Trauma Treatment and Evidence Based Practice

Moving the Ivory Tower Into the Swamp

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Are we really still talking about this (EBPs) 25 year later?

- The Trauma-Informed movement has lead directly to trauma treatments that are "evidence based" for trauma.
- This is a tremendous advance over the patchwork of individual practitioners, applying varying approaches, some of which were of dubious value.
- BUT-- there is concern that these treatments are too "cookie-cutter" and don't place enough emphasis on individual difference and the relationship between the practitioner and the client.
- This presentation will describe the pros and cons of evidence based approaches and integrate the value of evidence with the reality of life in the trenches.
Sackett, Rosenberg, Gray, Haynes, and Richardson (1996) described evidence-based medicine as

“The conscientious, explicit, and judicious use of current best evidence in making decisions about individual patients.”

Evidence-based practice in therapy is consistent with the past 20 years of work in evidence-based medicine, which advocated for:

“Improved patient outcomes by informing clinical practice with relevant research” (Sox & Woolf, 1993; Woolf & Atkins, 2001).
"A health care delivery system characterized by idiosyncratic and often ill-informed judgments must be restructured according to evidence-based medical practice, regular assessment of the quality of care and accountability.

The alternative is a system that makes life and death treatment decisions base on conflicting anecdotes and calculated appeals to emotion."

Millenson, ML. Demanding Medical Excellence: Doctors and Accountability in the Information Age. pg.6 University of Chicago Press, Chicago, 1997
SO...WHO CAN ARGUE WITH THAT?
The Ivory Tower

- The first wave sometimes moved into orthodoxy:
  - “Any mental health professional who is employing a treatment that has not been scientifically validated is committing professional malpractice.”
  - Policy Makers, Payers, and Regulators began developing narrow approved treatment lists and threatening to deny payment for services not on the list.
“We have found God, and he is on our side.”
SO...WHO CAN ARGUE THAT WE DON'T NEED EBPS?
Practitioners, Program Managers, and Some Researchers began to identify the failures of the EBP orthodoxy:

- There are huge gaps in our research: Effective models are those that are researched.
- The EPB research and meta-analyses are flawed—may not represent a real-life clientele, not “clean one owners”.
- Most studied models are the proprietary models or models with a research arm (cognitive-behavioral).
- Few models show superiority to other well-designed, well-implemented models (MATCH study).
The Swamp: Payback’s a Bitch

- Funding, supervision, documentation and implementation models are difficult in settings requiring high productivity
- Cost-Effectiveness of some models is in dispute
- Even the most effective EBPs fail for some clients
- Narrowing practice to a limited set of EBPs ossifies practice and stifles innovation
- Manualized approaches minimize relationship and individual client factors
- EBPs place emphasis on the model rather than the outcome
- An emergence of the concept of common factors as an alternative to EBPs
WHY NOT TAKE THE GOOD PARTS OF EBPS AND BUILD OUR OWN THING?
Orthodoxy

The second wave also moved towards orthodoxy.

“We have found God, and he is on our side.”
The Second Wave: Payback’s a Bitch

- The orthodoxy of the second wave:
  - An unintended consequence of anti-EBP positions is the failure to acknowledge differences in program quality, and the importance of well-designed, well-implemented treatment.
"The test of a first-rate intelligence is the ability to hold two opposed ideas in mind at the same time and still retain the ability to function. One should, for example, be able to see that things are hopeless and yet be determined to make them otherwise."
— F. Scott Fitzgerald
Three Legged Stools (APA)

- Evidence Based Practice
- Practitioner Expertise
- Evidence Supported Treatments
- Patient Preference/Culture
Trauma Responsive “Four-Legged Chair”

Evidence-Based Practice

- Trauma-Informed Organizational Practices
- Practitioner Expertise
- Evidence Supported Treatments
- Patient Preference/Culture
Practicing in an “Evidence-Based Way”

1. Select an “Evidence Supported Treatment”
   A. Identifying the treatment population
   B. Identifying the most evidence supported treatment for your population

2. Even in view of the flaws, EBPs:
   1. Provide an infrastructure of supports in implementation
   2. Provide means for on-going coaching
   3. Can be adopted as a team or organization
The Sources for Identifying EBS

1. The National Child Traumatic Stress Network (NCTSN)
2. The California Evidence-Based Clearinghouse for Child Welfare
3. SAMHSA Evidence Based Practice Resource Center
Trauma Treatments for Children (NCTSN)

Alternatives for Families - A Cognitive Behavioral Therapy
Modality: Individual, Family
AP-ORF is a trauma-informed, evidence-based treatment designed to improve the relationships between children and caregivers.

