Literature review: evidence-based treatments for childhood trauma and ptsd

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Because childhood trauma touches the lives of many youngsters and often leaves a lasting mark, it is a vital and meaningful area to study (Racco & Vis, 2015). Trauma exposure in children can result in Posttraumatic Stress Disorder (PTSD) as well as create difficulties in “ cognitive, physical, psychological, affective, interpersonal, and behavioural functioning” (Racco & Vis, 2015, p. 121). Experiencing a traumatic event when one is young can also lead to other struggles, like “ mood disorders, anxiety disorders, eating disorders, and self-injury” (Racco & Vis, 2015, p. 122). The effects of childhood trauma, then, are wide-ranged. They hold developmental implications as well—the age and maturity of the child at the time of the trauma also factor into how each youngster will be affected (Racco & Vis, 2015; Owaga, 2004). Because of the varied and severe consequences of childhood trauma, this points the importance of available treatments that are effective, backed up research, and can simultaneously meet the specific needs of children and adolescents (Racco & Vis, 2015). Struassner & Calnan (2014) state that in terms of trauma, its effect on youngsters “ is unique and particularly pernicious” (p. 325). This point further highlights the need for robust, evidence-based treatments upon which clinicans can rely.

For clarity’s purposes, in this literature review, trauma will be defined as an often shocking, sudden, or scary event that “ overwhelms the individual’s psychological ability to cope” and PTSD will be defined as per the DSM-5 criteria (Straussner & Calnan, 2014, p. 323). Much of the research surveyed includes children and adolescents from approximately 3-18 years of age. This literature review will focus on three approaches for trauma and PTSD treatment in childhood, briefly looking at research evidence as well as the

theoretical foundations and philosophy behind the approach. First, we will look at Trauma-Focused CBT, which has garnered much support in past and recent studies (Racco & Vis, 2015; Feather & Ronan, 2006; Scheeringa et al., 2011; Beer, 2014). Next, two approaches that have been deemed " emerging" will be examined: Creative Arts Therapy (CATs) and attachment models (Racco & Vis, 2015, p. 126). These approaches are included because several studies have pointed to the importance of not just a cognitive focus in treating trauma, but to embracing holistic, " mind-body interventions" which creative arts therapy and attachment theory approaches aim to do, albeit in different ways (Racco & Vis, 2015, p. 126). However, while looking briefly at the philosophy underlying the approach, the author will attempt to ask: has it been shown to work? Additionally, where applicable, benefits, and drawbacks to each model will also be explored.

Trauma-focused Cognitive Behavioral Therapy has illustrated its effectiveness in over 20 studies (Beer, 2013). Racco & Vis (2015) present it as a " validated treatment for children and parents" (p. 124). In a study by Silverman et al. (2008), cited by Racco & Vis (2015), he found TF-CBT to be more effective than other therapeutic approaches and " placebo" (p. 124). In a study by Scheeringa et al. in 2011, the researchers reported that TF-CBT could even be used to treat youngsters under seven years of age diagnosed with PTSD (p. 18). However, Scheeringa et al. (2011) also state that their study warrants repetition to garner more confidence in the results. Feather & Ronan (2006) studied youngsters under 14 years of age who had suffered chronic abuse and discovered that TF-CBT " was helpful in reducing PTSD symptoms and increasing coping" (p. 140). Therefore, with mounting

evidence to support it, many consider TF-CBT to be “ the only well-established treatment” for children who have experienced trauma (Racco & Vis, 2015, p. 124; Kenardy et al., 2010).

In research cited by Racco &Vis (2015), Deblinger et al. (2001) studied children under 12 who had suffered sexual trauma and found that TF-CBT decreased children’s “ PTSD symptoms” while also providing parents with important tools to help them better understand support their kids (p. 124). It is important to note that these results were found to be enduring, even a year after the brief treatment concluded (Racco & Vis, 2015). It is also vital to call attention to the aspect of caregiver support in TF-CBT. This is an essential aspect of the intervention, as parents’ reactions to the child, styles of parenting, and their own ability to cope with the event can impact the rate at which their children recover from trauma and PTSD (Kenardy et al. 2010).

