an interpreter required?
- Religious beliefs

Risk

- Explore the young person's mood
- Has the young person engaged in DSH?
- Does the young person have current suicidal ideation or thoughts of DSH?

Expectations for therapy

- What does the young person wish to achieve?
- What are the expectations of the family?

A formulation of the presenting difficulties which includes protective and risk factors should be used to inform intervention.

Section 8: Special considerations for specific groups

Below are some specific considerations that must be taken into account when carrying out assessments with specialist groups.

Children in Care (CiC)

Specific considerations for CiC

Care History

- Chronology of placements (birth family, extended family, foster placements)
- Age when taken into care
- Reasons for going into care

Professional Network

- The presence of a consistent supportive and well engaged professional network

Current placement

- Length of current placement
- Genogram of current placement and arrangement
- How is the foster carer responding to the current needs of the young person?
- Are the foster carers willing to work with services regarding the young person?
- How would you describe the relationship between the child and foster carer?

Contact Arrangements (from child's perspective and foster carer's, consider attachment and containment)

Does the person have contact with their birth family? If so with who? How often? Is it Supervised or unsupervised and by whom? What is the quality of the contact like?

Are there any indicators to suggest this a trigger for trauma?

Unaccompanied Asylum Seekers

Key points to consider when working with Unaccompanied Asylum Seekers

Unaccompanied asylum seeking minors are a particularly vulnerable group of young people, many of whom have experienced extremely traumatic events on their journeys to the United Kingdom. Such young people have either voluntarily embarked on their journey to the UK to escape impoverished environments torn by war, have been smuggled into the country by “agents” paid for by their families, or have been trafficked into the UK for exploitation purposes. Thus, regardless of the manner in which the young people enter the UK, they have evidently experienced some degree of trauma which may lead to presentations post-traumatic symptomatology. When embarking on trauma work with these young people, there are a number of variables that must be carefully considered.

On arrival

- On arrival at the port of Dover the young people who have been identified as minors are referred to the Kent social services Asylum Team, in which they will receive an age assessment to clarify whether they are under 18.
- All under 16's and female unaccompanied asylum seekers will be placed in foster care, whilst males over 16 will be placed in supported accommodation within the community.
- The young people will come into contact with many agencies, including social services, immigration, education, and physical health services. If it is felt that there is a mental health need, then they will be referred to ChYPS by their social worker. The initial choice assessment will take place with the social worker followed by either support for the foster families, or direct work with the young person.

Therapeutic work

- When the young person initially comes into contact with ChYPS they are usually unclear as to our exact role, as they have been in contact with many services and often cannot distinguish between them. Often unaccompanied minors do not trust professionals, particularly when disclosing their stories, as they may believe that this will affect their Asylum claim. Thus, it is imperative that a trusting therapeutic relationship is established over time.
- Within the current Trauma Pathway for mainstream ChYPS it is recommended that young people presenting with post-traumatic symptomatology receive preparatory resilience building work, along with establishing a supportive network around them. This is then followed by trauma-focused work which overtly addresses the trauma itself and the subsequent symptoms. For unaccompanied minors, however, it is the resilience building that is of upmost importance, in which clinicians should adopt a systematic approach that strengthens their network, and aids with the young person's integration into western culture. Without such extensive systematic support, it is unethical for the trauma to be explored as it may have a detrimental effect on the young person's emotional wellbeing. Often this systematic framework is sufficient in itself in reducing post-traumatic

symptoms, and trauma-focused work is not deemed necessary. This deviation from the NICE recommendation that there must be trauma-focused therapy integrated into the treatment plan is supported by Melzak (2009). Here it was proposed that it was not short-term treatments that focused on symptoms that were necessary when fostering safety and healing within unaccompanied young people; however was the establishment of a trusting support network.

Challenges for therapy

Culture

- When working with unaccompanied asylum seekers, clinicians must be mindful of the cultural background of the young person. Often these individuals are from non-western societies, in which even simple concepts, such as money, time, and the calendar, differ significantly; not to mention cultural attitudes towards broader concepts, such as gender. Thus, when working with these young people, one must be mindful of their anxieties regarding western cultural differences, and to help them make sense of these.
- The clinician must also be mindful and respectful of the young person's religious beliefs.

Language

- Often unaccompanied asylum seekers cannot speak English, thus there must be interpreters present within therapeutic sessions. The interpreter's role is to directly translate the speech of the clinician and relay this precisely to the young person, and vice versa. It is therefore imperative that the clinician and the interpreter have a good working relationship. It must be noted, however, that often the interpreter can interfere with therapy by asking the young person questions directly themselves, as opposed to solely translating the questions of the clinician, or by giving the child personal advice. This is inappropriate behaviour that can damage the therapeutic relationship between the young person and the clinician, and the working relationship between the interpreter and the clinician; thus it is vital that such behaviour is stopped.
- When interpreters are appointed, this is done so based on their language ability, not their ethnic background. Thus, although the young person and the interpreter speak the same language they are not necessarily of the same ethnicity. This can often be problematic as there may be conflict between cultural groups of the same language, which has traditionally led to prejudice back home. These cultural preconceptions may affect the relationship between the young person and the interpreter, as the young person may not want to engage due to their ethnicity.

Asylum claim

- The unaccompanied asylum seekers will be undergoing an asylum claim with the Home Office. This will undoubtedly lead to great anxiety, as they will be anxious as to whether they will gain the right to remain.

- As part of their claim they will have an extensive interview with the Home Office in which they may have to disclose traumatic memories. This may re-traumatise the young person, thus elevating their post-traumatic symptoms.

