A Trauma-Informed Approach to the Unified Protocol for Children with Exposure to Child Maltreatment

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I receive a royalty from the sales of the therapist guide and workbooks for the *Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents* (UP-C and UP-A).

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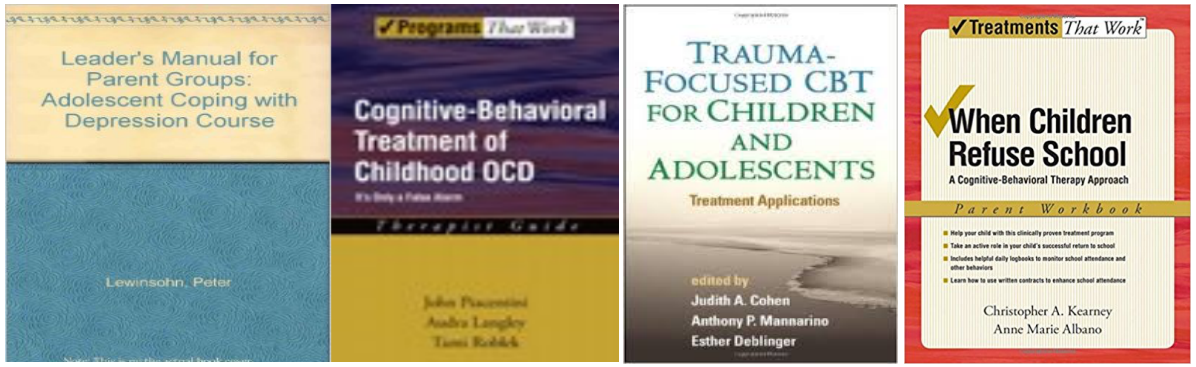
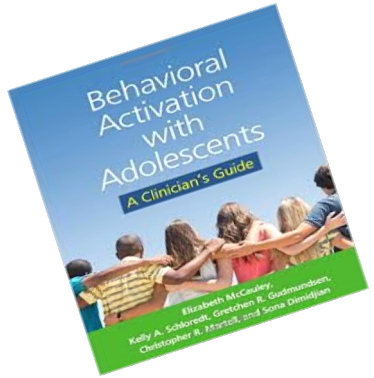
Overview

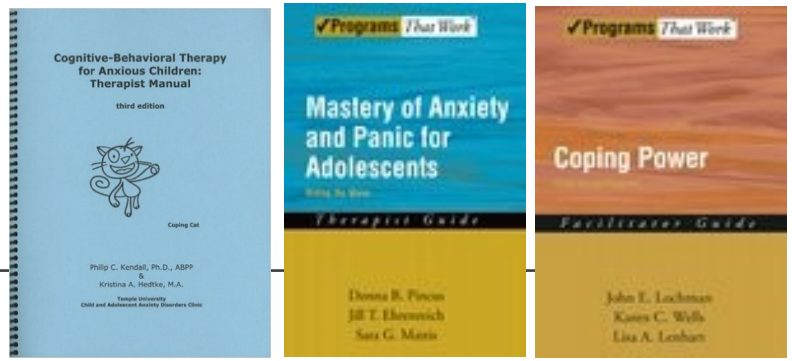
- Rationale for the Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C and UP-A)
- Research on the UP models, with emphasis on limited findings for trauma and PTSD
- Possible modifications of the UP when applied in child maltreatment settings
- Example: Application of the UP-C within a trauma-informed, campus-based program for youth with a history of maltreatment