In terms of the format of this approach, Trauma-Focused CBT consists of about “ 12 to 16 sessions” (Straussner & Calnan, 2014, p. 329). It involves elements such as emotional regulation tools, practicing calming exercises, getting to the “ trauma narrative,” as well as “ parenting skills…exposure…[and] cojoint parent-child sessions” (Straussner & Calnan, 2014, p. 329). In this, TF-CBT targets the child’s own traumatic memories, the family, and offers many practical skills that can enhance resiliency (Straussner & Calnan, 2014). TF-CBT practices may be able to target the areas of the brain involved in PTSD symptoms (Racco & Vis, 2015). Kendary et al. (2010) state that the “ way in which people remember and recount threatening events” impacts their sense of resiliency and ability to recover—and this cognitive focus is a part of TF-CBT models (p. 2).

In considering possible drawbacks of the approach, Kenardy et al. (2010) point out that many current studies on TF-CBT have focused on children within a “ narrow subgroup of traumatic events (e. g., sexual abuse)” (p. 2). Racco & Vis (2015) also state this, as TF-CBT has been shown to be useful, but mainly with child “ sexual abuse survivors” (p. 124). Sadly, there are many other types of traumas that children suffer. Kenardy et al. (2010) describe the need broaden the scope of traumas studied with TF-CBT and propose a methodology to investigate TF-CBT with youngsters with “ accidental injuries” (p. 2). Enlarging the scope of the types of trauma studied with TF-CBT will help determine its usefulness in a wider range of traumatic events (Kenardy et al., 2010).

Despite the strong evidence for Trauma-Focused CBT, there are some authors, including van der Kolk (2006) who posit that cognitive methods alone cannot “ address all levels of functioning affected by trauma exposure” (Racco & Vis, 2015, p. 124). These researchers advocate for approaches that include “ sensations” and bodily awareness (p. 124). They call for a more holistic view, one that sees the whole person as being affected by trauma, stating that trauma does not only exist in the mind, as cognitive approaches imply (Racco & Vis, 2015). There are also questions about whether TF-CBT would be successful with children who have suffered “ complex trauma,” especially in cases where dissociative states are present, as these youngsters may “ experience psychological and physical disconnect” perhaps rendering it tough to process trauma on a cognitive level (Racco & Vis, 2015, p. 122).

In a similar vein, Racco & Vis (2015) and Owaga (2004) point out that children do not express or experience trauma symptoms or PTSD in the same way as adults. While cognitive approaches have been shown to work very well with adults, perhaps these models are not as easily transferred to children (Straussner & Calnan, 2014). Ogawa (2004) mentions, for example, that children's trauma symptoms are often expressed " through trauma-inspired play" and that this has important treatment implications (p. 19). Ogawa (2004) cites research by Terr (1991) that detailed ways that youngsters may show trauma symptoms. Although children may experience " flashbacks" as adults do— these are far more likely to show up in youngsters' artwork or other activities (p. 21). Perhaps cognitive interventions lacking an element of " play" then, are not ideal (Owaya, 2004, p. 19). Additionally, because they are still developing, children often have " limited" words to express how they feel about what happened to them (Racco & Vis, 2015, p. 122). There is also evidence to suggest that talking about trauma head-on may not be the best approach, as researchers have observed that trauma can affect " Broca's area, the expressive speech center in the brain, the area necessary to communicate what one is thinking and feeling" (Zuch, 2010; Racco & Vis, 2015, p. 122).

It is proposed that Creative Arts Therapy (CATs) can help children who have experienced trauma find words through color, movement, and sound (Racco & Vis, 2015; Straussner & Calnan, 2014; van Westrhenen et al., 2016). Additionally, creating art can be a full-body experience, including emotions, textures of the art materials and visceral experiences that tap into memories, states, and feelings that words alone cannot reach (Racco & Vis,

2015; van Westrhenen et al., 2016). Art may also help in engaging right brain processes, which Shore (2014) states may be shrunken in cases of childhood trauma. Another important consideration is that CATs can aid traumatized children who speak English as a second language (van Westerhenen et al., 2016; Racco & Vis, 2015). This may also add an aspect of inclusiveness and multiculturalism into treatment, as arts activities can weave in different " cultural traditions" like " storytelling" thereby helping children of all cultures open up in ways that may be familiar or comfortable for them (van Westrhenen et al., 2016, p. 129).