Context within Kent

- Due to the port of Dover being located in Kent, there are a higher number of unaccompanied asylum seekers in Kent than any other county. Ideally, these young people would be placed in specialist foster placement who have experience working with unaccompanied minors. These foster carers would have the specialist skills to support the young person, which would lead to greater treatment outcomes. Due to the high demand in Kent, however, unaccompanied minors are usually placed in generic placements without such specialist knowledge. These young people will not receive the necessary support, which may impact the success rate of trauma work.
- Moreover, this high demand means that often there are not enough interpreters available for the number of young people. This can make therapy challenging as there will not be a means of effective communication.

Section 9: Measures and Questionnaires used

The Children's Impact of Event Scale - 8 (CRIES-8)

The Children's Impact of Event Scale – 8 (CRIES-8) is a screening tool intended to monitor the main phenomena of re-experiencing and avoidance of traumatic events, and the feelings evoked by the event. This tool is designed for use with children aged 8 years and above who are able to read independently. It consists of 4 items measuring Intrusion and 4 items measuring Avoidance - hence it is called the CRIES-8.

Evaluation and psychometric status

Psychometric data relevant to the reliability and validity of the 8-item version were presented in Yule (1997), which revealed that of the 62 children who received a DSM diagnosis of PTSD in response to a traumatic event they averaged 26.0 on the 8-item version while the 25 who did not reach DSM criteria for a diagnosis of PTSD only scored 7.8 ($P < 0.001$).

Despite the theoretical criticisms often made against using such self-completed scales in different cultures, the IES has now been applied in a variety of cultures, including studies with children. It is now clear that post-traumatic stress symptoms in children are more similar across cultures than they are different. Indeed, Intrusion and Arousal are robust factors of the Impact of Event Scale in children from different cultures.

CRIES-13

It must be noted that a 13 item version of the IES for children has also been developed, adding 5 items to evaluate Arousal. However, Perrin et al. (2005) revealed that the CRIES-8 performs equally well as the CRIES-13, thus suggesting that the addition of such arousal items do not add to the performance of the scale.

Scoring

There are 8 items that are scored on a four point scale:

- Not at all 0
- Rarely 1
- Sometimes 3
- Often 5

There are two sub-scales:

- Intrusion = sum of items 1+3+6+7
- Avoidance = sum of items 2+4+5+8

The lay-out has been designed so that scoring can be easily done in the two columns on the right hand side. The total for each sub-scale can be entered at the bottom of each column.

Disassociation scales

When a young person has experienced trauma they may disassociate, meaning that disassociation screening tools have been incorporated in the Trauma Care Pathway.

Adolescent Dissociative Experiences Scale – II (A-DES)

The Adolescent Dissociative Experiences Scale (A-DES) is A 30-item self-report measure designed to measure dissociation in adolescents (ages 11-17). The A-DES measures dissociation in four areas: dissociative amnesia, absorption and imaginative involvement, depersonalization and derealisation, and passive influence

Scoring

There are 30 items scored on a 10-point scale (0=never; 10 =always)

These items measure 4 constructs:

- Amnesia – items 2, 5, 12, 15, 22, 27
- Absorption & imaginative involvement – items 1, 7, 10, 18, 24, 28
- Depersonalisation & derealisation – items 3, 6, 9, 11, 13, 17, 20, 21, 25, 26, 29, 30
- Passive influence – items 4, 14, 16, 19, 23

The overall score is based on the mean of all items.

The clinical cut-off is a score of 4 and above

Child Dissociative Checklist (CDC)

The CDC is a tool which compiles observations by an adult observer regarding a child's behaviours, aged 5-12, on a 20 item checklist. Behaviours which occur in the present and for the last 12 months are included. As a research tool, the CDC can quantify dissociative behaviour for dimensional approaches and can generate cut-off scores that categorize children into low and high dissociation groups.

Scoring

There are 20 items scored on a 3-point scale (0=not true; 1 =somewhat true; 2=very true)

The overall score is based on the sum of all items. Scores can range from 0-40, with 12 being the clinical cut-off.

- 0 1 2 Child refers to himself or herself in the third person (e.g. as she or her) when talking about self, or at times insists on being called by a different name. He or she may also claim that things that he or she did actually happened to another person.
- 0 1 2 Child has rapidly changing physical complaints such as headache or upset stomach. For example, he or she may complain of a headache one minute and seem to forget about it the next.
- 0 1 2 Child is unusually sexually precocious and may attempt age-inappropriate sexual behaviour with other children or adults.
- 0 1 2 Child suffers from unexplained injuries or may even deliberately injure self at times.
- 0 1 2 Child reports hearing voices that talk to him or her. The voices may be friendly or angry and may come from "imaginary companions" or sound like the voices of parents, friends or teachers.
- 0 1 2 Child has a vivid imaginary companion or companions. Child may insist that the imaginary companion(s) is responsible for things that he or she has done.
- 0 1 2 Child has intense outbursts of anger, often without apparent cause and may display unusual physical strength during these episodes.
- 0 1 2 Child sleepwalks frequently.
- 0 1 2 Child has unusual night-time experiences, e.g. may report seeing "ghosts" or that things happen at night that he or she can't account for (e.g. broken toys, unexplained injuries).
- 0 1 2 Child frequently talks to him or herself, may use a different voice or argue with self at times.
- 0 1 2 Child has two or more distinct and separate personalities that take control over the child's behaviour.