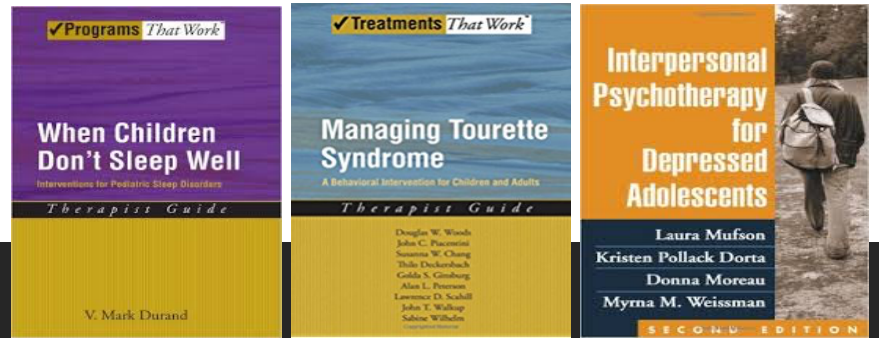




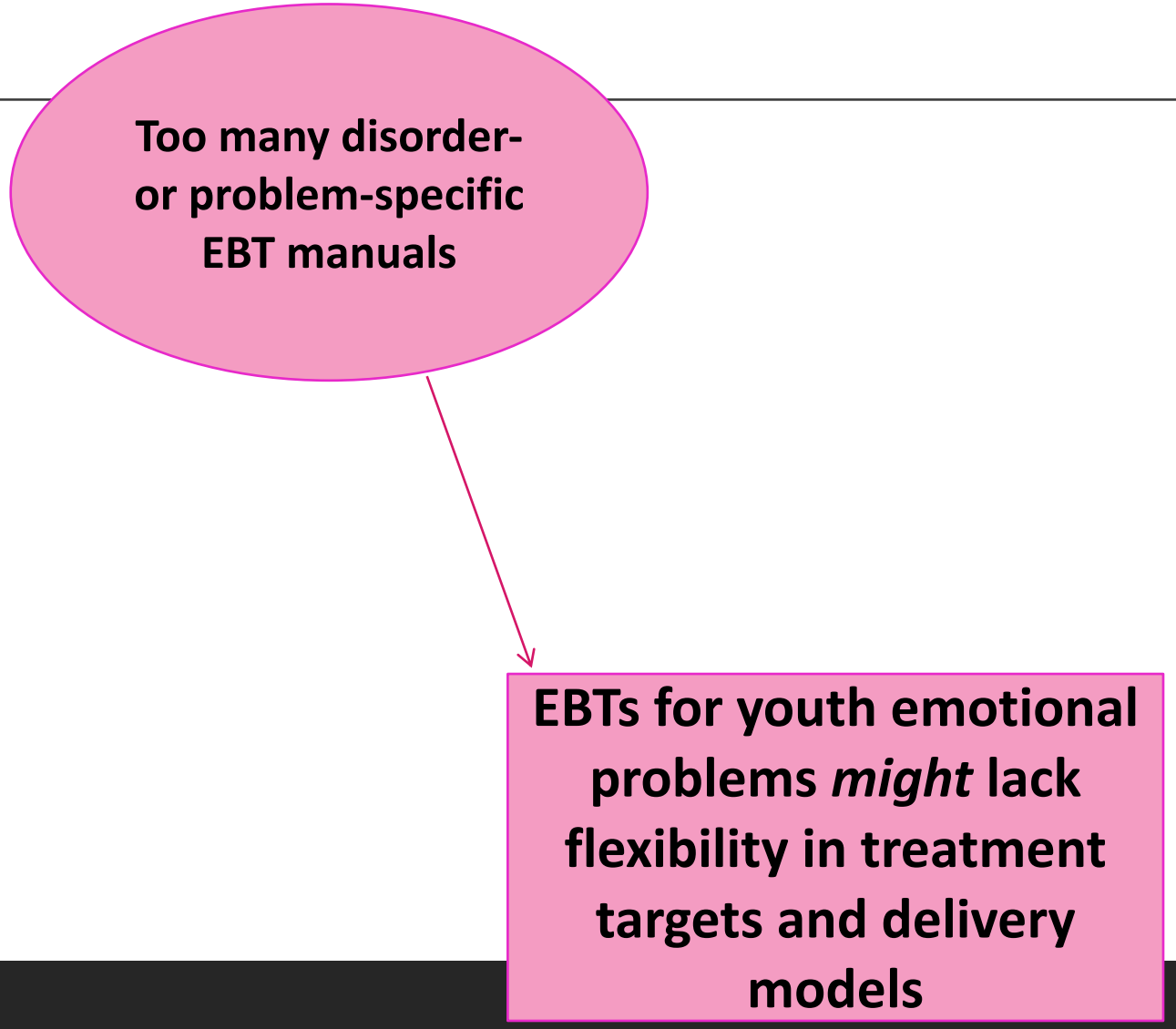
An Unexpected Barrier to Evidence-Based Treatment Use

WE HAVE A LOT OF *TREATMENTS THAT WORK* FOR YOUTH





Problem- or Disorder-Specific EBTs *Might* Lack Flexibility



Up to *75%* of children with an emotional disorder diagnosis have *concurrent* comorbid diagnosis

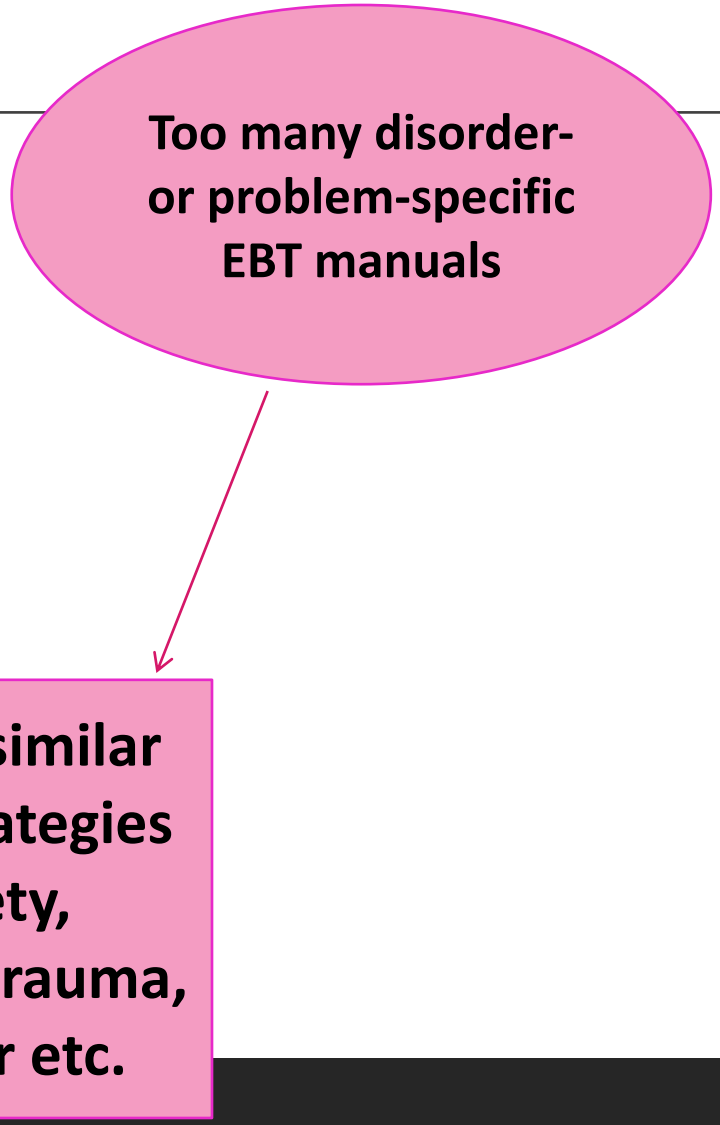
Problems also co-occur *over time*

True both within and between problem types.