A critical aspect of Creative Arts therapy is the use of symbols to support a child in safely telling their story—and in doing so, they can create a more coherent narrative as well as lessened fear around the trauma they experienced (Racco & Vis, 2015). This can feel empowering and give children a chance to get in contact with the creative potential inside them, which can also help youngsters feel more resilient (van Westrhenen et al., 2016). Additionally, Staussner & Calnan (2014) state that making art can be a playful and even joyous activity, which can engage children in therapy because the " natural language of children is play" (p. 329). Perryman, Blisard & Moss (2019) describe creative arts as " nonthreatening"—which can be important for youngsters (p. 81; Racco & Vis, 2014).

Although the research is young, there is some evidence that arts interventions can be effective for children who have PTSD or have experienced trauma (Racco & Vis, 2015). Recent research has shown the role of the arts in helping youngsters better " cope" and reduce problem behaviors (Racco & Vis, 2015, p. 126). However, many studies on CATs for

childhood trauma consist of case studies rather than experimental models (Racco & Vis, 2015). One such study by Shore (2014) details the clinician's sessions with a young girl, Eva. Through working with clay and creating a small cat, was able to give a voice to her sadness in saying how this little cat " was on its own" (Shore, 2014, p. 92-93). Giving voice to her emotions through her clay cat helped her express herself in a way that felt safe and encouraged her to begin to integrate her experiences and bond with her adoptive Mom (Shore, 2014). Zuch (2015) also discusses a case vignette with Ann, a young teen who had experienced multiple traumas, and how music therapy helped her feel comfortable to start to talk about her emotional hurts (p. 8).

In their 2017 study, van Westerhenen et al. did a group arts intervention with children and observed how the use of art activities engaged children in treatment. The researchers quoted a participant: " We were drawing, telling stories and talked about our feelings. And we were learning things we didn't know (p. 133). Zuch (2015) also speaks about the power of CATs in a group format to help children find a sense of community—as well as uncover new avenues of " expression," which can build self-efficacy (Zuch, 2015, p. 9). Pretorious & Pfeifer (2010) investigated an arts intervention for girls under 12 who had experienced sexual trauma which was shown to lessen participants' " depressive, anxiety…and trauma symptoms" (Racco & Vis, 2015, p. 127). Creative Arts Therapy may also be able to provide more than symptom relief and even encourage posttraumatic growth, which is defined as " a positive change as a result of the struggle with trauma" (van Westernhenen, 2017, p. 128). Although CATs show promise, there is a need

for more quantitative studies, randomized controlled trials, and sound experimental designs (Racco & Vis, 2015).

Attachment theory approaches are another approach to consider with childhood traumas, because these traumas so often involve other people, such as caregivers and family (van Westernehen et al., 2017). Horton-Parker & Brown (2002) state that these situations can constitute the essential shattering of a household. Cases of abuse can also " result in broken trust and suspicion towards relationships" (van Westrhenen et al., 2017, p. 129). This, then, can impact a child's ability to form later attachments as well as struggles with " empathy [and] self-awareness…" which can cause problems in many areas of life (Shore, 2014, p. 92).

In cases where children suffered abuse when young, this trauma may even impact how their brains are formed (Shore, 2014). Shore (2014) states that " the massive growth of the right hemisphere during infancy is a dydadic process promoted by relational sequences of behavior with the mother or primary caregiver" (Shore, 2014, p. 92). If this development is interrupted or complicated by trauma, a child can have difficulties with emotional regulation (Shore, 2014; Straussner & Calnan, 2014). Racco & Vis (2015) echo this perspective in stating that trauma exposure can affect children's development, especially during " sensitive periods," where it is important to reach certain milestones, which may not be as easily reached after this timeframe (p. 122). These points speak to the fact that youngsters do not develop in a vacuum, but in their environment with their families and caregivers—and that development itself is relationship-oriented (Racco & Vis, 2015; Shore, 2014; Horton-Parker & Brown, 2002).

