The doctor will not see you now: therapist-light therapy for PTSD in children as the way ahead?

Commentary on:

"Stepped care versus standard trauma-focused cognitive behavioral therapy for young children"

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Abstract:

Salloum and colleagues have presented data in support of a novel and cost-effective approach to the treatment of PTSD in young children. In this commentary I outline an argument for why their stepped-care model may be an important change to how psychological therapies for trauma-exposed youth are delivered, and propose further caveats that need to be addressed in future research.

There is a mild paradox inherent in most psychotherapies that have been found to efficacious for post-traumatic stress disorder (PTSD) in children and adolescents. Such therapies typically start with psychoeducation about the condition. Having stressed at great length how normal it is to experience symptoms of post-traumatic stress – how such phenomena are merely the body's natural and carefully evolved response to major, life-threatening stressors, and so on – the clinician will then proceed to make the case for sticking with the abnormal experience of undertaking months of one-to-one therapy with a complete stranger in an alien environment, and (as if that was not enough) extra homework.

Now, the clinician encouraging a young person and their family to undertake such a course of a treatment would be doing the right thing, given what we currently know about treatment for PTSD and other trauma-related psychopathology in youth. Left untreated, significant post-traumatic stress may persist for decades and have a major impact on functioning in adulthood. Multiple-session, cognitive and behaviourally-informed individual psychotherapies (notably the trauma-focused cognitive behavioural therapy devised by Judith Cohen and colleagues) are efficacious interventions for these post-traumatic stress in children and adolescents (Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2012; Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013). But could the whole process be more de-stigmatising, accessible, and cheap?

In their evaluation of a novel treatment approach for post-traumatic stress in young children, Salloum and colleagues have produced a paper that is innovative in three important ways. Firstly, the nature of their experimental intervention – stepped-care trauma-focused cognitive behavioural therapy (SC-TF-CBT), an approach that starts with only three in-office therapist-led sessions and

leads on to further parent-led work undertaken at home – is a far less intrusive experience than extant evidence-supported therapies for PTSD in youth (typically requiring at least eight individual sessions, and sometimes many more). SC-TF-CBT remains informed by robust cognitive- and behaviourally-informed theory, and includes demanding elements postulated to be central to treatment success, e.g. imaginal exposure. This is a significant and important departure from previous treatment trials for post-traumatic stress in youth. This treatment model more radically places control and responsibility into the hands of parents and caregivers, but appropriately equips them to undertake their role as "therapists". This approach appears inherently more normalising that current widely used and validated treatments, with the family unit supported in handling the experience of trauma on their terms to a great extent. That this approach (which involves escalating to more individual sessions if required) was no less efficacious than a full therapist-led course of individual trauma-focused cognitive behavioural therapy (TF-CBT) is genuinely exciting.

Secondly, this is (to my knowledge at least) the first clinical trial of an intervention for PTSD in youth to include an economic evaluation. This is very encouraging for the field – having established that it is possible to treat PTSD with a good degree of success, research is moving towards establishing the most cost-effective forms of intervention. The addition of this component to this trial makes the findings all the more noteworthy, especially for those whose role it is to consider how mental health care for trauma-exposed youth is to be implemented in real world settings.

Thirdly, this trial has paid careful attention to the issue of acceptability. Parent/caregiver assessment of treatment credibility and satisfaction were assessed, and complete the case for SC-TF-CBT: the prospect of undertaking a trauma-focused course of psychotherapy without the direct weekly involvement of a therapist external to the family unit was no less than acceptable than having that more intensive intervention throughout. That parents and carers of trauma-exposed youth are open to non-typical forms of psychotherapeutic intervention is very encouraging for future treatment innovation in this area.

Recent epidemiological surveys suggest that trauma exposure is a widespread feature of childhood and adolescence, and certainly not "lightning strike" experiences. Tackling the mental health consequences of these experiences is therefore an important public health question. Offering individual psychotherapy for PTSD – however efficacious this intervention might be – is likely to be simply too expensive for many (if not most) mental health services. The emergence of a stepped care approach is an important step towards the wider availability of cost-effective, evidence-based care.

The advantages of this form of treatment delivery may go beyond straight-forward cost-effectiveness, as important as this is. SC-TF-CBT allows for families to dip their toe in the waters of child mental health services. As a means of engaging families who might fear having their lives (and parenting) picked over and prodded, SC-TF-CBT offers a brief and circumscribed period of therapist contact that may be easier to stomach. The opportunity to take greater ownership of treatment – and any resultant gains – may promote a greater sense of mastery for family members; this may be an important source of resilience, given the potential for future trauma exposure.

There are caveats with a stepped-care approach. Salloum and colleagues have focused on young children, and further trials are need to establish whether SC-TF-CBT may be feasible and efficacious with older children and adolescents. Parents may be appropriate "therapists" with young children, but this may be less acceptable to older youth; guided self-help may be the more appropriate "first step" for this population. Translating these promising findings to older youth also raises the question of what should be promoted as the essential ingredients for psychological intervention for PTSD. A dismantling study of TF-CBT for younger children suggest that developing a trauma narrative is important (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011), while studies in older youth suggest that changes in trauma-related appraisals mediate treatment responsiveness (Smith et al., 2007). Further work is needed to clarify the situations where children may need to be "fast-tracked" to therapist-led work. In particular, the demands placed on parents in delivering therapy (who, as

Salloum and colleagues have helpfully documented, frequently have their own significant mental health difficulties, including PTSD) may require further consideration. Is taking such an active role in their child's treatment a major additional stressor for parents and caregivers, or beneficial?

More research is needed, but it is exciting that new avenues of investigation into treatment delivery will open up as a result of this study.

References

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