Assessment-Based Treatment for Traumatized Children
Assessment Pathway
Modality: Individual, Family, Systems
TAP is a treatment model that incorporates an assessment timeline essential components of trauma treatment into clinical pathways.

Attachment and Biobehavioral Catch-up
Modality: Individual, Family
ABC is a parent-child treatment approach designed to help caregivers provide nurturing care and engage in synchronous interactions with their infants. ABC helps caregivers re-interpret children's behavioral signals so that they can provide nurturance through parent coaching sessions.

Attachment, Self-Regulation, and Competence: A Comprehensive Framework
Modality: Individual, Systems
AFCR is a framework for intervention with youth and families who have experienced multiple or prolonged traumatic stress.

Attachment, Self-Regulation, and Competence: A Comprehensive Framework
Modality: Individual, Family
BFOB is a behavioral self-regulation and competence-based group intervention to teach children and their caregivers within various summer camps to cope with and help recover from their traumatic experiences.

Bounce Back: An Elementary School Intervention for Childhood Trauma
Modality: Family, Systems
CARE is a trauma-informed intervention for children ages 5-12, with interview parameters and standard trauma-specific measures administered at 2-month intervals to identify particular issues and issues requiring focused clinical attention.

Bounce Back: An Elementary School Intervention for Childhood Trauma
Modality: Family, Group
PC-CARE is a dyadic intervention designed to expose the caregiver to strategies for enhancing the caregiver-child relationship and promoting behavioral management effectiveness.

Child Adult Relationship Enhancement
Modality: Family, Systems
CARE is a trauma-informed modification of specific PCIT skills for general usage by non-clinical adults who interact with traumatized children and their caregivers within various settings. CARE has been adapted for use in homeless serving systems.

Child Development-Community Policing Program
Modality: Individual, Family, Systems
CPPRI is an intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, or behavioral problems, including posttraumatic stress disorder.

Child-Parent Psychotherapy
Modality: Individual, Family, Systems
CPP-R is an intervention designed to be put into place immediately following disasters, terrorism, and other emergencies, with the mission to stabilize the parents and children in trauma-focused services.

Early Pathways
Modality: Family
EP is a home-based, mental health services program, which is designed to treat and prevent disruptive behaviors in young children.

Family Centered Treatment
Modality: Family
FCT provides a holistic approach to meeting the needs of children, families, and caregivers in their homes. It emphasizes all areas of family functioning relevant to treatment needs, as based on families' identification of both their needs and barriers to their functioning well as a family system.

Integrative Treatment of Complex Trauma for Adolescents
Modality: Individual, Family, Systems
ICCTA is a component-based, assessment-driven, multitreatment model for traumatized adolescents (aged 12 to 17 years) and their families.

Integrative Treatment of Complex Trauma for Children
Modality: Family
ICCTC is an assessment-driven, multicomponent, evidence-based treatment for children ages 5-12, with interview parameters and standard trauma-specific measures administered at 2-month intervals to identify particular issues and issues requiring focused clinical attention.

Integrative Treatment of Complex Trauma for Children
Modality: Individual, Family
ICCTC is an assessment-driven, multicomponent, evidence-based treatment for children ages 5-12, with interview parameters and standard trauma-specific measures administered at 2-month intervals to identify particular issues and issues requiring focused clinical attention.

Let's Connect
Modality: Individual, Family
LC is a parenting intervention that helps caregivers identify and respond to children's emotional needs and behaviors in a way that builds connection and warmth and promotes children's emotional competence and sense of emotional security.

Problematic Sexual Behavior- Cognitive-Behavioral Therapy for School-Age Children
Modality: Group
PSB-CBT is a family-oriented, cognitive-behavioral, behavioral, and supportive treatment group designed to reduce or eliminate incidents of problematic sexual behavior.

