HHS Public Access

Author manuscript

Pediatr Clin North Am. Author manuscript; available in PMC 2023 August 01.

Published in final edited form as:

Pediatr Clin North Am. 2022 August ; 69(4): 633–644. doi:10.1016/j.pcl.2022.04.011.

Family-Based Prevention of Child Traumatic Stress

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Keywords

prevention; children; adolescents; trauma; families; PTSD; parenting; family-based intervention

Childhood Traumatic Stress

Exposure to potentially traumatic events (PTEs), unfortunately, is common in childhood, with nearly two-thirds of children experiencing at least one PTE before age 18.[1] Childhood PTEs can include child maltreatment (physical abuse, neglect, sexual abuse, emotional abuse), exposure to violence at home or in the community, serious accidents or injuries (e.g., motor vehicle crashes), life-threatening illnesses or medical conditions, natural disasters, and sudden or violent death of a loved one. Although most children are resilient to these events or experience natural recovery from distress, about 1 in 6 PTE-exposed children develop clinically significant posttraumatic stress disorder (PTSD), with girls, children of color, and those exposed to interpersonal trauma at highest risk.[2–4] Children of color, especially Black/African American and Hispanic/Latino children, are more likely than their White peers to experience PTEs and to develop trauma-related mental health concerns, yet they are less likely to receive trauma-focused treatment.[3] These disparities may be partially due to pervasive and structural factors such as racial discrimination, unjustified mass incarceration, and other forms of systemic racism that lead to unfavorable social conditions (e.g., poverty), leaving children at higher risk of unaddressed traumatic stress.[5,6]

PTSD symptoms include intrusions such as unwanted memories, nightmares, or flashbacks; avoidance of trauma-related stimuli; negative thoughts or feelings such as self-blame and decreased interest in activities; and hyperarousal or reactivity in the form of irritability, risky or disruptive behavior, difficulty concentrating, or heightened startle response. Aside from PTSD, many children display a range of subthreshold emotional and behavioral difficulties in response to PTE exposure. Phases of traumatic stress include an acute phase (immediately following the PTE), a peritraumatic phase (first month after the PTE), and a posttraumatic phase (the months following the PTE)—all presenting opportunities for prevention.

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Disclosure statement: The authors have nothing to disclose.

Manifestations of traumatic stress vary across development. For example, preschool-aged children may exhibit separation anxiety, temper tantrums, and loss of interest in play activities, whereas school-aged children are more likely to develop social problems, somatization, and feelings of guilt.[7] Adolescents may exhibit social withdrawal, school difficulties, and risky behavior. Childhood exposure to PTEs may cause long-term difficulties lasting into adulthood including heightened risk for mental illness, chronic physical health conditions, worse employment and income outcomes, and interpersonal and social difficulties.[8] Positive family relationships and support may protect youth against negative long-term impacts of trauma,[9] suggesting a potential role of parents and families in prevention and intervention.

Conceptualization for Prevention of Child Traumatic Stress

As with most adverse conditions, PTEs can be addressed from a treatment and a prevention perspective. The broad and multifaceted nature of child traumatic stress makes the defining of prevention a more complicated one. The approach adopted here is to break prevention down into three categories emphasizing temporal considerations. The first category is the prevention of child exposure to PTEs. Risk for trauma undoubtedly starts with exposure to adverse events or circumstances, some of which might be preventable. This first category focuses only on exposure before it occurs.

The second category is the prevention of child traumatic stress reactions following exposure to the precipitating stressor. The source of the stressor can emanate from inside or outside the family. Extra-familial PTEs include natural disasters, experiencing or witnessing motor vehicle accidents, witnessing community violence, and childhood bullying. Examples of intra-familial stressors include child maltreatment, witnessing interparental violence, death of a relative, chronic or life-threatening parental health condition, or parental substance misuse. This category focuses on preventing children's emotional or behavioral difficulties in the short-term aftermath of these adverse events.

The third category is the prevention of negative sequalae following traumatic stress. This category applies to children and youth who have been exposed to PTEs and who have begun to show ill effects. The range of traumatic stressors is broad and can also include scenarios where the exact events or timing are unknown. The preventive interventions in this category focus on mitigating the negative long-term impact of traumatic stress in children exhibiting symptoms.

The Institute of Medicine's prevention framework and stages of healthcare model is also applicable to prevention of child traumatic stress.[10] In this model, universal prevention focuses on an entire population of children and youth, not just those with specified risks. Selective prevention is aimed at children and youth with identifiable risks, and indicated prevention at those beginning to show signs or symptoms of the particular clinical conditions. For prevention of exposure (the first category noted above), universal and selective interventions are particularly relevant. Prevention after exposure (the second category) can include universal (all children exposed to the stressful event) or selective

(exposed children who belong to a more vulnerable group) interventions. Interventions in the third category, prevention of negative sequalae, would qualify as indicated prevention.