Additional screening tools

Name	Age Group	Description
Pediatric Emotional Distress Scale (PEDS)	2-10	A parent report 21-item measure designed to rapidly assess and screen for elevated symptomatology in children following exposure to a traumatic event. It consists of behaviors that have been identified in the literature as associated with experiencing traumatic events, including 17 general behavior items and 4 trauma-specific items, all of which are scored on a 4-point Likert scale.
Child's Reaction to Traumatic Events Scale-Revised (CRTES-R)	6-18	A 23-item self-report measure designed to assess psychological responses to stressful life events. The measure is based on the Horowitz Impact of Events Scale and was initially modified to assess Intrusion and Avoidance symptoms based on DSM-III-R criteria. The scale was recently modified to include assessment of Arousal and to update the items with regard to DSM-IV criteria.
Trauma Symptom Checklist for Children (TSCC)	8-16	The TSCC is a 54-item self-report scale originally designed for trauma symptoms related to sexual abuse and other traumatic events. It is made up of two validity scales (indicating over- and under-reporting of symptoms) and six clinical scales (Anxiety, Depression, Posttraumatic Stress, Sexual Concerns, Dissociation, and Anger). The child is presented with a list of thoughts, feelings, and behaviors and is asked to mark how often each thing happens to him or her. Items are rated on a 4-point scale (from 0 = "never" to 3 = "almost all the time").

We remind clinicians that one cannot make a clinical diagnosis from scores on the self-completed scales alone. A proper clinical diagnosis relies on much more detailed information obtained from a structured interview that assesses not only the presence and severity of stress symptoms, but also the impact on the child's overall social functioning.

Section 10: Partnership Agencies

<i>Choices</i>	Provide services for those experiencing domestic violence, eg. Family Advice Worker for young people.	Email: info@choicesdaservice.org.uk
<i>Dandelion Time</i>	Provide families with a background of trauma, abuse and neglect with an individually focussed therapy. <i>(please note that they can recommend a referral, but cannot directly make referrals)</i>	Telephone: 01622 814001 E-mail: info@dandeliontime.org.uk Website: www.dandeliontime.org.uk
<i>Hearsay Charitable Trust</i>	Counselling Service for those on low incomes.	Telephone: 01227 271172 Email: enquiries @ hearsaytrust.org.uk Website: www.hearsay-trust.org.uk
<i>Catch 22</i>	Support with addiction, employment and education for young people with complex backgrounds.	Website: www.catch-22.org.uk
<i>NSPCC</i>	Offer a wide range of services to young people at risk of or experiencing abuse, or those who have experienced abuse in the past.	Telephone: 0808 800 5000 (help line) 0800 1111 (ChildLine for under 18's) Email: help@nspcc.org.uk Website: www.nspcc.org.uk

<i>Samaritans</i>	Telephone and face-to-face services for those who experience anxiety, distress or despair, including those who may contemplate suicide.	Telephone: 116 123 Email: jo@samaritans.org.uk Website: www.samaritans.org.uk
<i>Harbour lights</i>	Harbour Lights provide low cost counselling the Ashford and Deal area. The offer counselling for: Stress Anxiety Panic Trauma Feeling Down Low Confidence Relationship Struggles Abuse Bereavement & Loss Cognitive & Integrative Approach	Telephone 07517 224321 or 01304 363388
<i>Family matters</i>	The Family Matters counselling practice is supported by qualified professionals - specialists in the areas of childhood sexual abuse and rape. Their expertise is wide-ranging and covers physical abuse, depression, anxiety, post-traumatic stress, child protection, trauma, bereavement, self-esteem issues, and anger management. They also address how being vulnerable impacts on work related problems, sexuality issues and - where appropriate - related drug and alcohol problems. They support families across Kent.	Telephone: 01474 537392 Email: admin@familymattersuk.org Website: http://www.familymattersuk.org/

Section 11: Resource List

Assessment tools

Perrin, S., Meiser-Stedman, R. & Smith, P. (2005) The Children's Revised Impact of Event Scale (CRIES): Validity as a screening instrument for PTSD. *Behavioural and Cognitive Psychotherapy*, 33 (4), 487-498.

Yule, W. (1997) Anxiety, Depression and Post-Traumatic Stress in Childhood. In I. Sclare (Ed) *Child Psychology Portfolio*. Windsor: NFER-Nelson

Recent research

Lenz, A. S., & Hollenbaugh, K. M. (2015). Meta-analysis of trauma-focused cognitive behavioral therapy for treating PTSD and co-occurring depression among children and adolescents. *Counseling Outcome Research And Evaluation*, 6(1), 18-32.
doi:10.1177/2150137815573790

Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A. M., & Stams, G. J. (2009). Efficacy of EMDR in children: A meta-analysis. *Clinical Psychology Review*, 29(7), 599-606.
doi:10.1016/j.cpr.2009.06.008

NICE guidelines

<https://www.nice.org.uk/guidance/cg26>

Appendix A

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)

