NCTSN The National Child Traumatic Stress Network

TST: Trauma Systems Therapy

GENERAL INFORMATION

Treatment Description

Acronym *(abbreviation)* **for intervention:** TST

Average length/number of sessions: Length varies by level of severity and phases of treatment administered. There are 3 phases of treatment in TST: Safety Focused Treatment, Regulation Focused Treatment, and Beyond Trauma Treatment. Length of treatment varies depending on which phase a child starts in (determined by the TST assessment process). Typical length of treatment is between 7 and 9 months.

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:**
The intervention includes a module, 'Ready set go' that specifically addresses strategies to engage both youth and caregivers by building a treatment alliance across different cultural perspectives and identifying treatment goals that are consistent with the families' view of what is most important to them. At the core of TST implementation is a multidisciplinary team that emphasizes the inclusion of community figures (such as teachers, spiritual leaders, community advocates, and case managers) in treatment planning. Because of this unique engagement strategy, TST is applicable across cultures.

TST has been adapted for use with several populations, including refugee and immigrant groups, substance abusing adolescents, medical trauma, school based treatments, foster care, and residential settings.

Trauma type *(primary)*: TST is applicable across all trauma types. It has most often been used with children and teens who have experienced complex, chronic traumatic events, in settings such as foster care, inpatient units, residential treatment, and with specialized populations such as refugees, and substance abusing adolescents.

Trauma type *(secondary)*: See above.

Additional descriptors *(not included above)***:** Trauma Systems Therapy is both a clinical model as well as an organizational model. TST is implemented within an organization to serve as a framework for organizing a multi-disciplinary team of providers from within and without an organization to coordinate their interventions. Providers are brought together to address the complex needs of traumatized youth and families using TST as an organizing model concern in the child's social environment. TST requires the ability to provide both office-based to both build awareness and regulation skills for youth, while also identifying areas of strength and psycho-therapy as well as home and community based interventions. TST utilizes a comprehensive assessment process that identifies patterns of links between triggering stimuli in the child's environment which lead to dysregulated emotions and behaviors which are related to the child's history of trauma. TST provides intensive training and technical assistance to organizations for a period of 1-2 years to help embed the model within organizational practice. A sustainability plan, including certification and a train the trainer process is included as well.

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Target Population	**Age range:** 5 **to** 21 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: Ethnic groups which have been treated with TST include refugees and recent immigrants (e.g. Somalia, Bhutan),multi-generation African Americans, multi-generation multinational Latinos, Caucasian. TST is being implemented in child welfare in the country of Singapore, which serves youth from multiple ethnic groups (Chinese, Indian, Malaysian) and religions (Buddhist, Christian, Muslim). TST is applicable across ethnic groups. **Other cultural characteristics** *(e.g., SES, religion)*: Not limited to, but has been used with Low SES, Muslim (e.g., Somalis) as well as youth in the child welfare system. **Language***(s)*: English, Spanish **Region** *(e.g., rural, urban)*: TST is being implemented in both urban & rural settings. **Other characteristics** *(not included above)*: TST is designed for children and adolescents who are prone to triggered patterns of survival in the moment states as a result of the interaction between their traumatic experience and current stressors in the social environment.
Essential Components	**Theoretical basis:** TST was inspired in part by Bronfenbrenner's social-ecological model (Bronfenbrenner, 1979), which acknowledges the complexity of the social environment that surrounds an individual, and how disruptions in one area of the social ecology may create problems in another. Interventions in TST are designed to work in two dimensions: strategies that operate through and in the social environment to promote change, and strategies that enhance the individual's capacity to self-regulate. The TST model involves choosing a series of interventions that correspond to the fit between the traumatized child's own emotional regulation capacities and the ability of the child's social environment and system-of-care to help him or her manage emotions or to protect him or her from threat. TST also includes regulation skill building, exposure therapy, and cognitive processing based on Cognitive Behavioral approaches. **Key components:** TST is designed to meet the needs of a "trauma system," which is defined as: a traumatized child who experiences survival in the moment states in specific definable moments, and a social environment and/or system of care that is not able to help the child to regulate these survival states or protect the child from harm. In this program, social context includes family, school, and neighborhood. Services are tailored to the needs of the trauma system by using a 3 X 3 matrix with ability of the social environment to meet the child's needs on one axis and the child's ability to regulate survival states on the other.