Family-Based Preventive Interventions and Programs

A number of behavioral and psychosocial family-based interventions address the prevention or mitigation of child traumatic stress. Focusing on interventions designed to benefit children in the 2- to 15-year old age range, this article describes several examples of these interventions, which all have in common the central involvement of parents and in some instances whole families. Beyond age range and family involvement, all of the chosen interventions are: (a) trauma-focused and were specifically designed to address trauma exposure or its consequences; (b) prevention-based along the continuum described earlier; and (c) supported by some evidence pertaining to efficacy and feasibility. Most but not all of these interventions have been widely disseminated in multiple communities.

Prevention of Child Exposure to Potentially Traumatic Events

Interventions to prevent child exposure to potentially traumatic events draw primarily on universal prevention when focused for example on unintentional injuries in the general population. Selective prevention is especially relevant when children are at risk of PTE exposure, such as living in an unsafe neighborhood where there is a heightened risk of community violence exposure, or with a parent who uses coercive discipline that may escalate to physical abuse.

ACT Raising Safe Kids Program (ACT Program).—The American Psychological Association's Violence Prevention Office (VPO) developed the ACT Program (previously called the Adults and Children Together Against Violence/Parents Raising Safe Kids Program), a group-delivered parenting intervention aimed at the promotion of positive parenting skills to parents and caregivers of children birth to age 10. The program is predicated on the assumption that if parents use physical punishment and other coercive forms of discipline, their children will be more likely to use violence to resolve their own conflicts. The ACT Program, which is part of the VPO's plan to prevent child maltreatment and youth violence, uses an educational format to address ages and stages of child development, parent-child relationships, and positive parenting free from abuse. Multiple studies suggest that the ACT Program yields improvement in self-reported parenting.[11,12] For example, one study that randomized parents to the program versus services as usual found a significant reduction in self-reported harsh parenting despite a significant increase in parenting stress.[11] A multi-setting study that randomized parents to intervention and control conditions found gains on self-reported parenting measures, notwithstanding 50% attrition in the recruited sample and failure to use intent-to-treat analysis.[12] The available studies of the ACT Program relied solely on parental self-report of parenting, without providing convergence from other outcome sources such as observation of parent-child interaction or independent measures of child maltreatment. Access to the ACT Program, which is being disseminated in the United States (U.S.) and in other countries, can be found at https://www.act.apa.org.

Triple P—Positive Parenting Program system.—The Triple P—Positive Parenting Program (Triple P) is a multi-level system of parenting support interventions designed to promote healthy parenting at the familial and population levels, to reduce child social-emotional and behavior problems, and to prevent child maltreatment.[13,14] Rather than a single program, Triple P is an array of programs of varying intensities, applications, and formats, all sharing a common set of positive parenting principles, an emphasis on parental and child self-regulation, and a large menu of parenting mini-strategies. Delivery modalities include extended sessions with individual families, brief parental consultation, a group format, large parenting "seminars", and online programs. Triple P has been subjected to considerable research over more than 25 years. The full evidence base, which reflects over 350 published evaluation studies including 175 randomized controlled trials, can be found at https://pfsc-evidence.psy.uq.edu.au. A consistent outcome across Triple P studies has been demonstrable reduction of coercive parenting practices.[14] With respect to prevention of child maltreatment, a population-level place randomization study showed that counties where Triple P was disseminated through workers in several service sectors reduced substantiated maltreatment cases, foster care placements, and hospital-treated child maltreatment injuries, compared with control counties.[15,16] Access to Triple P, which is being disseminated in the U.S. and 29 other countries, can be found at https://www.triplep.net/glo-en/home/.

SafeCare.—SafeCare is a home-delivered intervention intended primarily for use with parents in the child welfare system who have exhibited substantiated or suspect child abuse or neglect.[17] The program focuses on families with a child 0–5 years. The program seeks to promote: (1) a nurturing relationship, focusing on skills for positive parent-child interactions; (2) a safe environment to protect against neglect and unintentional injury, including childproofing the home; and, (3) caregiver skills for child health, to prevent risk factors for medical neglect. The evidence base in support of SafeCare includes several controlled outcome studies.[18–20] The program has produced significant outcomes in terms of reducing child-maltreatment recidivism, increasing parenting skills, decreasing use of violent discipline practices, and improving child functioning. SafeCare, which is available in the U.S., Canada, and six other countries, is accessible at: https://safecare.publichealth.gsu.edu/about-safecare/.