Name, Author, Date	Type of trauma	Aims/Research focus	Methodology	Findings/conclusions	Quality of research/ study limitations	Future research
<p><i>The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth</i> (Cary & McMillan, 2012)</p>	<p>Various</p>	<p>To examine the efficacy of TF-CBT in reducing PTSD symptoms in comparison with other treatment modalities and waiting list conditions immediately after treatment, and 12-months later.</p> <p>To examine the efficacy of TF-CBT in reducing co-morbid depression and behavioural problems that occur alongside PTSD, in comparison to control conditions and other treatments.</p>	<p>Ten studies (twelve articles) were selected for inclusion in three sets of meta-analyses:</p> <ol style="list-style-type: none"> 1. Meta-analysis of the branded version of TF-CBT 2. Meta-analysis of studies including all 5 of the recommended components of TF-CBT <ul style="list-style-type: none"> ➤ Exposure ➤ Cognitive reprocessing/re-framing ➤ Stress management ➤ Parental treatment ➤ Psycho-education 3. Meta-analysis of studies including any 4 of the 5 recommended components <p>Other requirements:</p> <ul style="list-style-type: none"> ➤ Under 18 (pp aged 3-18) ➤ Randomised studies that compare TF-CBT with control/other treatment ➤ Pp with PTSD symptoms 	<p>TF-CBT was more effective at reducing PTSD symptoms than waiting list conditions, standard community care, and attention control immediately after treatment, and 12-months later.</p> <p>TF-CBT was also more effective than control conditions in reducing symptoms of depression and behavioural problems that are co-morbid with PTSD. However this effect is only seen immediately after treatment, not after a 12-month period – potentially due to natural reduction in depressed symptoms with time.</p>	<p>Meta-analysis, therefore in category 1A</p> <p>All studies included were of a high standard (randomised, controlled, used appropriate analytic methods). However some specific problems with individual studies included:</p> <ul style="list-style-type: none"> ➤ Retention rates ➤ Not all post treatment assessments were double blind – rater knew if individual was in TF-CBT group <p>Despite being a meta-analysis the sample size was small relative to the average meta-analysis, which was due to small samples in some individual studies</p>	<p>Analysis of the individual components of TF-CBT (i.e. which components are leading to improvement in PTSD symptoms</p> <p>Establish the ideal duration of TF-CBT sessions, and the length of the overall treatment course</p>
<p>Trauma-focused Cognitive Behavioural Therapy For children: Impact of the trauma narrative and treatment length (Deblinger et al., 2011)</p>	<p>Child sexual abuse (CSA)</p>	<p>To determine how many TF-CBT sessions are necessary to achieve clinical efficacy in reducing PTSD symptoms in children who have experienced sexual abuse.</p> <p>Examine whether the trauma narrative component of TF-CBT is essential</p>	<p>Two hundred and ten children (aged 4–11 years) referred for CSA and posttraumatic stress disorder symptoms were randomly assigned to one of the four treatment conditions:</p> <ul style="list-style-type: none"> ➤ 8 sessions with no Trauma Narrative (TN) ➤ 8 sessions with TN ➤ 16 sessions with no TN ➤ 16 sessions with TN <p>Post-traumatic improvements were measured using 14 outcome measures that assessed both the parents and the child.</p>	<p><u>Overall pattern</u></p> <p>The overall pattern of results indicate that TF-CBT was effective in enhancing affective and behavioural functioning as well as parenting and child personal safety skills. The pre- to post-treatment changes in all four groups represented “moderate-to-large” effect sizes, suggesting that all TF-CBT conditions were efficacious.</p> <p><u>Parenting</u></p> <ul style="list-style-type: none"> ➤ Parents in the 16 No TN group reported significantly greater improvements in parenting practices than those assigned to the Yes TN groups. ➤ Children who were treated without the TN component were rated by their parents as having less severe externalizing behaviour problems than those who were treated with the TN component. 	<p>Randomised, controlled study, therefore category 1B.</p> <p>However, despite original sample of 210, only 158 for the post-treatment assessments. Researchers noted that each condition only included 35-44pp, which they considered to be a small sample.</p> <p>Concerns arose regarding whether the findings could only be generalised to CSA related trauma, rather than trauma in general</p> <p>Some of the children studied were very young (from age 4),</p>	<p>Analysis of the efficacy of TF-CBT for PTSD with co-morbid conditions, such as depression</p> <p>Further explore the role of parental involvement in treatment</p>

				<p>devoted more time to the parent training component, which might have resulted in the greater improvements in both parenting practices and their children's externalizing behaviours.</p> <p><u>Abuse-related fear</u></p> <ul style="list-style-type: none"> ➤ Regardless of treatment length, the levels of abuse-related fear were less for the children who had been assigned to the Yes TN groups. ➤ Findings suggest that the 8 Yes TN group seemed to be the most efficient and efficacious means of addressing parental abuse-specific distress as well as children's abuse-related fear and general anxiety. <p><u>PTSD symptoms</u></p> <p>Longer length of treatment was associated with a decrease in the number of avoidance and re-experiencing symptoms. However, the addition of eight more sessions yielded a decrease in approximately only one PTSD symptom – thus 16 sessions did not greatly improve treatment</p>	<p>so not all outcomes could be completed. This reduced the statistical power of the analyses.</p>	
<p>Trauma-Focused Cognitive-Behavioural Therapy for Children Sustained Impact of Treatment 6 and 12 Months Later (Mannarino et al., 2012)</p>	<p>Child sexual abuse (CSA)</p>	<p>To conduct a follow-up analysis of the data collected by Deblinger and colleagues (2011) to determine whether TF-CBT leads to sustained reduction in PTSD symptoms and related anxiety.</p>	<p>Follow-up of 158pp from Deblinger and colleagues (2011) at 6-months and 12-months post-treatment using 14 outcomes assessing both the children and parents.</p>	<p>Follow-up results indicated that the overall significant improvements across 14 outcome measures that had been reported at post-treatment were sustained 6 and 12 months after treatment; thus highlighting durability of TF-CBT.</p> <p>On two of the measures (child self-reported anxiety and parental emotional distress) there were additional improvements at the 12-month follow-up from the 6-month follow-up. Reductions in child self-reported anxiety were thought to be due to ongoing practise and consolidation of skills acquired during therapy; whilst reductions in emotional distress being as a result of sustained improvement in their child's wellbeing.</p> <p>These improvements were regardless of which condition the individual was in; however researchers warn that this should not deter clinicians from including the trauma narrative, despite not being "statistically better" as this may be due to methodological concerns. They stated that trauma narratives often reveal idiosyncratic dysfunctional abuse-related beliefs that if undetected</p>	<p>Follow up from a randomised, controlled study, therefore category 1B?</p> <p>Limitations included a relatively small sample, with small numbers in each condition; and a lack of self-report measures for young children</p>	

