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. The Surviving phase (indicated for most acutely symptomatic children), for example, averages three months in length. A child starting at this phase may be in the program for 12 months with the duration of services reduced based on placement at assessment in later phases.

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 treatment barriers. Examples of barriers to be addressed include language barriers and transportation barriers. In addition, this module (which can be viewed as a treatment-engagement module) specifically addresses building a treatment alliance across different cultural perspectives and identifying treatment goals that are consistent with the families' views of what is most important. At the core of TST implementation lays a multidisciplinary team that emphasizes the inclusion of community figures (such as teachers, spiritual leaders, community advocates, and case managers) in the treatment planning. TST has been adapted for use with several populations, including refugee and immigrant groups, substance abusing adolescents, medical trauma and pediatric settings, school based treatments, and residential settings.

Trauma type *(primary)*: Various

Trauma type *(secondary)*: Various

Additional descriptors *(not included above)***:** TST is not limited to one specific trauma type. Children that have participated in the program have experienced a wide range of traumas, such as domestic violence, physical abuse, sexual abuse, exposure to war, and medical trauma. Many of the children who have received TST experienced multiple traumas. In addition, TST specifically addresses social-environmental factors that compound the problems associated with trauma exposure, such as poverty or inappropriate school placements.

Target Population

Age range: 6 **to** 19

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 treated with TST include refugees and recent immigrants (Somalia, Nigeria, Liberia, Sierra Leone, Uganda, Mexico, Guatemala, Honduras), multigeneration African Americans, multigeneration multinational Latinos, Caucasian.

Other cultural characteristics *(e.g., SES, religion)***:** Not limited to, but has been used with Low SES, Muslim (e.g., Somalis).

Language*(s)***:** English, Spanish

Target Population continued	**Region** *(e.g., rural, urban)*: TST has been used in both urban & rural settings **Other characteristics** *(not included above)*: TST is targeted at children and adolescents who are having difficulty regulating their emotions as a result of the interaction between the traumatic experience and 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. **Key components:** Trauma Systems Therapy can be seen as a framework for organizing a series of empirically validated interventions to address the real-world needs of children facing considerable adversity. It is designed to help children and families where there is ongoing stress in the social environment. Traumatic stress and the intervention involve two elements: • a child with difficulty regulating his or her emotional state, and • a system of care that cannot effectively regulate the child's response to his or her social environment. In this program, social context includes family, school, and neighborhood. Services are tailored to the child/family using a 3 X 3 matrix with stability of social environment on one axis and the child's ability to regulate emotions on the other. The program has up to five phases: Surviving, Stabilizing, Enduring, Understanding, Transcending. The phase is chosen depending on the degree to which the child can regulate emotional behavioral responses and whether the social environment is stable, distressed, or threatening. Within each phase there are prescribed treatment modules, many of which have their own demonstrated efficacy. These treatment modules include: • Home and Community Based Services • Services Advocacy • Emotional Regulation Skills Training • Cognitive Processing • Psychopharmacology

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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)*. 4

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**

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

If YES, please include citation*(s)* **from last five presentations:**
International Society for Traumatic Stress Studies (ISTSS): Ellis, Saxe & Hansen, 2005

American Psychological Association (APA): Casey, Saxe, Ellis, Rubin & Allee, 2005

Boston University Trauma Conference: Saxe & Ellis, 2005; Saxe, Ellis & Kaplow, 2004

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, Ellis & Fogler, 2005

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.

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	
Randomized Controlled Trials	**N=**20 **By other cultural factors:** African American, Caucasian and Hispanic clients	
Studies Describing Modifications	**N=**Ongoing open trial of Substance Abuse Adaptation	

Research Evidence continued	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Other Research Evidence	**By other cultural factors:** Cognitive Processing module is an adapation of TF-CBT.	

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?
TSCC, PTSD RI, TST Weekly Check-In (9-point rating scale, adolescent self-report, assessing subjective sense of emotional regulation, behavioral regulation, traumatic reminders, and social environmental strengths/support).

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.

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 videotaping of team meetings. 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.

Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.
Saxe, Ellis & Kaplow, 2006. Available from Amazon.com, Guilford Press, Barnes and Noble bookstores and other major book sellers.

How/where is training obtained?
Training is currently available through individual agency contracts.

What is the cost of training? Variable

Are intervention materials *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No**

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.

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 a long time (e.g., one year). 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.

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References

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Ellis, B. H. (2004, October). *Trauma Systems Therapy for refugees.* Paper presented at the International Conference, Anthropology and Health: Cross-Cultural Aspects of Mental Health and Psychosocial Well-Being in Immigrant/Refugee Adolescents. Hvar, Croatia.

Ellis, B. Heidi, Saxe, G. & Hansen, S. (2005, November). *Trauma Systems Therapy: Dissemination and implementation in two settings.* Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, Toronto, Canada.

Saxe, G. & Ellis, B. H. (2005, June). *Comprehensive care for traumatized children: Trauma Systems Therapy.* Paper presented at the annual Boston University Trauma Conference, Boston, MA.

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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., Ellis, B. H. & Kaplow, J. (2004, June). *Treating child traumatic stress: Self regulation and the social environment.* Paper presented at annual Boston University Trauma Conference, Psychological Trauma: Maturational Processes and Therapeutic Interventions. Boston, MA.

Saxe, G. N., Ellis, B. H. & Kaplow, J. (2006, October). *Collaborative care for traumatized children and teens: A Trauma Systems Therapy approach.* Guilford Press, NY.