Recommendations to Reduce Psychological Harm from Traumatic Events Among Children and Adolescents

Task Force on Community Preventive Services

Introduction

Exposure to traumatic events such as physical abuse, sexual abuse, witnessing domestic violence, community violence, and natural disasters is a common occurrence among children in the U.S.[1,2] According to a nationally representative sample of children aged 2–17 years, surveyed at the end of 2002 and early in 2003, one in eight children experienced a form of child maltreatment, one in 12 experienced sexual victimization, and more than one in three witnessed violence or experienced another form of indirect victimization.[1] The psychological harms that may result from exposure to such traumatic events include post-traumatic stress disorder (PTSD) and PTSD symptoms, depressive disorders and symptoms, externalizing behaviors, internalizing behaviors, suicidal ideation, and complicated grief. Traumatic exposures may lead to other health consequences as well, including risk-taking behavior and chronic physical disorders.[3,4]

The reduction of psychological harm caused by exposure to traumatic events is thus a critical goal of public health. This report provides conclusions on the effectiveness of seven approaches to reducing the psychological harm that children and adolescents may experience following traumatic exposures, including intentional events such as sexual abuse and terrorist attacks, and unintentional events such as vehicle crashes and hurricanes.

The recommendations in this report represent the work of the Task Force on Community Preventive Services (the Task Force). The Task Force, an independent, nonfederal group, is developing the *Guide to Community Preventive Services* (*Community Guide*) with the support of the U.S. Department of Health and Human Services (USDHHS) in collaboration with public and private partners. Although CDC provides staff support to the Task Force for development of the *Community Guide*, the recommendations presented in this report were developed by the Task Force and are not necessarily the recommendations of CDC, USDHHS, or collaborating agencies or partners. The specific methods for and results of the reviews of evidence on which these recommendations are based are provided in the accompanying article.[5] The methods for conducting evidence reviews and translating the evidence on effectiveness into recommendations for the *Community Guide* have been previously published.[6]

Information from Other Advisory Groups

The findings of this report coincide with the conclusions of other agencies, but some agencies also recommend interventions whose effectiveness we were not able to prove. The National Center for Post-Traumatic Stress Disorder (NCPTSD) supports the use of certain interventions to treat children with PTSD.[7] According to the NCPTSD, the majority of studies have found that cognitive–behavioral therapy (CBT) is safe and effective to use for children with PTSD, and play therapy can be used to treat young children with PTSD, because young children are not able to deal with the trauma more directly. However, as is done here, NCPTSD cautions that the lack of research precludes an evaluation of the effectiveness of pharmacologic therapies.[7] The American Academy of Child and Adolescent Psychiatry recommends psycho-education and trauma-focused therapy, including cognitive behavioral techniques, among other interventions for children with PTSD.[8] Similarly, the National Institute of Mental Health (NIMH) reports that CBT has been shown effective for children and adolescents suffering from PTSD.[9] NIMH also suggests that play and art therapy may be helpful, particularly for younger children with PTSD.

In 2001, the U.S. Departments of Defense, Justice, and Health and Human Services (NIMH); Veterans Affairs (including the National Center for PTSD); and the American Red Cross jointly held a conference on early interventions (<1 month after trauma) for child and adult victims and survivors of mass violence. The consensus was that early interventions, administered quickly and appropriately, can be helpful.[10] Workshop participants agreed that cognitive behavioral approaches can reduce the incidence, duration, and severity of acute stress disorder, PTSD, and depression in trauma survivors. In addition, as is done here, they cautioned that there was "evidence suggesting that early intervention in the form of a single one-on-one recital of events and expression of emotions

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evoked by a traumatic event (as advocated in some forms of psychological debriefing) does not consistently reduce risks of later developing PTSD or related adjustment difficulties."[10] Workshop participants further noted that these particular early interventions (e.g., psychological debriefing) may place survivors at heightened risk for adverse outcomes. The WHO also recommends against the use of psychological debriefing in the treatment of survivors of disaster and war.[11]

Intervention Recommendations

Individual CBT: Recommended

Trauma-focused, individual CBT was developed to alleviate symptoms of PTSD, depression, and anxiety symptoms, as well as to address fundamental distortions of perception regarding self-blame, safety, and the trustworthiness of others.[12] On the basis of strong evidence of effectiveness, the Task Force recommends the use of individual CBT to reduce psychological harm in symptomatic children and adolescents exposed to trauma. In the systematic review on which this conclusion is based,[5] individual CBT was offered to traumatized children and adolescents of varying ages, geographic locations, and subject to diverse traumatic exposures; the Task Force was unable to assess the relative effectiveness of individual CBT across these dimensions.