So, PROBLEM specific EBT manuals might not be the most useful for child clients. *Less true for PTSD?*

Multi-Problem Youth are the Norm

Techniques in EBT Manuals May Not Differ



Shared Psychosocial Treatment Components for Youth Emotional Disorders

Focus on ***emotion identification*** and affective labeling

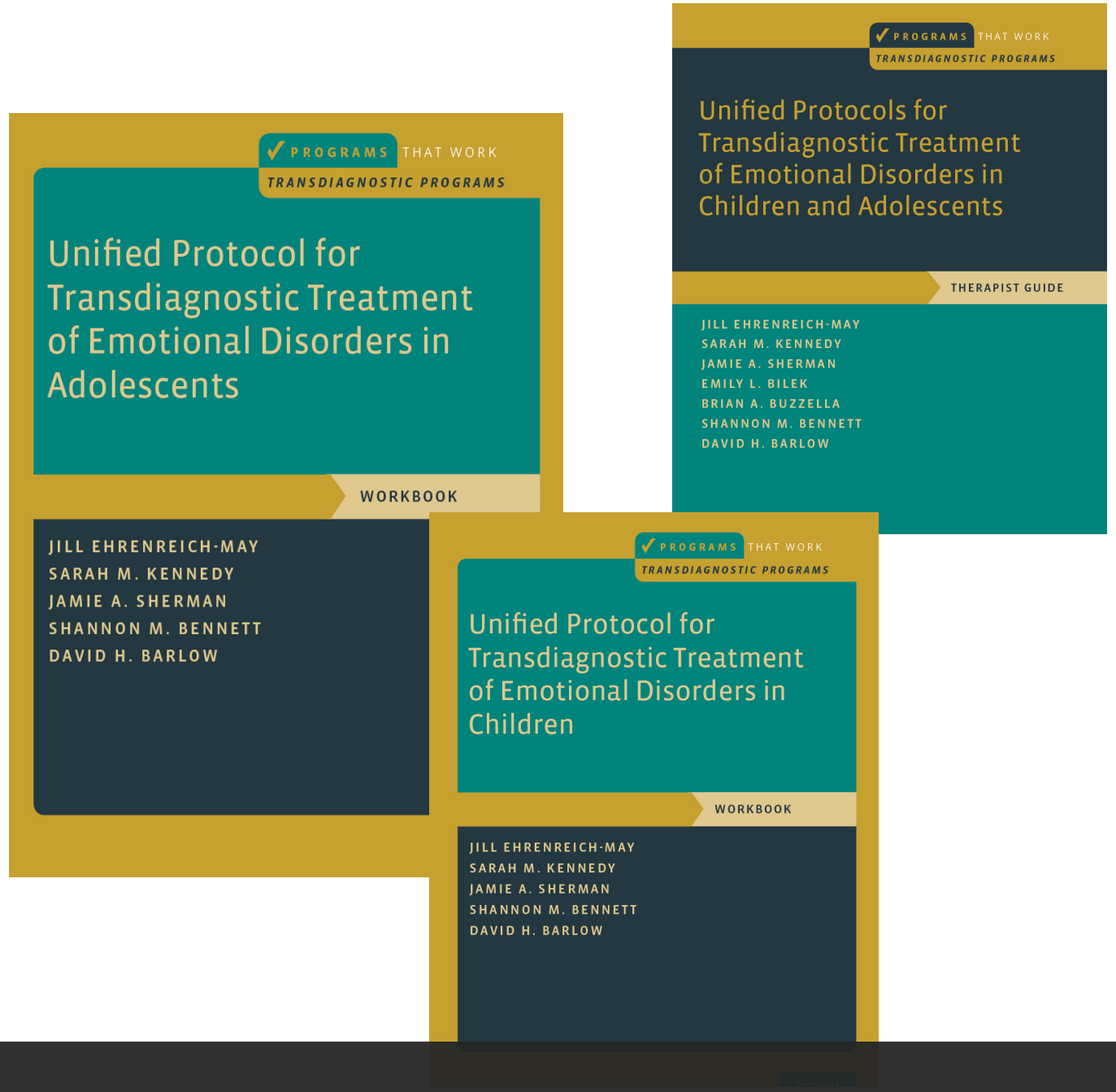
Education about how ***emotions impact behavior***, prompting avoidance, escape, aggressions, compulsions, etc.

Cognitive strategies: restructuring, mindful awareness, behavioral experiments

Opposite action strategies: behavioral activation, problem-solving, exposure

Caregiver strategies: **psychoeducation, strategies for adjusting "emotional" caregiving behaviors that impact child emotional disorders**

Transdiagnostic Treatment Approaches to Emotional Disorders in Youth



The Unified Protocols for Treatments of Emotional Disorders in Children and Adolescents

A “core dysfunction” approach that also features a modular structure and core or common treatment principles that may be flexibly applied to a range of emotional disorder conditions by focusing on excess fear, anxiety, sadness and/or irritability/anger in youth during treatment delivery.

What is this *Core Dysfunction* believed to cut across emotional disorder presentations?

NEUROTICISM

The trait-like tendency to experience negative emotions and the intensity of that experience

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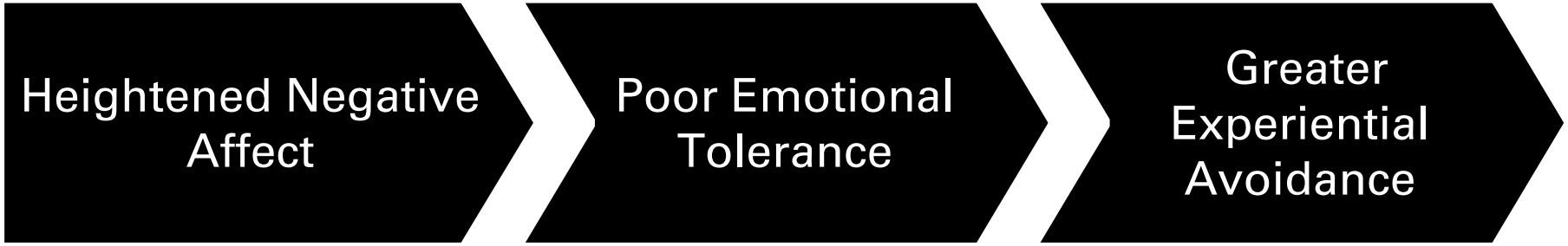


The Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Children (UP-C)