				<p>might undermine children’s psychosocial development</p> <p>However, 12 children (11%) still met the full diagnostic criteria for PTSD at the 12-month follow up. This was said to be due to high levels of co-morbid depression, which led to the suggestion that TF-CBT may need to be modified for individuals with high levels of co-morbid depression.</p>		
<p>Trauma-Focused Cognitive Behavioral Therapy for Youth: Effectiveness in a Community Setting (Webb et al., 2014)</p>	<p>Various</p>	<p>To examine the effectiveness of trauma-focused cognitive behavioural therapy (TF-CBT) in treating child traumatic stress when implemented in community settings on a state-wide level.</p> <p>To examine whether TF-CBT could be transported to a state-contracted community mental health agency and used effectively by clinicians with little prior TF-CBT experience</p>	<p>72 young people (aged 7-16) with a history of documented trauma (sexual or physical abuse, traumatic loss, or domestic or community violence) and symptoms of PTSD received an average of 10 sessions, delivered in a state-contracted mental health agency.</p> <p>PTSD symptoms and internalizing and externalizing behaviour problems were assessed at pre-treatment and then at 3, 6, 9, and 12 months after intake. The UCLA PTSD Reaction Index for DSM–IV (UPIID; Pynoos et al., 1998) was used to assess changes in PTSD symptoms, and the parent version of the Child Behaviour Checklist 6–18 (CBCL; Achenbach, 2001) was used to assess for changes in children’s emotional and behavioural problems.</p> <p>In order to deliver these sessions, 12 clinicians were trained to provide TF-CBT. Four coders were employed to ensure that the clinicians were adhering to the original TF-CBT protocol (Cohen et al., 2006)</p>	<p>Analysis revealed that symptoms of PTSD, as well as internalizing and externalizing problems, decreased significantly over the 6 months after intake (pre-treatment, 3-month, and 6-month assessments), and these gains were maintained over the next 6 months (6-, 9-, and 12-month assessments).</p> <p>Symptoms of externalizing symptoms increased somewhat during the follow-up period, but this change was not statistically significant.</p> <p>These findings suggest that TF-CBT can be implemented effectively in community settings. Treatment outcomes were similar to those reported in efficacy trials of TF-CBT delivered in specialty clinic settings. Improvements in PTSD symptoms and internalizing and externalizing problems were maintained up to 1 year after treatment began, although the changes in externalizing symptoms were the least stable.</p>	<p>Controlled study, however no randomisation to experimental and control conditions, therefore category 2A.</p> <p>] The strengths of the study include:</p> <ul style="list-style-type: none"> ➤ The wide range of trauma explored within the study as this enhances the generalizability of the findings ➤ The sample accurately reflects the client base typically admitted to outpatient public mental health settings within USA ➤ Independent adherence checks carried out to ensure the TF-CBT delivered was identical <p>However, significant weaknesses include:</p> <ul style="list-style-type: none"> ➤ No control group so cannot make causal inferences! ➤ Pp were not stopped from continuing current treatment, so improvements were not necessarily due to TF-CBT ➤ The training received was not identical to that of 	

					clinicians specialising in TF-CBT, so may not be clinically representative	
Trauma-focused cognitive-behavioural therapy for posttraumatic stress disorder in three through six year-old children: A randomized clinical trial (Scheeringa et al., 2011)	Various	To examine the efficacy and feasibility of TF-CBT for treating PTSD in 3 to 6 year-old children exposed to various types of traumas	64 children aged 3 to 6 who display symptoms of PTSD following exposure to various types of trauma were randomly assigned to an immediate treatment group, in which they immediately receive TF-CBT; or a waiting list condition. Within the treatment condition, children received 12 sessions of TF-CBT which had been adapted from a protocol developed for sexually abused pre-schoolers. Checklists were carried out to ensure that clinicians completed the prescribed tasks from the protocol. Children's symptoms were assessed at pre-treatment and a 6-month follow-up using the Pre-school Age Psychiatric Assessment (Egger et al., 2006), which is a structured interview with the parent focusing on symptoms associated with PTSD, MDD, SAD, ODD, and ADHD	The 6-month follow-up revealed that the waiting list condition showed an absence of improvement; whilst the immediate treatment condition led to substantial improvement. This suggests that TF-CBT is effective in treating pre-schoolers with PTSD as a result of various types of trauma exposure The study also examined the feasibility of TF-CBT for such young children: <ul style="list-style-type: none"> ➤ The average completion rate of prescribed TF-CBT tasks was 80-90%; however this was higher for the older children (5/6 years) ➤ 3-year olds had difficulty on some tasks, but achieved almost all tasks eventually (too slightly longer) ➤ 3-year olds had particular difficulty in self-ratings of anxiety, which is due to their difficulty in understanding emotions at this age ➤ When psycho-education was presented verbally no 3-year olds grasped it, half of the 4 year olds, and all 5/6 year olds. When presented visually children of all ages clearly understood 	Randomly assigned to control/treatment conditions, therefore category 1B. Limitations, however, include the high attrition rate, leading to a much smaller than anticipated sample, particularly at the 6-month follow-up (just 16 of 25 participants in the treatment group). Attrition due to Hurricane Katrina striking during the study	Look at how treatment effects are sustained over time
Meta-analysis of trauma-focused cognitive behavioural therapy for treating PTSD and co-occurring depression among children and adolescents (Lenz & Hollenbaugh, 2015)	Various	To determine to what degree TF-CBT is effective for decreasing symptoms of PTSD, as well as co-morbid symptoms of depression	Conducted a meta-analysis of 21 between-group outcome studies published between 2000-2014 that estimated the efficacy of TF-CBT for treating the symptoms of PTSD, and co-occurring depression among individuals who had been exposed to traumatic events. This represented the data of 1,860 children and adolescents: 1,009 having received TF-CBT, 631 having received an alternative treatment, and 220 having received no treatment.	<u>PTSD symptoms</u> <ul style="list-style-type: none"> ➤ Waiting list – 7 studies compared TF-CBT with a waiting list condition and found that TF-CBT significantly improved PTSD symptoms when compared to the waiting list – large effect size ➤ Alternative treatment – 14 studies compared TF-CBT with an alternative treatment and found that TF-CBT significantly improved PTSD symptoms – medium effect size <u>Co-morbid depression</u> <ul style="list-style-type: none"> ➤ Waiting list – 7 studies compared TF-CBT with a waiting list condition and found that TF-CBT significantly improved co-morbid depression – medium effect size ➤ Alternative treatment – 10 studies 	Meta-analysis, therefore category 1A. However, researchers suggested that more studies focusing on the effect of TF-CBT with co-occurring depression were needed to establish more concrete conclusions regarding its effectiveness in terms of co-morbidity	