Group CBT: Recommended

Like individual CBT, group CBT is frequently used to reduce psychological harm in children exposed to trauma. On the basis of strong evidence of effectiveness, the Task Force recommends the use of group CBT to prevent psychological harm in symptomatic children and adolescents exposed to trauma. In the systematic review on which this conclusion is based,[5] group CBT was offered to children and adolescents of varying ages and geographic locations, and exposed to various traumas; the Task Force was unable to assess the relative effectiveness of group CBT across these dimensions.

Play Therapy: Insufficient Evidence to Determine Effectiveness

Play therapy has been used as a means to enhance communication about and facilitate the resolution of trauma-related issues for child crime victims.[13] The Task Force found insufficient evidence to determine the effectiveness of play therapy in reducing psychological harm in children and adolescents because of substantial heterogeneity in the body of evidence, particularly in the intervention format.

Art Therapy: Insufficient Evidence to Determine Effectiveness

Art therapy has been proposed as an indicator of a child's mental processing and as a means of resolving traumatizing exposures.[14] The Task Force found insufficient evidence to determine the effectiveness of art therapy in reducing psychological harm in children and adolescents, because only one study of fair quality of execution was found.

Psychological Debriefing: Insufficient Evidence to Determine Effectiveness

Psychological debriefing, also known as critical-incident stress management, is intended to be a group meeting offered shortly after a traumatic event for the purpose of preventing the development of adverse reactions.[15,16] The Task Force found insufficient evidence to determine the effectiveness of psychological debriefing in reducing psychological harm in children and adolescents, because only one study of good quality of execution was found and suggested no effect.

Psychodynamic Therapy: Insufficient Evidence to Determine Effectiveness

The goal of psychodynamic therapy is to allow a traumatized individual to review unconscious thoughts and emotions and to integrate the traumatic event into a revised understanding of life.[17] The Task Force found insufficient evidence to determine the effectiveness of psychodynamic therapy in reducing psychological harm in children and adolescents because only one qualifying study of greatest design suitability and fair execution was identified.

Pharmacologic Therapy: Insufficient Evidence to Determine Effectiveness

The intent of pharmacologic therapy is to focus on disabling the symptoms that follow trauma, so that a traumatized child is able to pursue a normal developmental pattern and to increase tolerance to emotionally distressing material and work through such distress.[18] The Task Force found insufficient evidence to determine the effectiveness of pharmacological therapy in reducing psychological harm in children and adolescents because there were too few studies and the effects assessed were short-lived.

Additional *Community Guide* Violence-Related Reviews

The Task Force has previously reviewed and published evidence on the effectiveness of early childhood home visitation, firearms laws, and therapeutic foster care for the prevention of violence, with a focus on juvenile violence.[19-21] Systematic reviews also have been recently

published on the effectiveness of school-based programs for the prevention of juvenile violence and on the consequences, in terms of violent outcomes, of laws facilitating the transfer of juveniles from the juvenile to the adult justice system.[22,23] The present review focuses on treating the consequences of victimization by violence and other events; however, insofar as untreated traumatic exposure is a risk factor for future violence, this review might also be regarded as relevant to violence prevention.

Interpreting and Using the Recommendations

This report summarizes the findings of systematic reviews of the effects of seven therapies to reduce psychological harm in children and adolescents who have been exposed to a traumatic event. Given that traumatic exposure in youth is widespread and causes considerable morbidity in the U.S., the findings and recommendations in this report should be relevant to public health professionals and practitioners who implement these therapies and to public health personnel preparing for and responding to traumatic events. Recommendations from the Task Force can assist a variety of audiences, including psychologists, social workers, public health workers, educators, and others responsible for improving the health and well-being of youth. Insofar as psychologists, social workers, and other providers are interested in reducing psychological harm in youth exposed to traumatic events, the evidence provided in this review may serve as a guide to promising therapies. Those responsible for the training of mental health professionals should also consider a focus on evidence-based practices in training curricula. Given the large incidence of traumatic exposures among children and adolescents in the U.S. and around the world, the need to disseminate and use evidence-based recommendations is urgent.

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