The UP-C is a 15-session emotion-focused group treatment for children ages ~6-13

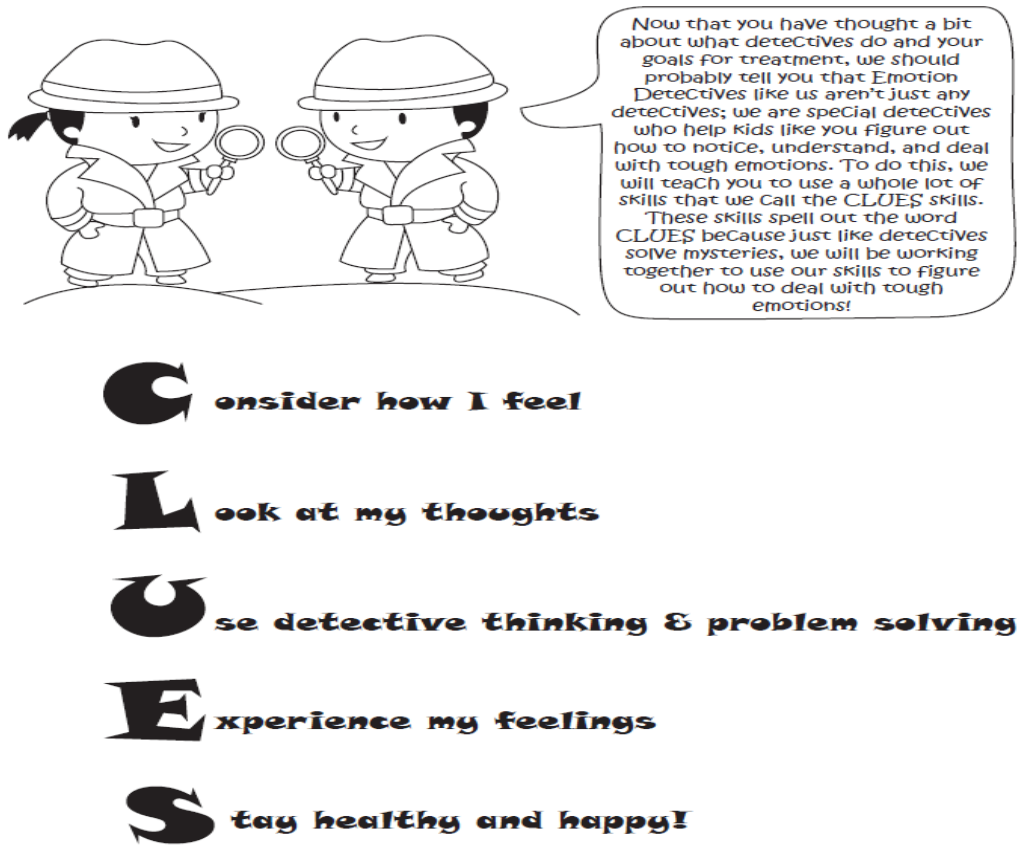
Delivered using **Emotion Detectives** metaphor

- *Can also refer to as "Emotion Scientists"*

Participants learn the **CLUES Skills:**

- *Consider how I feel*
- *Look at my thoughts*
- *Use detective thinking and problem solving*
- *Experience my emotions*
- *Stay healthy and happy*

Figure 1.1: CLUES Skills



Some Additional UP-C Details

- Families typically meet weekly in the group format
- Separate caregiver and child session time described for delivery in a group format
- Heavy emphasis on *activity-focused learning* and positive reinforcement throughout
- Chapter 23 of the UP-C/UP-A therapist guide details delivery of UP-C as an individual therapy approach

UP-C (Sessions; CLUES Skills)
C (Consider How I Feel) Skill: Intro to the UP-C; Top Problems and Goals
C Skill: Getting to Know Your Emotions
C Skill: Using Science Experiments to Change our Emotions and Behavior
C Skill: Our Body Clues
L Skill: Look at My Thoughts
U Skill: Use Detective Thinking
U Skill: Problem-Solving & Conflict Management
E Skill: Awareness of Emotional Experiences
E Skill: Introduction to Emotion Exposure
E Skill: Experience our emotions (*5 sessions*)
S Skill: Wrap Up and Relapse Prevention

Content of the UP-C

Research Support for the UP-C

Open trial findings (Bilek & Ehrenreich-May, 2012)

- d = 1.07-1.38 for global severity/primary disorder

RCT (*n*=47; Kennedy, Bilek & Ehrenreich-May, 2018) compared UP-C to Cool Kids (Lyneham, Abbott, Wignall, & Rapee, 2003).

Results generally support equivalence between EBPs like findings for adult UP (Barlow et al., 2017).

Some evidence suggests that the UP-C may be more robust to symptom recurrence at 6-month follow-up

Larger scale RCT going on currently in Portugal

Emotional Caregiving Behavior	Examples
Accommodation/Overprotection	**Not allowing the child to engage in age-appropriate activities for fear something might happen to them** Making excuses to others for withdrawal/avoidance/aggression
Negative Social Attention/Criticism	**Focusing on negative aspects of the child's behavior and ignoring the positive aspects** Speaking about child negatively to others
Inconsistency	**Inconsistent reward and punishment** Excessive (or absent) discipline behaviors
Modeling of Intense Emotions	**Demonstrating excessive emotional reactions to stimuli or avoidance of such** Using aggressive behaviors or swearing often when angry

The Four Emotional Caregiving Behaviors

Impact of UP-A and UP-C on Caregiver Functioning

Parent anxiety, depression, stress, cognitive reappraisal, and distress tolerance (DT) significantly improve following UP-C/A (N=91 youth; Tonarely et al., in press).

Unsupportive parenting behaviors decreased from pre- to post-treatment on the CCNES.

Change in **parent distress tolerance** and **baseline youth symptoms** predicted post-treatment parent-rated youth symptoms (Tonarely et al., in press).

We completed a RCT in 2020 to test **UP-Caregiver**, a 4-session preventative intervention for parents with emotional disorder symptoms during COVID-19

- Positive effects on distress tolerance and parenting self-efficacy (Halliday et al., in preparation)

What conditions have the UPs been used with (Ehrenreich-May & Kennedy, 2021)?

- All anxiety disorders
- Obsessive-compulsive disorders (e.g., OCD; Shaw et al., 2021)
- Depressive disorders
- Emerging evidence for: **Eating disorders** (Thompson-Brenner et al., 2018; Eckhardt et al., 2020), **borderline personality features and disorder** (Sauer-Zavala, Bentley, & Wilner, 2016; Tonarely et al., in press), **bipolar disorder II** (Ellard, Deckersbach, et al., 2012), **anger and irritability** in youth (Hawks, Kennedy, Holzman & Ehrenreich-May, 2020; Grossman & Ehrenreich-May, 2020), **early onset serious mental illness** (Weintraub et al., 2020), **sexual minority stress** (Seager van Dyk et al., in preparation).