Psychological First Aid
Modality: Individual
PFA is an evidence-based intervention designed to be put into place immediately following disasters, terrorism, and other emergencies, with the mission to stabilize the parents and children in trauma-focused services.

Real Life Heroes
Modality: Individual, Family
RLH is an intervention that provides practitioners with a way to assess the level of safety, help-seeking, and psychological distress of the child and family after the event, and critical incident is trauma-focused.
# Trauma Treatments for Children (NCTSN)

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<tr>
<th>Safety, Mentoring, Advocacy, Recovery, and Treatment</th>
<th>Sanctuary Model</th>
<th>Skills for Psychological Recovery</th>
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<td>Modality: Individual, Family</td>
<td>Sanctuary is a trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community to help people heal from trauma. It addresses the marginalization of specific cultural groups through exposure to trauma.</td>
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<td>SPF is a manualized, evidence-informed intervention that is designed to foster short- and long-term adaptive coping in disaster survivors who are exhibiting moderate levels of distress.</td>
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<th>Structured Psychotherapy for Adolescents Responding to Chronic Stress</th>
<th>Support for Students Exposed to Trauma: School Support for Childhood Trauma</th>
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<td>Modality: Family, Group</td>
<td>SPF is a manualized, empirically-supported group treatment designed to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma and/or separate types of trauma.</td>
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<td>SCFT is a manualized trauma-focused, skill-building intervention. It is designed for families living in traumatic contexts with the goal of reducing the symptoms of posttraumatic stress disorder and other trauma-related disorders in children and adult caregivers.</td>
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<td>TST is a model of care for traumatized children that addresses both the individual child’s emotional needs as well as the social environment in which he or she lives.</td>
<td>Trauma-Focused Cognitive Behavioral Therapy is a comprehensive method for treating traumatic stress in children and adolescents that adapts to individually-based approaches by specifically addressing social environmental/system-of-care factors that are believed to be driving a child’s stress problems.</td>
<td>Trauma Systems Therapy for Refugees addresses the emotional and behavioral needs of children and adolescents who have been exposed to traumatic events.</td>
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Bringing the Ivory Tower into the Swamp

1. Selecting an “Evidence Supported Treatment”
   A. Identifying the treatment population
   B. Identifying the most evidence supported treatment for your population

2. Implement EST into a Trauma Informed Organization
Trauma: Core Components (NCTSN)

- Motivational interviewing (to engage clients)
- Risk screening (to identify high-risk clients)
- Triage to different levels and types of intervention (to match clients to the interventions that will most likely benefit them/they need)
- Systematic assessment, case conceptualization, and treatment planning (to tailor intervention to the needs, strengths, circumstances, and wishes of individual clients)
- Engagement/addressing barriers to service-seeking (to ensure clients receive an adequate dosage of treatment in order to make sufficient therapeutic gains)
- Psychoeducation about trauma reminders and loss reminders (to strengthen coping skills)
- Psychoeducation about posttraumatic stress reactions and grief reactions (to strengthen coping skills)
Trauma Core Components (NCTSN)

- Teaching emotional regulation skills (to strengthen coping skills)
- Maintaining adaptive routines (to promote positive adjustment at home and at school)
- Parenting skills and behavior management (to improve parent-child relationships and to improve child behavior)
- Constructing a trauma narrative (to reduce posttraumatic stress reactions)
- Teaching safety skills (to promote safety)
- Advocacy on behalf of the client (to improve client support and functioning at school, in the juvenile justice system, and so forth)
- Teaching relapse prevention skills (to maintain treatment gains over time)
- Monitoring client progress/response during treatment (to detect and correct insufficient therapeutic gains in timely ways)
- Evaluating treatment effectiveness (to ensure that treatment produces changes that matter to clients and other stakeholders, such as the court system)
Moving the Ivory Tower into the Swamp

3. Intentionality: Much (most?) of the effect of EST comes from the fact that they are well-designed and well-implemented

4. Modifications to EST with Intentionality (versus for reasons of ease)

5. Outcome monitoring
"EVERYTHING SIMPLE IS FALSE. EVERYTHING WHICH IS COMPLEX IS UNUSABLE."

Bonini’s Paradox
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