Joubert, Webster & Hackett (2012) highlight “ unresolved/disorganized attachment” as a possible attachment style when a child experiences trauma. The authors go on to describe this as a “ façade;” an “ extreme defensive process in response to conditions of severe perceived threats to the self” (p. 472). However, this is costly for the individual to maintain, and their painful memories are not integrated, so they will rise up with a force when triggered (Joubert, Webster & Hackett, 2012). This knowledge, though, can aid us in understanding how youngsters deal with severe trauma and can help clinicians reflect on how to attune the therapy relationship to be successful with youngsters who have experienced trauma (Joubert, Webster & Hackett, 2012).

Thus far, there is little research on how to apply attachment theory for trauma treatment in youngsters. As with Creative Arts Therapy, the research is mainly comprised of case studies (Shore, 2014; Smith, 2016.) Other studies, such as Joubert, Webster & Hackett (2012) look to connect attachment styles to childhood trauma exposure. The aforementioned researchers found in their study with over 50 teens who had experienced abuse that a positive relationship exists between disorganized attachment and “ trauma symptoms” (p. 474). Another meaningful finding in their research speaks to how those with this attachment style may also struggle with lessened “ capacity for selective attention and…short term memory” (Joubert, Webster & Hackett, 2012, p. 481). Other articles, such as Levendosky, Lannert & Yalch (2012) are more theoretical and descriptive. These authors focused on surveying current literature on how domestic violence can influence a child and Mother. They discuss that in terms of

attachment, an abused child may learn that relationships “ hurt” (Levendosky, Lannert & Yalch, 2012, p. 402). Unfortunately, an expectation or feeling of intense “ betrayal” can accompany them into adulthood (p. 398).

Levendosky, Lannert & Yalch (2012) go on to illustrate potential behaviors that children with disorganized attachment may show when reunited with their Mothers in the “ Strange Situation” studies: “ freezing, fear, disorientation” and going both towards and away from their Mom (p. 401). The authors also discuss the possibility of “ intergenerational transmission of intimate partner violence” (Levendosky, Lannert & Yalch, 2012, p. 398). Specifically, these researchers describe how relational violence affects both the Mother and child—creating patterns that can stay with them throughout their lives (Levendosky, Lannert & Yalch, 2012, p. 398). As therapists, it is crucial to know how to target these patterns (Levendosky, Lannert & Yalch, 2012). Horton-Parker & Brown (2002) echo this perspective in saying that caregivers who experienced abuse in their own childhood are “ 6 times more likely than the general population… [to end up] abusing their own children,” so these patterns across generations are vital to keep in mind (p. 133). Overall, however, in terms of attachment theory to treat trauma and PTSD in children, the research is still budding, and attachment approaches are often used in conjunction with other models, such as Art Therapy (Shore, 2014). It is also vital to note that the relationship of a shrunken right hemisphere and traumatic events is not something that has been validated through research (Racco & Vis, 2015, p. 122). More solid research needs to be conducted in order to investigate the clinical applications of attachment theory.

To summarize the findings in this literature review, three approaches to treating childhood trauma were examined: TF-CBT, Creative Arts Therapy, and attachment models. Currently, TF-CBT shows the most substantial data (Racco & Vis, 2015; Beer, 2013; Feather & Ronan, 2006; Kenardy et al., 2010). However, CATs and attachment theory both hold promise as well. It is necessary to consider that even though TF-CBT has been shown to be effective in many studies, " treatment failure still occurs" (p. 127). Because of the numerous developmental implications of childhood trauma and PTSD, we must continue to ask ourselves why this is the case.

Perhaps as Racco & Vis (2015) posit, " no one model fits the needs of all children and youth from birth to 18" (p. 127). However, budding evidence tells a story of embracing a more holistic approach that includes attuning to relationship patterns, as well as to the body and senses (Racco & Vis, 2015, p. 126). Perhaps the approaches explored in this literature review will eventually be woven together and made stronger by each other, as Racco & Vis (2015) suggest that " body awareness and sensory mastery prior to cognitive and/or behavioral interventions" could result in a powerful combination (p. 123). It is also important to continue orienting to the specific needs of children in treatment, as they may experience trauma and PTSD differently than adults—and therefore, be more engaged in treatments that welcome " play" (Owaga, 2004, p. 22). As we see how future research unfolds, we can continue to advocate for the best possible treatments for our children and youth—helping them find resiliency, wholeness, and joy (Ogawa, 2004).