- A review by Cassiello-Robbins et al. (2020) found strongest effects have been demonstrated for white persons (especially females) in the US with anxiety or depression.

Treating PTSD with the Unified Protocols

PTSD is associated with high levels of comorbid mood and anxiety disorders.

Although effective treatments exist for youth PTSD (e.g., TF-CBT), current treatments not designed to target the full range of comorbid conditions per se.

All published research has been with adults:

Varkovitzky et al. (2017) – Pilot study with 52 veterans with PTSD that received a UP group. Depression, emotion regulation and PTSD reduced at post-treatment, with reductions in emotion regulation associated with lower symptom ratings.

O'Donnell et al. (2021) – RCT of UP vs. usual care with 43 adults. UP > usual care on PTSD, depression and agoraphobia symptom ratings at post- and 6-month follow-up.

What I Thought Adaptation of the UP-C for Child Maltreatment Might Look Like!

- Session-by-session group structure may need to be abbreviated
- More modular or flexible use of materials (similar to how UP-C is used individually) may be most appropriate (e.g. mindfulness sessions coming earlier)
- Cognitive reappraisal sessions adapted to better acknowledge traumatic experiences
- Forms in the manual for developing a trauma narrative, but may need better explication or guidance for those less experienced
- Caregiver materials may be less appropriate or require adaptation

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Work with 4,000+ children & youth annually across 30 programs

Standard care informed by Neurosequential Model of Therapeutics (Perry and Hambrick, 2008)

- Argues child maltreatment causes maladaptive brain plasticity
- Customized interventions to rescue under-developed brain regions
  (e.g. repetitive somatosensory activities, promoting attachment)

Study Program: Pre-Adolescent Treatment Program

Works with kids age 4-13

All children involved with child welfare authority
- Most on guardianship order

Group home with 3:1 ratio of staff to children

Average child has 6-7 failed placements before arriving in program

Study Design

Research Question

- Can the UP be successfully adapted to treat the mental health issues of youth impacted by severe child maltreatment?

Phase 1

- Qualitative interviews with staff, youth and caregivers
- Understand barriers and facilitators to implementing UP
- Modify manualized UP based on stakeholder input

Phase 2

- Pilot studies of UP in successive cohorts
- Qualitative interviews with stakeholders after each cohort
- Modify intervention design (as needed) after each cohort

Stakeholder Input on Implementation

Barriers to Implementing UP

- Multiple placements means lack of consistent caregiver to reinforce content
- Developmental delays caused by trauma exposure
- Concerns about emotion exposure leading to emotion dysregulation
- Difficult for caregivers to attend weekly sessions (lack of transportation and/or childcare)

Facilitators to Implementing UP

- Low staff to client ratio (3:1)
- Standard care already makes link between activities and emotions

Successful Adaptations

Inclusive language: "caregiver" instead of "parent"

Floor Staff (entry-level role) work with youth on homework and exposures

Floor staff support clinicians during UP sessions

- Help youth stay focused on content, discussions and activities
- In case of emotion dysregulation, remove youth from room and work one-on-one to help youth rejoin group

Family Connection Facilitators (advanced role) support caregivers to make sure they are working on UP skills with their youth

Conducting caregiver sessions over Zoom to increase access (e.g. participation despite other childcare responsibilities)

Caregivers and staff complete assessments of child's behaviour

- Reduces missing data when there is a change in caregiver or staff

Unsuccessful Adaptations

01

Reframing “Top Problems” as “Top Priorities” to be solution focused

- Too confusing to rate the “emotional severity” of a priority
- Detracts from focus on emotions and emotional behaviours

02

Having Family Connection Facilitators run UP sessions in clients’ homes

- Impractical for researchers to assess intervention fidelity
- Difficult to get family liaisons to complete fidelity assessments for every visit with every family

03

Conducting child UP sessions over Zoom (due to COVID-19 restrictions)

- Kids easily distracted
- Hard to do games and activities that are a key part of UP

