Evidence Brief

Best Practices for Trauma-Informed Work with Children & Youth Witnesses to Violence

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How Did We Compile This Evidence?

We searched YouthREX's Library for Youth Work, and searched in online databases using the following key terms: "children," "youth," "witness," "domestic violence," "intimate partner violence," "trauma-informed," and "evidence-based." We then used the 'related articles' function on Google Scholar to find additional resources. Some of the resources we included are specifically about young people who have witnessed violence, while others are about treating trauma in young people more generally.

Key Terms

Trauma-informed practice brings an awareness of the prevalence and impacts (physical, emotional, neurological, spiritual) of trauma to every level of an organization and every aspect of care (Poole, Talbot, & Nathoo, 2016). It focuses on creating a sense of empowerment for individuals who have experienced trauma, while building their sense of safety and ensuring they have access to choice and connection throughout service (SAMHSA, 2018). Rather than focusing on specific treatment interventions, trauma-informed practice is more about the nature of the relationship between the organization/service provider and the young people/families. Taking a trauma-informed approach shifts questions about young people's difficulties or behaviours "from 'what is wrong with you?'...to 'what has happened to you'" (SAMHSA, 2014, p. 268). Trauma-informed services are not offered specifically to those who have disclosed experiences of trauma; rather, they are applied universally (Poole, Talbot, & Nathoo, 2016).

Trauma-specific services use specific, specialized, clinical interventions or traditional healing practices to facilitate recovery, usually from a trauma disorder (e.g. post-traumatic stress disorder). Trauma-specific services are offered within a broader trauma-informed setting, by practitioners with specialized skills, in order to treat trauma and its symptoms (Poole, Talbot, & Nathoo, 2016).

In this Evidence Brief, we have included resources that address aspects of both **trauma-informed care** and **trauma-specific services**.

Summary of Evidence

1) **Trauma Focused-Cognitive Behavioural Therapy (TF-CBT)** has the **most empirical support** as a treatment intervention for children who have witnessed violence (Social Policy Evaluation and Research Unit, 2017; Powell & Morrison, 2017; Lucio & Nelson, 2016; Puccia et al., 2012; Burillo, 2011; Cohen, Mannarino, & Iyengar, 2011; American Psychological Association, 2008). TF-CBT generally works with both the young person and their parent/caregiver, and uses **skill building** and **planned exposures** to trauma triggers to **treat symptoms and build resilience**. Many studies that evaluate treatment interventions don't sufficiently engage racialized participants, and therefore it is difficult to make claims about their effectiveness with people of colour; however, TF-CBT has been studied with Indigenous, Black, and Latino youth, and, in these contexts, has been shown to be effective (Lucio & Nelson, 2016). A good overview of TF-CBT and other evidence-informed interventions can be found in Chamberlain (2014).

2) Whether using TF-CBT or another approach, **involving the 'non-offending' parent in treatment is recommended** when working with young people who have witnessed violence (Pernebo, Fridell, & Almqvist, 2018; Social Policy Evaluation and Research Unit, 2017; Howarth et al., 2016; Chamberlain, 2014; Graham-Bermann & Miller, 2013; Barbeau, 2009). This is important because the relationship with the 'non-offending' parent can be damaged through the experience of violence that has occurred, and having a strong caregiver-child relationship allows parents/caregivers to better care for their children, while giving young people the space to recover (Powell & Morrison, 2017; National Traumatic Stress Network, 2016; Graham-Bermann, Miller-Graff, Howell, & Grogan-Kaylor, 2015). Involving the 'non-offending' parent can happen through parallel groups (groups for parents that occur while the children attend separate groups) and/or through having individual counselling sessions with parents and children together (Tutty, LeDrew, & Abbott, 2008).

3) While TF-CBT does have a great deal of empirical support for its effectiveness in improving coping, there is also evidence that an approach that addresses children's **broader social environments** may be even more effective in treating their trauma symptoms. The approach, called **Trauma Systems Therapy**, focuses on two main components: a) improving children's abilities to **regulate their emotions and behaviours** when triggered by reminders of trauma; b) **stabilizing/enhancing their social environment** to make it more conducive to healing (e.g. addressing issues related to safe housing, poverty, access to quality education etc.) (Saxe, Ellis, & Brown, 2015). In an open trial of this approach, researchers found that, over 15 months of treatment, children were less **likely to require crisis stabilization and their functioning and emotional regulation were improved, as was the stability of their**

environments (Ellis at al., 2012; Saxe et al., 2005).

4) Another alternative to TF-CBT that has some empirical support in treating trauma in children under seven-years-old is **child-parent psychotherapy (CPP)** (Schneider, Grilli, & Schneider, 2013; Cohen, 2010; Lang, Ford, & Fitzgerald, 2010). CPP takes **parts of CBT**, combined with elements of the **psychodynamic approach**, and focuses on "modeling positive behaviors, helping parents interpret children's emotions and feelings, and learning to communicate effectively, correcting cognitive distortions, developing a new family narrative, and dealing with traumatic grief" (Lucio & Nelson, 2016, p. 473).

5) Regardless of the approach used, **completing a thorough assessment** is important so that children and youth can be **matched with an appropriate intensity and phase of treatment** (Social Policy Evaluation and Research Unit, 2017; Powell & Morrison, 2017; Bunston, Pavlidis, & Cartwright, 2016; Ellis et al., 2012; American Psychological Association, 2008). This is especially important for individual counselling, to **determine the frequency and type of counselling to be offered** (Barbeau, 2009; American Psychological Association, 2008). As part of the assessment, a child's **development stage** should be taken into account when determining what treatment intervention would be best suited (e.g. groups for younger children should be shorter in length to suit their attention spans) (Social Policy Evaluation and Research Unit, 2017; Listenbee et al., 2012; Burillo, 2011; Barbeau, 2009; Tutty, LeDrew, & Abbott, 2008).

6) Some practitioners argue that programs should adopt a **feminist perspective** when working on issues around intimate partner violence (Barbeau, 2009). They insist that this is important because it acknowledges **the role that mainstream gender roles and gendered power imbalances play in perpetuating violence** (Namy et al., 2017). If adopting a feminist approach, it would also be important to consider how gender intersects with other aspects of women's identities to shape their experiences of violence.

7) Some programs have found success in integrating **art and play as part of the therapeutic process** (Johal, 2017). The resource referenced here has lots of great ideas, templates, and activities (VIDEA, 2012). It should be noted that while using art and play may **help young people express their feelings and process their traumatic experiences and reactions**, studies that have investigated their effectiveness empirically have generally had small sample sizes and other limitations, meaning it is difficult to comment definitively on their impacts (Social Policy Evaluation and Research Unit, 2017; Powell & Morrison, 2017; Lucio & Nelson, 2016).

8) Evidence-based treatments designed to address exposure to violence should be **looked at critically** to ensure they are **culturally-safe** for participants (Poole, Talbot, & Nathoo, 2016; Klinic Community Health Centre, 2013), and **adapted to reflect cultural beliefs** and **practices** of participants if appropriate (Listenbee et al., 2012). Ideally, **cultural identity and practices** can be a source of **strength and resilience** for young people as they heal from trauma (DeBoard-Lucas, Wasserman, McAlister Groves, & Bair-Merritt, 2013). As in all clinical therapy, developing a **strong therapeutic relationship** between the clinician and the young person is critical. However, young people and families who come from marginalized communities may have hesitations about engaging in this type of relationship due to experiences of institutional racism in healthcare (and other) settings, and because clinicians may not have a solid understanding of the young person's context. The American Psychological Association (2008) suggests that offering **culturally-responsive** programs can help to address these challenges.

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