				<p>compared TF-CBT with alternative treatments and found that TF-CBT was significantly better at improving co-morbid depression, however there was a small effect size</p> <p>Therefore, TF-CBT is a promising intervention for alleviating symptoms of PTSD and co-occurring depression among children and adolescents when compared to no treatment or alternative treatments.</p>		
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Eye Movement Desensitisation and Reprocessing (EMDR)

<p><i>Efficacy of EMDR in children: A meta-analysis (Rodenburg et al., 2009)</i></p>	<p>Various</p>	<p>To determine the magnitude of the difference (i.e. effect size) in PTSD symptoms between the children receiving EMDR and the children receiving control treatments</p> <p>To compare children receiving EMDR with those receiving other established treatments (TF-CBT)</p>	<p>A meta-analysis was conducted including 7 studies that met the following inclusion criteria:</p> <ul style="list-style-type: none"> ➤ Include a control group (waiting list condition) ➤ PTSD reactions to trauma ➤ Randomisation of groups ➤ Children under 18 	<p>Results highlighted an overall medium effect size for improvement in PTSD symptoms using EMDR when compared to a control group</p> <p>There was a small effect size when comparing the incremental efficacy of EMDR when compared to existing treatment modalities (CBT)</p> <p>Researchers found that fewer sessions were associated with better treatment outcomes, with those with less deeply engrained trauma respond faster to EMDR.</p> <p>Girls do not respond as well to EMDR treatment when compared to boys. It was suggested that this was due to girls reacting more strongly to traumatic events as there are biological differences. Researchers suggested that EMDR treatment should be more intense with more sessions for girls</p> <p>EMDR was more effective with type 1 trauma (unique, unexpected events, or single-incident traumas; Fleming, 2012)</p>	<p>Meta-analysis, therefore category 1A</p> <p>However, study limitations include:</p> <ul style="list-style-type: none"> ➤ Only 7 studies used, therefore may not be generalizable due to relatively small sample size. Individual studies also included small sample sizes. ➤ Studies mainly examined whether PTSD symptoms had improved, and did not explore whether the clinical status of the individual had changed (i.e. did they still qualify for a diagnosis of PTSD) 	<p>To analyse the efficacy of EMDR for specific types of trauma</p>
<p><i>Wait-list controlled pilot study of eye movement desensitization and reprocessing (EMDR) for children with post-traumatic stress disorder (PTSD) symptoms from motor vehicle accidents (Kemp, Drummond & McDermott, 2010)</i></p>	<p>Motor vehicle accidents</p>	<p>To compare EMDR to a wait list control to determine whether there is an improvement in PTSD symptoms, and non-PTSD symptoms (such as anxiety, depression, behavioural problems)</p>	<p>The present study investigated the efficacy of four EMDR sessions in comparison to a six week wait-list control condition in the treatment of 27 children (aged 6 to 12 years) suffering from persistent PTSD symptoms after a motor vehicle accident.</p> <p>The efficacy of EMDR was identified on primary outcome and process measures including the Child Post Traumatic Stress – Reaction Index, clinician rated diagnostic criteria for PTSD, Subjective Units of Disturbance and Validity of Cognition scales.</p> <p>All participants initially met two or more PTSD criteria.</p>	<p>The number of children presenting at least two or more PTSD criteria decreased to 25% in the EMDR group, but remained at 100% in the wait-list group. These treatment gains were maintained at three and 12 month follow-up.</p> <p>These findings support the use of EMDR for treating symptoms of PTSD in children</p>	<p>Randomised, controlled study, therefore category 1B.</p> <p>However study limitations include:</p> <ul style="list-style-type: none"> ➤ A single therapist completed the EMDR treatment and the outcome measures, meaning that demand characteristics and bias may have affected results ➤ The study adopted a small sample, all of which had experience type 1 trauma in the form of motor vehicle accidents – therefore not necessarily generalizable to all traumatised children ➤ The sample used was subclinical in that they did not necessarily have an official diagnosis of PTSD, they just displayed some symptoms – once again questions generalizability 	<p>Replicate findings to examine clinical paediatric patients with PTSD diagnosis who have experience other type 1 traumas, with a larger sample</p> <p>To compare EMDR to other treatment modalities, such as TF-CBT</p>
<p><i>EMDR for Childhood PTSD After Road</i></p>	<p>Road traffic accidents</p>	<p>To examine the efficacy of EMDR in</p>	<p>A case series was conducted to evaluate EMDR treatment of 11 children (aged 8-15) with diagnosed</p>	<p>At post-treatment, none of the children met the diagnostic criteria for PTSD, or any co-morbid disorders (except 1 GAD case).</p>	<p>Case-series design, therefore no waiting list control as a means of comparison, therefore category 3?</p>	<p>To further explore implicit, cognitive</p>