Participant Demographics

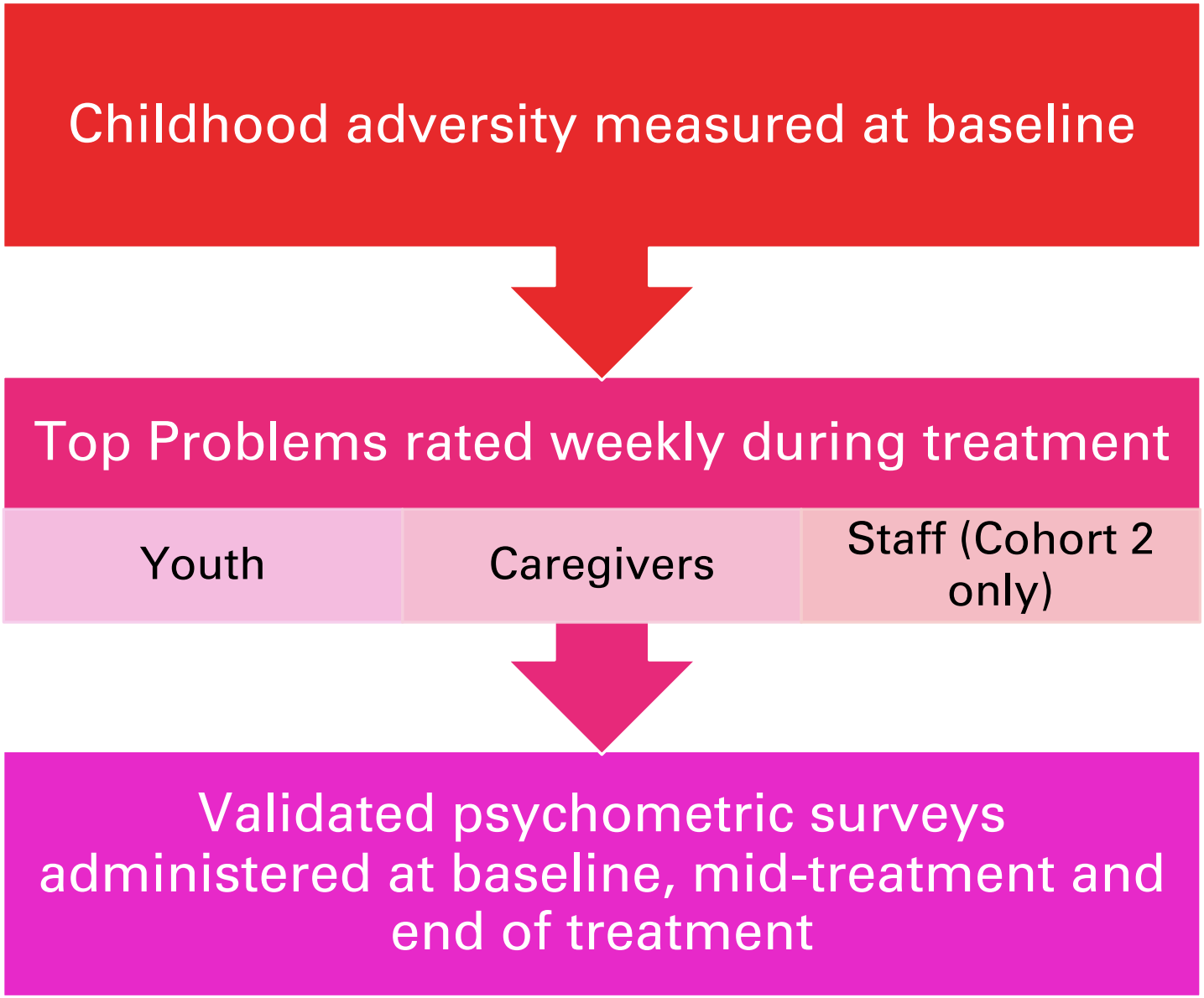
Cohort 1: Jan. – Apr. 2020

Cohort 2: Nov. – Feb. 2021

Cohort 3: Recruiting now

	Youth, n = 13	Caregivers, n = 14
Age, mean (range)	11 (9 – 13)	45 (32-60)
Gender		
Female	5	9
Male	7	5
Don't have One	1	0
Ethnicity		
European	7	11
Native / Indigenous	3	1
African	1	0
Other	0	1
Unsure	2	1
Relationship to Youth		
Extended Family	-	5
Adoptive Parent	-	4
Foster Parent	-	3
Biological Parent	-	2

Quantitative Measurements



Child Adversity Measures

Client-reported items

- Child maltreatment
  - Child Trauma Questionnaire – Short Form (Bernstein et al., 2003)
- Non-maltreatment adversity
  - Select items from Expanded ACEs scale (Cronholm et al., 2015)

Chart reviews

- Child maltreatment
  - Modified maltreatment classification system (Barnett et al., 1993)
  - Data extraction on-hold due to COVID-19 pandemic

Informants for Child Adversity Measures

Child trauma measures completed by caregivers due to staff concerns about children's age, maturity and vulnerability

- Caregivers who were not involved in child maltreatment often unaware of child's life events
- Caregivers who were involved in child maltreatment may be hesitant to report

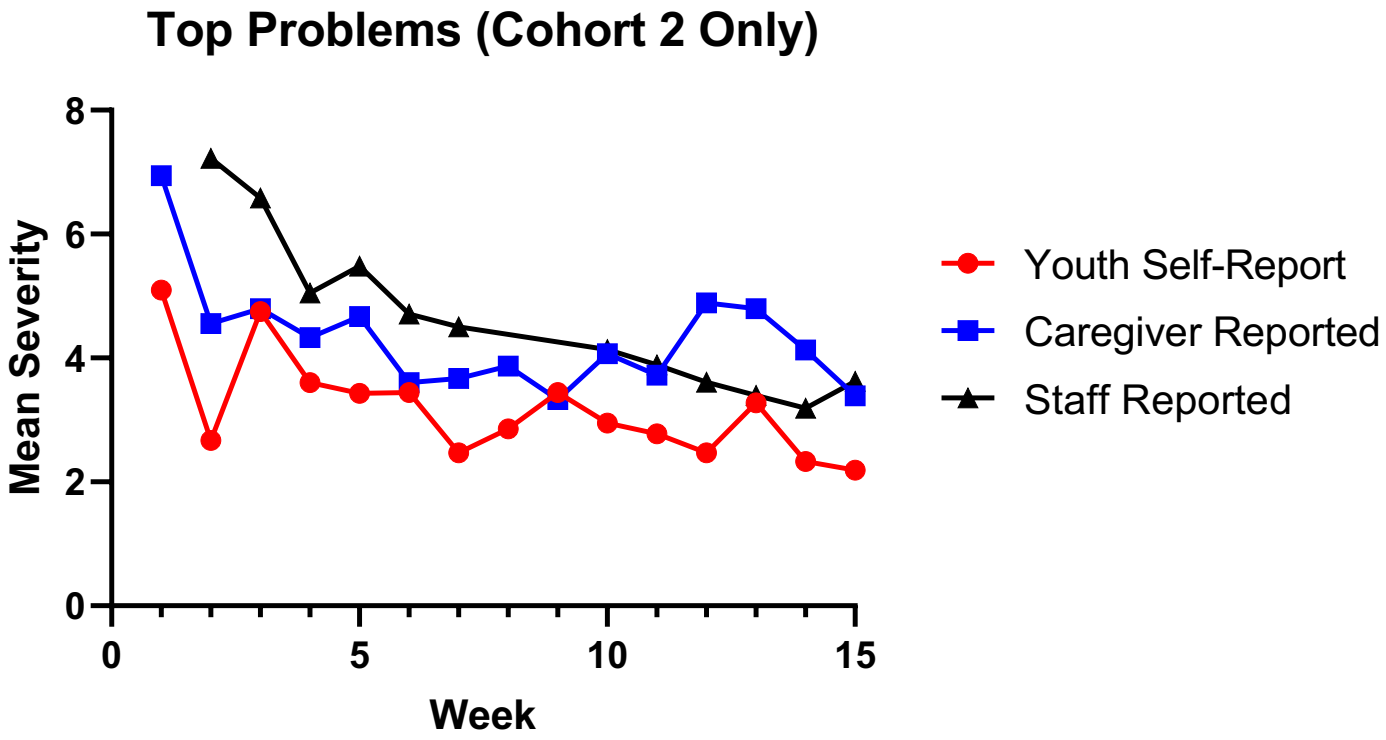
Unable to access government data on child maltreatment due to legal / privacy concerns

