
GUIDELINE 2

Acute Interventions for Children and Adolescents

Description

Over the past several decades, there have been a variety of acute interventions for children and adolescents after traumatic experiences. Acute interventions comprise those provided in the first 6 weeks after exposure. Such strategies have included psychoeducation; bereavement support; various forms of psychological debriefing; eye movement desensitization and reprocessing (EMDR), clarification of cognitive distortions; discussion of thoughts and feelings; reinforcement of adaptive coping and safety behaviors, and use of support systems; structured and unstructured art and play activities; and massage. Interventions have been delivered in a variety of modalities, including individual, group, and classroom sessions; community-based programs; crisis intervention groups; psychoeducational materials; and crisis hotlines.

General Strength of the Evidence

There is a paucity of evidence regarding the effectiveness of acute posttrauma interventions for children and adolescents. Much of the material describing these efforts has not been published in mainstream psychological and psychiatric journals, but in journals devoted to other disciplines that have less stringent standards for methodological rigor. In addition, the majority of these reports provide only anecdotal findings; relatively few have used randomized designs with adequate control groups. Most studies to date have suffered from small sample size, lack of adequate control/comparison groups, and absence of long-term follow-up. Whereas some studies have geared evalu-

ation metrics to specific intervention objectives, others have used available child or adolescent measures. Such standardized instruments may not be adequately sensitive in detecting the benefits of the intervention, especially if these domains are not intervention targets. Another problem is the time variability posttrauma in which the intervention is delivered, making cross-study comparisons difficult.

Systemic Approaches

Systemic approaches have included psychoeducation; consultation with school personnel, media, and parents; crisis hotlines; and community-based programs. The overall evidence regarding the benefits of these types of interventions falls within the Agency for Health Care Policy and Research (AHCPR) Level C category. The most comprehensive study documented the benefits of community-based services in four areas, including program responsiveness, visibility of staff, responsiveness to ethnic differences, and overall quality of the program. This type of community approach holds great promise, but more rigorous quantitative studies with appropriate controls are needed.

Art and Massage Therapies

One art therapy study (AHCPR Level A) showed no statistically significant differences between experimental and control groups. Due to lack of dose of exposure methodology, it is difficult to determine whether there were potential benefits of the intervention associated with different levels of trauma. Future studies need to use exposure groups in analyzing findings. In regard to massage therapy, one study meeting AHCPR Level A criteria demonstrated potential benefits in a number of outcome domains but did not evaluate PTSD postintervention. Future studies in this area need to examine the benefits of this type of therapy in regard to amelioration of PTSD.

Eye Movement Desensitization and Reprocessing

A variety of EMDR protocols or adaptations have been studied in the acute aftermath of trauma. EMDR treatment includes eight phases: history taking, preparation, assessment of a traumatic memory, desensitization, strengthening positive responses to traumatic memories and reminders, body scan for somatic symptoms, closure, and reassessment. Variability in the duration of EMDR interventions studied posttrauma has included interventions that have been provided during the acute phase and those that have been continued up to 1 year posttrauma (AHCPR Level B). As components of EMDR overlap with those that have been incorporated in many other approaches, future studies need to identify the active ingredients specific to this promising approach.

Debriefing

Three studies have examined the effectiveness of various forms of debriefing in children and adolescents after different types of trauma (AHCPR Levels A and B). Current evidence suggests that debriefing cannot effectively prevent the subsequent development of PTSD or other anxiety disorders in traumatized children and adolescents. Although these studies have combined debriefing with other acute interventions, and have differed in timing, debriefing is not recommended at this time.

Cognitive-Behavioral Approaches

Many clinicians are familiar with and have utilized cognitive-behavioral approaches in acute settings. Although these approaches have been found to be effective in longer-term treatment outcome studies of traumatized children and adolescents, no studies in the acute aftermath have formally evaluated outcome (AHCPR Level C). This approach holds great promise; however, more studies are needed in order to determine the effectiveness and optimal timing of cognitive-behavioral approaches.

Psychological First Aid

Psychological first aid (PFA) approaches include many of the intervention strategies that comprise other acute intervention protocols for children and adolescents. PFA allows tailoring of these interventions to meet the specific needs of children and families. In addition, many of the PFA recommendations are supported by a vast literature on the utility of enhancing coping, social support, and problem solving, and have been informed by clinicians with extensive experience. Although PFA has not yet been systematically studied, one PFA field operations guide has been based on years of experience in providing acute assistance to traumatized children and families, and has been found to be acceptable to and well received by consumers (AHCPR Level C). Establishing the evidence base for PFA approaches will require standardized protocols and trainings, documentation of fidelity, rigorous outcome evaluation, and longitudinal studies that document course of recovery.

Course of Treatment

There are currently no definitive data regarding the optimal length or timing of acute interventions for traumatized children and adolescents. The optimal length of intervention will likely vary broadly depending on the degree of exposure and loss, and severity of posttrauma adversity and distress. These factors make it difficult to identify a potentially optimal length of intervention that would fit across differentially affected individuals. In response to

these considerations, more recent efforts have focused on tailoring flexible acute interventions to meet the specific needs of affected children and adolescents.

Recommendations

Given the current state of knowledge, a good deal more research on the effectiveness of acute interventions for children and adolescents impacted by a traumatic event is needed, thus precluding any definitive recommendations regarding intervention selection or timing. Five major categories of acute interventions have been used.

Summary

There are many gaps in our knowledge about providing optimal assistance to children and adolescents in the acute aftermath of trauma. There is a great need for both program evaluation and randomized controlled trials to examine the effectiveness of acute interventions across trauma types, age ranges, cultural groups, and different settings. In reviewing the literature, it is apparent that many studies have not utilized strict protocols or adhered to intervention guidelines. Future research needs to examine the optimal timing of acute interventions and the possible differential effectiveness of intervention strategies for differentially affected subpopulations.

Suggested Readings

- Bisson, J. I., & Cohen, J. A. (2006). Disseminating early interventions following trauma. *Journal of Traumatic Stress, 19*, 583–595.
- Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek J., Steinberg, S., et al. (2006). *Psychological first aid: Field operations guide, second edition*. Washington, DC: National Child Traumatic Stress Network and National Center for PTSD. Available at www.nctsn.org and www.ncptsd.va.gov
- McNally, R. J., Bryant, R. A., & Ehlers, A. (2003). Does early psychological intervention promote recovery from posttraumatic stress? *Psychological Science in the Public Interest, 4*, 45–79.
- Stallard, P., Velleman, R., Salter, E., Howse, I., Yule, W., & Taylor, G. (2006). A randomised controlled trial to determine the effectiveness of an early psychological intervention with children involved in road traffic accidents. *Journal of Child Psychology and Psychiatry, and Applied Disciplines, 47*, 127–134.