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Essential Components continued

The program has three phases: Safety Focused Treatment, Regulation Focused Treatment, and Beyond Trauma Treatment.

Each phase has two guides associated with it, which spell out the intervention process; one for providers to organize the treatment, and one to be used directly with youth and caregivers. Many of the interventions described in the guides have their own demonstrated efficacy.

TST treatment modalities include:

- Home and Community Based Services with specific intervention protocols
- Services Advocacy to ensure basic needs are met
- Emotional Regulation Skills Training
- Cognitive Processing
- Trauma narrative development and rescripting with modules for both single incident and chronic trauma
- Psychopharmacology

Clinical & Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ Yes ☒ No ❒ Uncertain

Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time)***.** 5

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ Yes ☒ No

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No**
Organizations implementing TST have reported decreases in the use of seclusion and restraint, decreased number of hospitalizations, decreased numbers of foster care placement disruptions, increased staff and foster parent satisfaction and retention, and improved emotional and behavioral regulation in children and teens.

Has this intervention been presented at scientific meetings? ☒ Yes ❒ No

If YES, please include citation*(s)* **from last five presentations:**
11/6/15 – 20th Annual Conference on Advancing School Mental Health, New Orleans, Louisiana – An Adaptation of Trauma Systems Therapy in a Public School Setting – Adam Brown, Lisa Baron

10/16/15 – 5th Annual D.C. Evidence Based Summit, Washington, D.C. – Trauma Systems Therapy – Susan Hansen

10/27/15 -American Academy of Child and Adolescent Psychiatry 62nd Annual Meeting, San Antonio, Texas – Using Trauma Systems Therapy to Decrease Use of Medication for Children in Foster Care – Glenn Saxe

Clinical & Anecdotal Evidence continued

11/5/14 – International Society for Traumatic Stress Studies, 30th Annual Meeting, Miami, Florida – Four Leading Model Developers Address Complex Case Material and Real World Implementation Issues- Adam Brown, Glenn Saxe, Anthony Mannarino, Julian Ford, Margaret Blaustein

11/8/14 - International Society for Traumatic Stress Studies, 30th Annual Meeting, Miami, Florida – The Trauma Systems Therapy Innovation Community – Adam Brown, Glenn Saxe, Kelly McCauley, Lisa Baron

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:

Saxe, G.N., Ellis, B.H & Brown, A.B. (2015). Trauma Systems Therapy for Traumatized Children and Teens, 2nd edition. New York, New York: Guilford Press

Navalta, C.P., Brown, A.D., Nisewaner, A., Ellis, H.B., & Saxe, G.N. (2013). Trauma Systems Therapy. In J.D. Ford, & C.A. Courtois (Eds.), *Treating Complex Traumatic Stress Disorder in Children and Adolescents: Scientific Foundations and Therapeutic Models* (pp. 329- 347). New York, NY: Guilford Press.

Brown, A.D., Navalta, C.P., Tullberg, E., & Saxe, G.N. (2014). Trauma Systems Therapy: An Approach To Creating Trauma-Informed Child Welfare Systems. In Reece, R., Hanson, R. & Sargent, J. (Eds.) Child Abuse Treatment: Common Ground for Mental Health, Medical and Legal Professionals second edition. Johns Hopkins University Press.

Brown, A.D., McCauley, K., Navalta, C.P., & Saxe, G.N. (2013). Trauma Systems Therapy for children in residential care: Improving Emotion Regulation and the Social Environment of Traumatized Children and Youth in Congregate Care. *Journal of Family Violence, 28*, 693-703.