Child Adversity Results

Expanded ACEs	Household Substance Abuse	Household Mental Illness or Suicidality	Household Incarceration	Exposure to Intimate Partner Violence	Parental Separation	Lived in Foster Care
Yes	11	11	6	10	12	11
No	2	2	4	3	1	2
Missing Data	0	0	3	0	0	0

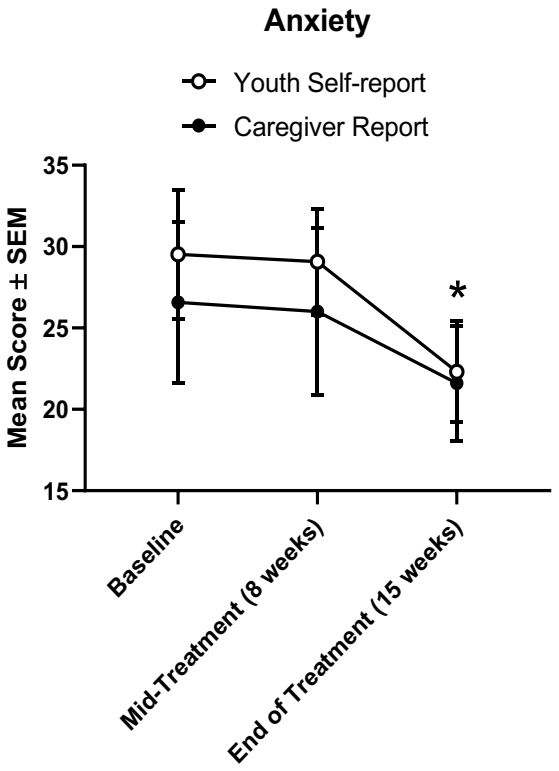
Expanded ACES	Victimized by Peers	Lived in Safe Neighbor-hood	Lived in Trusting Neighbor-hood
Never	0	0	1
Some of the time	8	8	9
Most of the time	4	3	2
All of the time	1	1	0
Missing Data	0	1	1

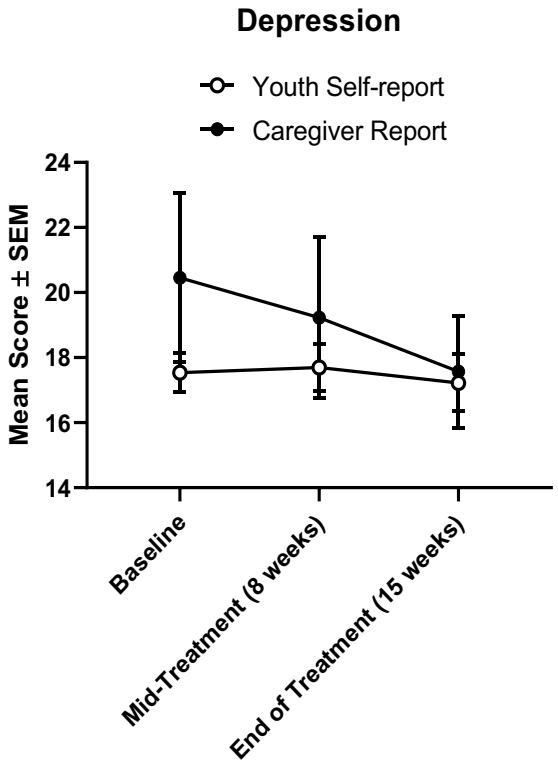
CTQ	Emotional Abuse	Physical Abuse	Sexual Abuse	Emotional Neglect	Physical Neglect
None or Minimal	1	4	8	1	1
Low	1	0	1	2	0
Moderate	4	1	1	3	1
Severe	7	6	0	7	11
Missing Data	0	2	3	0	0