<p><i>Traffic Accidents: Attentional, Memory, and Attributional Processes (Richester, Yule & Duncan, 2010)</i></p>		<p>relieving symptoms of PTSD in children who had experienced road traffic accidents</p>	<p>PTSD following a road traffic incident. One child was also diagnosed with MDD, and 7 with GAD.</p> <p>Children received 1-4 sessions of EMDR (mean = 2.4 sessions), and efficacy was assessed using self-report measures, parent-report measures, standard clinical interviews with parents and children, and computer testing of attention, memory, and attribution processes associated with PTSD.</p>	<p>Significant improvements were found on all self-report and parent-report measures of PTSD, anxiety, and depression immediately after treatment, and at a follow-up (1-4 months post-treatment).</p> <p>Improvement was reported in clinical interviews, and treatment was found to be associated with a significant trauma-specific reduction in attentional bias on the modified Stroop task – highlights implicit as well as explicit improvement</p>	<p>The case study design and absence of a waitlist control in the current study cannot rule out the possibility that EMDR had no effect over and above non-specific treatment factors. However, it did allow for a comparison between the degree of change between screening and pre-treatment assessment on each measure, and of degree of change following the start of treatment and at follow-up.</p>	<p>measures by comparing state before and after EMDR treatment</p>
<p><i>A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children (Roos et al., 2011)</i></p>	<p>Type 1 trauma from a fireworks factory exploding</p>	<p>The primary aim was to compare the effectiveness and efficiency of Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).</p>	<p>Children ($n=52$, aged 4–18) were randomly allocated to either CBT ($n=26$) or EMDR ($n=26$) in a disaster mental health after-care setting after an explosion of a fireworks factory. All children received up to four individual treatment sessions over a 4–8 week period along with up to four sessions of parent guidance.</p> <p>Blind assessment took place pre- and post-treatment and at 3 months follow-up on a variety of parent-rated and self-report measures of post-traumatic stress disorder symptomatology, depression, anxiety, and behaviour problems.</p>	<p>Both treatment approaches produced significant reductions on all measures and results were maintained at follow-up.</p> <p>Treatment gains of EMDR were reached in fewer sessions; thus suggesting that EMDR is more efficient in alleviating the effects of type 1 trauma</p>	<p>Randomised, controlled study, therefore category 1B.</p> <p>However study limitations include:</p> <ul style="list-style-type: none"> ➤ Relatively small number of participants, which may have resulted in a lack of sufficient power and sensitivity to detect small differences between the groups ➤ The study lacked a no-treatment control group. ➤ Follow-up assessments were undertaken at only 3 months post-treatment, thereby limiting conclusions regarding the sustainability of the treatment gains over a longer time period 	

<p><i>A Comparison of CBT and EMDR for Sexually-abused Iranian Girls (Jaberghaderi et al., 2004)</i></p>	<p>Sexual abuse</p>	<p>To directly compare the efficacy of CBT and EMDR in the treatment of sexually-abused girls. We were also interested in the relative acceptability and efficiency of these treatments</p>	<p>14 randomly assigned Iranian girls ages 12–13 years who had been sexually abused received up to 12 sessions of CBT or EMDR treatment.</p> <p>Assessment of post-traumatic stress symptoms and problem behaviours was completed at pre-treatment and 2 weeks post-treatment</p>	<p>Both treatments showed large effect sizes on the posttraumatic symptom outcomes, and a medium effect size on the behaviour outcome, all statistically significant. This suggests that both CBT and EMDR can help girls to recover from the effects of sexual abuse</p> <p>EMDR was significantly more efficient, and despite three individuals in the CBT group requiring further treatment, non from the EMDR group required such additional treatment</p>	<p>Randomised, controlled study, therefore category 1B.</p> <p>However study limitations include:</p> <ul style="list-style-type: none"> ➤ Very small number of participants from a different culture with a specific type of trauma exposure – may not be generalisable to traumatised children within the UK ➤ No control group ➤ No long-term follow-up – which group would have had the better long-term effects? ➤ No independent verification of treatment fidelity 	<p>To explore the long-term effects of treatment</p> <p>Future research</p>
<p>Reducing acute stress in a 16-year old using trauma-focused cognitive behaviour therapy and eye movement desensitization and reprocessing (Bronner et al., 2009)</p>	<p>Medical trauma</p>	<p>To assess the effects of trauma-focused cognitive behaviour therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) for the treatment of acute stress in an adolescent.</p>	<p>A combination of TF-CBT and EMDR was provided to a 16-year-old girl with distressing memories, anxiety and flashbacks.</p> <p>For measurement of the efficacy of the treatment package, the Children’s Revised Impact of Event Scale (CRIES-13) was used.</p>	<p>Acute stress reactions decreased considerably after treatment and remained stable. CRIES-13 scores showed substantial reduction in stress scores. The girl reported no more flashbacks of the injury, sleeping difficulties or recurrent and distressing memories.</p> <p>This case study illustrates the potential efficacy of a combination of TF-CBT and EMDR for patients with acute stress reactions.</p>	<p>Case study, therefore category 3?</p> <p>Study limitations include:</p> <ul style="list-style-type: none"> ➤ Case study design therefore only one participant. Cannot be generalised to a broad range of trauma cases of individuals of differing ages, genders, and ethnicities 	<p>Future studies should examine the efficacy of this treatment package in a large sample of children using a controlled experiment</p>