Has the intervention been replicated anywhere? ☒ Yes ❒ No

Other clinical and/or anecdotal evidence *(not included above)*:

In pilot RCT of TST vs. Care as Usual we found that at 3 month follow-up all 10 TST individuals remained in treatment while only 1 Care as Usual case remained in treatment. This suggests that TST may be more effective than usual care in engaging families in treatment.

At 15 month follow up of the above study, children who were able to transition from crisis-stabilization to office-based services during early treatment tended to stay in treatment and improve through late treatment. For the 72% of youth who completed treatment, the need for crisis-stabilization services at 15 months was reduced by over 50%. Compared to children served prior to the implementation of TST, hospitalization rates were 36% lower and the average length of stay was 23% lower (Ellis, B. H., Fogler, J., Hansen, S., Beckman, M., Forbes, P., Navalta, C. 2011).

In a small, randomized controlled trial of traumatized youth (N=20), 90% of TST participants were still in treatment whereas only 10% of “treatment as usual” participants remained at the three-month assessment (Saxe, Ellis, Fogler, & Navalta, 2011).

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Clinical & Anecdotal Evidence continued	In a study of TST implementation in a 20 bed intensive residential program in Boston, the use of seclusion and physical restraint significantly decreased, a result which was sustained over time, and which, importantly, was not accompanied by an increase in staff or child assaults (Brown, A.D., McCauley, K., Navalta, C.P., & Saxe, G.N., 2013). In a study of TST implementation in a residential treatment program in Kansas, a significant drop in levels of functional impairment as measured by the CAFAS in all eight domains was demonstrated, with an average exit score of 56 by the end of the first year of TST (versus an average exit score of 120 for a pre-TST 2008 comparison group). Significant reductions in the use of seclusion and restraint were seen in this setting as well. In as foster care setting in Kansas, a significant improvement in placement stability was demonstrated in foster and kinship homes after TST implementation, with an average of 1.4 placement moves after implementation, as compared to an average of 3.4 placement moves prior to implementing TST (Brown, A.D., McCauley, K., Navalta, C.P., & Saxe, G.N.,2013).	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**110 **By other cultural factors:** Rural and Urban	Ellis, B. H., Fogler, J., Hansen, S., Beckman, M., Forbes, P., Navalta, C. 2011.
Randomized Controlled Trials	**N=**20 **By other cultural factors:** African American, Caucasian and Hispanic clients	Saxe, Ellis, Fogler, & Navalta, 2011
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** TST has a defined assessment and treatment planning process fully embedded in the model. Thera are accompanying forms to facilitate these processes. There is also a package of assessment tools to support research and program evaluation. These measures are designed to be free, simple and quick to administer and interpret. Included are two measues designed by the model developers: the Child Stress Disorders Checklist and the Child Ecology Check In, as well as the Pediatric Symptom Checklist. In addition, we have created a web-based system to support all data collection and tracking within programs implementing TST. **If research studies have been conducted, what were the outcomes?** An open trial with 110 families produced reduction of traumatic stress symptoms and decrease in family and school related problems over three months.	

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Implementation Requirements & Readiness	**Space, materials or equipment requirements?** In order to implement TST, 4 types of services must be available on the team: skill-based psychotherapy, home and community-based therapy, legal advocacy, and psychopharmacology. These four elements can be assembled creatively out of resources available in a particular community. **Supervision requirements** *(e.g., review of taped sessions)***?** Not required, although treatment fidelity can be monitored through consultant review of paperwork and participation in team meetings via teleconference. Typically clinicians receive individual supervision as well as group supervision through a weekly team meeting. **To ensure successful implementation, support should be obtained from:** Because TST requires a system shift for most agencies, support must be obtained from agency leadership and is typically supported by ongoing consultation from the TST Development team.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Saxe, G.N., Ellis, B.H & Brown, A.D.. (2015). Trauma Systems Therapy for Traumatized Children and Teens, 2nd edition. New York, New York: Guilford Press Available from Amazon.com, Guilford Press, and other major book sellers. **How/where is training obtained?** Training is currently available from the TST Development team through individual agency contracts in addition to current grant supported projects through SAMHSA and ACYF. **What is the cost of training?** Variable **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** Our treatment manual, Trauma Systems Therapy for Children and Teens, has been translated into Korean and Armenian.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** This intervention is designed to address some of the 'real world' problems that have typically been barriers to treatment engagement and/or implementation of EBP. For instance, this treatment provides a specific module on treatment engagement that addresses practical barriers and cultural barriers. In addition, this treatment specifically addresses social environmental issues that are contributing to traumatic stress symptomatology, such as living in substandard housing, poverty, and immigration status. A module called Services Advocacy specifically details how to incorporate legal advocacy into treatment in ways that specifically address social environmental issues that are affecting mental health. Thus, this treatment is particularly useful for families who face barriers to treatment engagement, who experience social environmental problems, and who may have experienced more than one traumatic event.