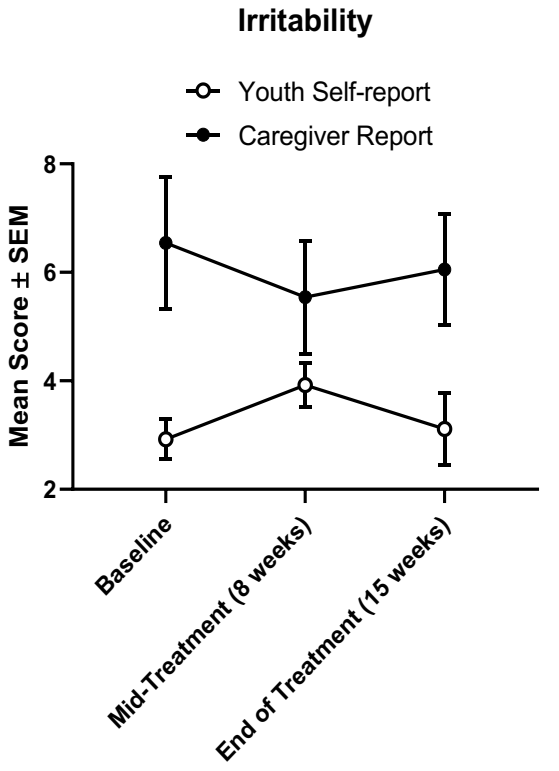


Quantitative Results

TREND FOR REDUCTIONS IN YOUTH'S TOP PROBLEMS ACCORDING TO ALL THREE INFORMANTS

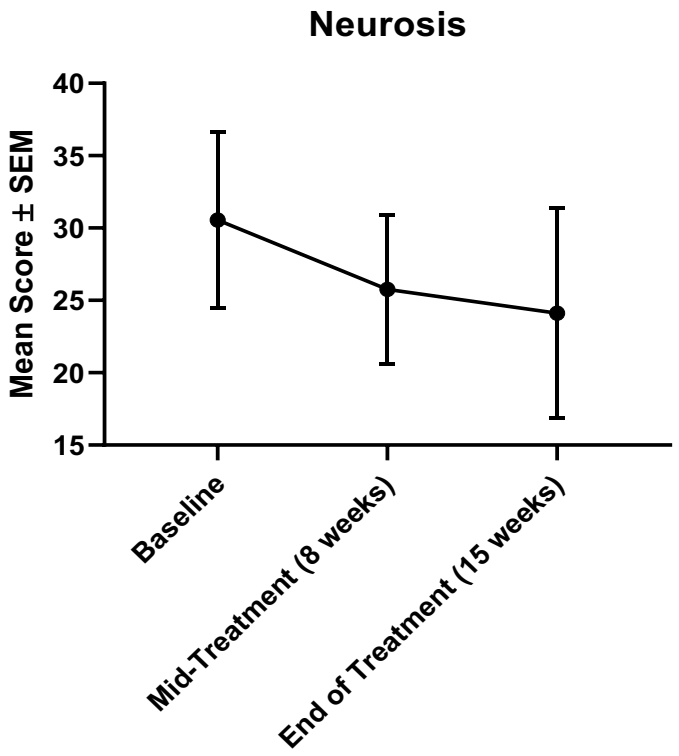


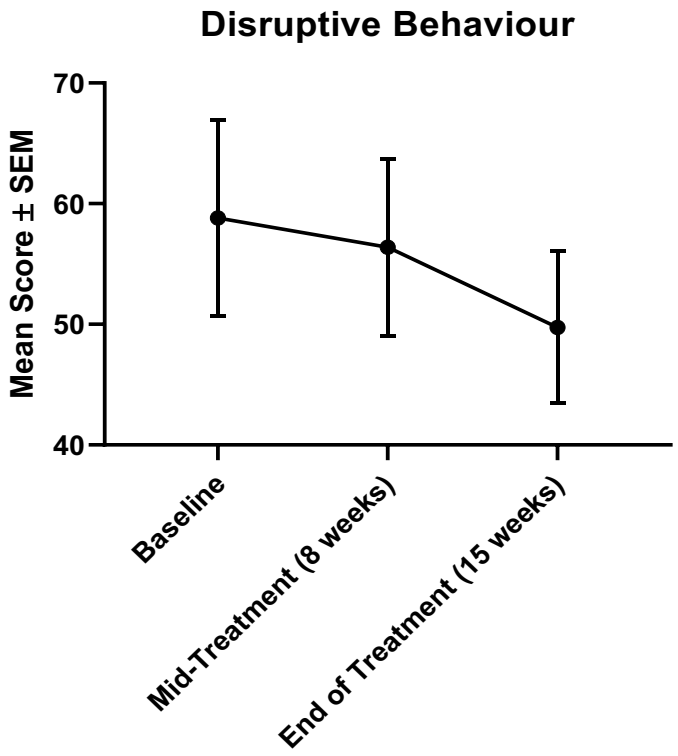


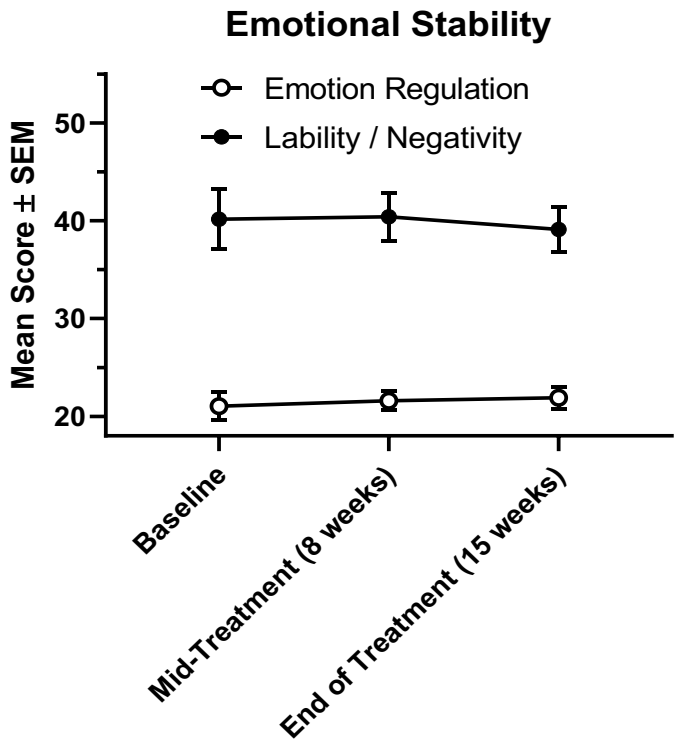


Quantitative Results

REDUCED ANXIETY OVER COURSE OF TREATMENT WITH TREND FOR REDUCTION IN DEPRESSION







Quantitative Results

TRENDS FOR REDUCTIONS IN NEUROSIS AND DISRUPTIVE BEHAVIOUR

Results Summary

Feasibility

- Caregivers able to participate in weekly sessions over Zoom
- Youth able to participate in weekly sessions within group home

Acceptability

- 100% treatment completion rate for youth and caregivers

Effectiveness (preliminary data)

- Decrease in Top Problems severity
- Decrease in anxiety with similar trends for depression, neurosis and disruptive behaviour

Challenges and Limitations

High turnover among caregivers and staff makes it difficult to track long-term outcomes for youth

- Partially remedied by obtaining measures from many informants but this is time-consuming for participants and staff

Legal and practical issues with collecting data on child maltreatment

- Ideally, have access to administrative data from child welfare authority

Future Plans: Implementing UP into Therapeutic Milieu

Train all Floor staff in UP since they often do more child care than the “caregivers”

Create reference materials for quick review

Top Problems and Emotion Exposures worked into daily therapeutic activities for each youth

Senior staff coach junior staff to maintain intervention fidelity and prevent drift