References

- Beer, R. (2013). Review of Trauma-focused CBT for children and adolescents Treatment applications. *European Child & Adolescent Psychiatry* , *22* (9), 581–582. https://doi. org/10. 1007/s00787-013-0448-0.
- Feather, J. S., & Ronan, K. R. (2006). Trauma-focused cognitive behavioural therapy for abused children with posttraumatic stress disorder: A pilot study. *New Zealand Journal of Psychology, 35* (3), 132-145. Retrieved fromhttps://0-search-proquest. com. library. acaweb. org/docview/212440305? accountid= 13505.
- Horton-Parker, R., & Brown, N. (2002) The Unfolding life: Counseling across the Lifespan. Westport, CT: Bergin & Garvey.
- Joubert, D., Webster, L., & Hackett, R. K. (2012). Unresolved attachment status and trauma-related symptomatology in maltreated adolescents: An examination of cognitive mediators. *Child Psychiatry and Human Development, 43* (3), 471-83. doi: http://0- dx. doi. org. library. acaweb. org/10. 1007/s10578-011-0276-8.
- Kenardy, J., Cobham, V., Nixon, R. D. V., McDermott, B., & March, S. (2010). Protocol for a randomised controlled trial of risk screening and early intervention comparing child- and family-focused cognitive-behavioural therapy for PTSD in children following accidental injury. *BMC Psychiatry, 10* , 92. doi: http://0-dx. doi. org. library. acaweb. org/10. 1186/1471-244X-10-92.
- Ogawa, Y. (2004). Childhood trauma and play therapy intervention for traumatized children. *Journal of Professional Counseling, Practice, Theory, & Research, 32* (1), 19-29. Retrieved fromhttps://0-search-

proquest-com. library. acaweb. org/docview/212437441? accountid= 13505.

- Perryman, K., Blisard, P., & Moss, R. (*2019*) Using creative arts in trauma therapy: The Neuroscience of Healing. *Journal of Mental Health Counseling* : *41* (1) 80-94.
- Racco, A., & Vis, J. A. (2015). Evidence based trauma treatment for children and youth. *Child & Adolescent Social Work Journal* , *32* (2), 121–129. https://doi. org/10. 1007/s10560-014-0347-3.
- Scheeringa M. S., Weems C. F., Cohen J. A., Jackson, A. L., Guthrie, D. (2011). Trauma-focused cognitive behavioral therapy for posttraumatic stress disorder in three through six year old children: A randomized clinical trial. *Journal Child Psychology & Psychiatry, 52,* 853–860.
- Shore, A. (2014). Art therapy, attachment, and the divided brain. *Art Therapy* , *31* (2), 91–94. https://doi. org/10. 1080/07421656. 2014. 903827.
- Smith, J. (2016). Healing hidden hurts: transforming attachment and trauma theory into effective practice with families, children and adults. *Child & Adolescent Mental Health* , *21* (1), 76. https://doi. org/10. 1111/camh. 12154.
- Straussner, S. L. A., & Calnan, A. J. (2014). Trauma through the life cycle: A review of current literature. *Clinical Social Work Journal* , *42* (4), 323–335. https://doi. org/10. 1007/s10615-014-0496-z.
- van Westrhenen, N. V., Fritz, E., Oosthuizen, H., Lemont, S., Vermeer, A., & Kleber, R. J. (2017). Creative arts in psychotherapy treatment protocol for children after trauma. *The Arts in Psychotherapy, 54* , 128-135. doi: 10. 1016/j. aip. 2017. 04. 013.

- Zuch, M. T. (2015). The Effectiveness of Arts in Trauma Intervention. *Vanderbilt Undergraduate Research Journal* , *10* , 1–15. Retrieved fromhttp://0- search. ebscohost. com. library. acaweb. org/login. aspx? direct= true&db= aph&AN= 111456634&site= ehost-live.