Art Therapy

<p><i>The Effectiveness of Art Therapy Interventions in Reducing Post Traumatic Stress Disorder (PTSD) Symptoms in Pediatric Trauma Patients (Chapman et al., 2001)</i></p>	<p>Medical trauma</p>	<p>To determine the outcome of a specific art therapy treatment intervention in reducing PTSD symptoms in a population of hospitalized children</p>	<p>Studied 31 children, aged 7-17, who had been admitted to hospital following injury and were receiving the Chapman Art Therapy Treatment Intervention. These children were compared to those receiving standardised hospital treatment.</p> <p>Pre-treatment and post-treatment assessments were conducted using the Children's Post Traumatic Stress Disorder Index (PTSD-I)</p>	<p>No significant overall difference in patients' PTSD-I scores were found between those who received the CATTI and those receiving standard hospital treatment.</p> <p>Although no statistically significant difference was determined, examination of individual symptom clusters revealed that intervention produced a reduction in all DSMIV PTSD Criteria C (avoidance) symptoms at 1 week and sustained that decrease 1 month. This may indicate that the CATTI may be effective in reducing acute stress symptoms, and may allow children to discuss and process their traumatic experiences more effectively when compared to the standard treatment group.</p>	<p>Randomised, controlled study, therefore 1B</p> <p>Study limitations include:</p> <ul style="list-style-type: none"> ➤ Small sample size, with mild to moderate injuries meaning the sample may not be generalizable to various trauma cases ➤ The intervention was designed to be administered as a component of on-going psychological paediatric trauma care, and previous interaction with the injured child and his or her family. In the study sample, children were seen without prior interaction with the therapist facilitating the intervention. 	
<p><i>Art Therapy for Adolescents with Posttraumatic Stress Disorder Symptoms: A Pilot Study (Lyshak-Stelzer et al., 2007)</i></p>	<p>Various</p>	<p>This study examined the efficacy of an adjunctive trauma-focused art therapy intervention in reducing chronic child posttraumatic stress disorder (PTSD) symptoms in an inpatient psychiatric facility for youth</p>	<p>Researchers studied 13 inpatients aged 13-18, diagnosed with PTSD.</p> <p>They compared 2 treatment conditions, each delivered in one 1-hour group sessions over 16 weeks: (a) a trauma-focused expressive art therapy protocol (TF-ART) and (b) a treatment-as-usual (TAU) control condition, the standard arts-and-craft-making activity.</p> <p>Youths were randomized to either treatment condition, and assessed before and after treatment using the UCLA PTSD Reaction Index, administered as an interview.</p>	<p>There was a significant treatment-by-condition interaction indicating that adolescents in the TF-ART condition had greater reduction in PTSD symptom severity than youths in the TAU condition.</p> <p>Results indicate that TF-ART may be a promising adjunctive treatment for inpatient adolescents with PTSD symptoms</p>	<p>Randomised, controlled study, therefore 1B</p> <p>Study limitations include:</p> <ul style="list-style-type: none"> ➤ Didn't have a group which included a treatment not based on art therapy – i.e. need to compare art therapy with another treatment modality, such as TF-CBT or EMDR ➤ This was simply a pilot, therefore a full scale study should be conducted 	
<p><i>Group art therapy with sexually abused girls (Pretorius & Pfeifer, 2010)</i></p>	<p>Sexual abuse</p>	<p>To evaluate a group art therapy intervention designed by the authors aimed at reducing depression, anxiety, sexual trauma and low self-esteem among sexually abused girls</p>	<p>The sample consisted of 25 females aged 8-11, who experienced a history of sexual abuse. Participants were randomly assigned to experimental conditions, who received group art therapy; or control conditions. Components in the art therapy included painting, role play, and mutual story telling.</p> <p>The first experimental group (Group 1) was assessed on the TSCC (Trauma Symptom Checklist for Children) and HFD (Human Figure Drawing) prior to and after the treatment. The first control group (Group 2) was assessed on the pre- and post-test in the absence of the intervention. The second</p>	<p>Results indicated that individuals in the experimental group displayed a decrease in depressive, anxiety, and sexual trauma symptoms compared to individuals on a waiting list; however there was no change in low self esteem</p>	<p>Randomised, controlled study, therefore 1B</p> <p>Study limitations include:</p> <ul style="list-style-type: none"> ➤ The small sample size ($n = 25$) is a significant weakness of this study. The limited number of participants assigned to each group is likely to have an adverse impact on the validity of the obtained results ➤ Doesn't directly look at PTSD symptoms 	<p>To examine the efficacy of art therapy in a larger sample</p>

			experimental group (Group 3) was assessed only on the post-test after the intervention whereas the second control group (Group 4) was assessed only on the post-test in the absence of the intervention. An independent psychologist with no knowledge of the groups scored all the tests.			
<i>Art Therapy with Sexually Abused Children and Adolescents: Extended Research Study (Pifalo, 2006)</i>	Sexual abuse	To examine the combination of art therapy and CBT in reducing symptoms of PTSD in a four year follow-up	<p>All of the participants in this study met one hour weekly for eight weeks in groups that were structured to meet the developmental needs for children 8-10, 11-13, and 14-16 years of age. All group sessions utilized a treatment model that combined art therapy and cognitive behavioral therapy.</p> <p>All group members were evaluated using the Trauma Symptom Checklist for Children (TSCC) (Briere, 1995) before and after their participation in the trauma-focused therapy program.</p>	The results of this extended study support the combined use of art therapy (AT) and cognitive behavioural therapy (CBT) as an effective long-term intervention to reduce symptoms most often associated with childhood sexual abuse.		
<i>Creative Arts Therapy as treatment for child trauma: An overview (van Westrhenen & Fritz, 2014)</i>	Various	To establish the extent of research in the last 12 years that has been based on the use of creative arts therapy, as well as the value of the evidence available on the topic	<p>A literature review was conducted to highlight studies that met the inclusion criteria:</p> <ul style="list-style-type: none"> ➤ Examine children under 18 who have experienced a traumatic event ➤ Includes a creative arts intervention ➤ Evaluates the intervention program ➤ Published between 2000-2012 <p>38 studies were included and evaluated by 2 independent researchers using 4 criteria:</p> <ul style="list-style-type: none"> ➤ Internal validity ➤ External validity ➤ Reliability ➤ Objectivity <p>The studies included children aged 16 months to 18 years who had experienced a number of traumatic events, and received either short-term (2-12 sessions weekly) or long-term (4months – 4 years) interventions</p>	<p>The literature review concluded that the effectiveness of interventions could not be determined due to poor quality of research.</p> <p>44% of articles found to be non-empirical and merely descriptive of the therapist's or child's personal experience. Highlighted that often it is argued that it is impossible to conduct laboratory-based research on creativity under controlled conditions, as often art therapy is unique and client-centred.</p>		Higher quality of research is needed to establish firm conclusions