Pros & Cons/ Qualitative Impressions continued	**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Treatment is phase-based, thus for acutely symptomatic children treatment may last 7-9 months. Treatment requires an interdisciplinary team, which agencies will need to assemble through various funding sources. TST was specifically designed to be possible with existing funding sources (e.g., not grant funded, paid for through 3rd party payees or other existing services)–nonetheless, for agencies new to TST they will need to examine existing resources within their community and assemble an interdisciplinary team based on what is available. TST utilizes an organizational planning process to help with this.
Contact Information	**Name:** Glenn Saxe, MD **Address:** Child Study Center at NYU Langone Medical Center 1 Park Ave, NYC 10016 **Email:** glenn.saxe@nyumc.org
References	Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist, 34*, 844-850. Brown, A.D., McCauley, K., Navalta, C.P., & Saxe, G.N. (2013). Trauma Systems Therapy for children in residential care: Improving Emotion Regulation and the Social Environment of Traumatized Children and Youth in Congregate Care. *Journal of Family Violence, 28*, 693-703 Brown, A.D., Navalta, C.P., Tullberg, E., & Saxe, G.N. (2014). Trauma Systems Therapy: An Approach To Creating Trauma-Informed Child Welfare Systems. In Reece, R., Hanson, R. & Sargent, J. (Eds.) Child Abuse Treatment: Common Ground for Mental Health, Medical and Legal Professionals second edition. Johns Hopkins University Press. Ellis, B. H., Fogler, J., Hansen, S., Beckman, M., Forbes, P., Navalta, C. P. (2011, August 22). Trauma Systems Therapy: 15-Month outcomes and the importance of effecting environmental change. *Psychological Trauma: Theory, Research, Practice, and Policy*, Advance online publication. doi: 10.1037/a0025192. Navalta, C.P., Brown, A.D., Nisewaner, A., Ellis, H.B., & Saxe, G.N. (2013). Trauma Systems Therapy. In J.D. Ford, & C.A. Courtois (Eds.), *Treating Complex Traumatic Stress Disorder in Children and Adolescents: Scientific Foundations and Therapeutic Models* (pp. 329- 347). New York, NY: Guilford Press. Saxe, G. N., Ellis, B. H. & Fogler, J. (2005). Comprehensive care for traumatized children: An open trial examines Trauma Systems Therapy. *Psychiatric Annals, 35*(5), 443-448. Saxe, G. N., Ellis, B. H., Fogler, J., & Navalta, C. P. (2011). Preliminary evidence for effective family engagement in treatment for child traumatic stress: Trauma systems therapy approach to preventing dropout. *Child and Adolescent Mental Health, doi: 10.1111/j.1475-3588.2011.00626.x.* Saxe, G. N., Ellis, B. H. & Kaplow, J. (2006, October). *Collaborative care for traumatized children and teens: The Trauma Systems Therapy approach*. Guilford Press, NY. Saxe, G.N., Ellis, B.H. & Brown, A.D. (2015) Trauma Systems Therapy for Children and Teens: 2nd edition. Guilford Press, NY