Prevention of childhood unintentional injuries.—The broad area of prevention for childhood unintentional injuries crosses over into family-based programming. Pediatricians and family practice physicians routinely provide guidance to parents regarding for example empirically supported strategies to prevent bicycle accidents, swimming accidents[21] and drowning, fires in the home, gun accidents, injury or death from motor vehicle crashes, poisoning, and thermal injuries (e.g., scalding).[21,22] Communication of the safe practices in these various contexts can combine public health and primary care mainly in universal prevention.

Prevention of Child Traumatic Stress Reactions Following Exposure

Following exposure to stressful events, it is possible to intervene within the peritraumatic phase via family-based interventions with the goal of early prevention of traumatic stress reactions. The aim of these programs is to prevent the onset of clinically significant distress.

Disaster Recovery Triple P.—Disaster Recovery Triple P (DRTP)[23] is a single-session universal parenting seminar intervention designed to prevent children's traumatic stress reactions following recent (within 1–3 months) exposure to a natural disaster event. DRTP was initially developed in response to the 2010–2011 floods in Queensland, Australia, a major natural disaster impacting 2.5 million people. Within the Triple P system described above, it is a Level 2 "light touch" psychoeducational seminar comprising didactic content, disaster-related media clips, and video-recorded interviews with families impacted by disasters. Content includes psychoeducation about the range of children's responses to disasters, common triggers for disaster-related distress, strategies for supporting children and managing media exposure, and parents' self-care. An overarching theme is that though dangerous things happen, the world is not always dangerous. DRTP was implemented with 196 parents following the Queensland floods, and attendees reported high levels of satisfaction with the program and high intentions to implement the parenting advice.[24] A quasi-experimental study with 43 parents revealed reductions in parent-reported child general and disaster-related behavioral and emotional problems at two-week and six-month follow-ups.[24]

Child and Family Traumatic Stress Intervention.—The Child and Family Traumatic Stress Intervention (CFTSI),[25] a 5–8-session intervention for children aged 7–17 and their caregivers, is designed to be delivered within 30 days of a child's PTE exposure with the goal of preventing traumatic stress reactions. In the initial assessment phase of the CTFSI, parent and child reports of child traumatic stress are assessed separately, and discrepancies are discussed as opportunities for improvement in communication. Treatment emphasizes behavioral skills relevant for the family (e.g., related to sleep disturbance, depressive withdrawal, oppositional behavior, intrusive thoughts, anxiety and avoidance, and managing traumatic stress reactions). The program incorporates ongoing symptom monitoring from child and parent perspectives, providing further opportunities to improve communication about the child's functioning. Following treatment completion, the family may be referred for a future booster session or more intensive treatment for PTSD as needed.

In a randomized pilot trial conducted with 112 families in the U.S., children who received the CFTSI showed lower posttraumatic stress symptom severity and were 65% less likely to meet diagnostic criteria for PTSD at three-month follow up, compared with control children who had received supportive therapy.[25] PTSD symptom clusters of avoidance and re-experiencing, but not hyperarousal symptoms, were significantly reduced in the CFTSI condition. Some evidence has accrued that the CTFSI can reduce caregiver posttraumatic stress[26] and discrepancies between parent and child report of symptoms.[27] The pilot trial was conducted with a racially and ethnically diverse U.S. sample, and intervention materials are available in English and Spanish. More information is available on the program website (https://medicine.yale.edu/childstudy/communitypartnerships/cvtc/cftsi/).

Focus Family Resilience Program.—The Families OverComing Under Stress (FOCUS) Family Resilience Program[28] is designed to improve family functioning and reduce parent and child distress for families who have experienced stressful or traumatic events. Initially designed for military families facing difficulties following deployment,

FOCUS is also implemented more broadly in community mental health, medical, and school settings.[28] The program generally applies to children ages 3 and older, with some adaptations made for preschool-aged children. The program consists of 8–12 sessions, initially with parents only, then with children only, and finally with the whole family. Drawn from three evidence-based interventions,[29–31] core elements of the intervention include eliciting family concerns and goals, educating the family regarding child development and common reactions to trauma, developing a shared family narrative of the traumatic event(s), enhancing openness and effective family communication, and developing family resilience skills (e.g., emotion regulation, goal setting). The intervention employs a narrative timeline technique in which individual members and the family as a whole construct a visual representation of major events and experienced distress, aimed at reducing misunderstandings contributing to family conflict.

Nonrandomized evaluations with military families have shown that participation in the FOCUS program was associated with reductions in parent and child distress and improvements in child emotional and behavioral adjustment,[32,33] with evidence of family-functioning improvement as a mediator.[32] The FOCUS program has been implemented with military and civilian, single- and two-parent household, foster and adoptive, and immigrant families, as well as families experiencing stress related to community violence, chronic illness, domestic violence, parental substance use, and grief.[28] A list of FOCUS sites is available on the website (https://focusproject.org/).

Care Process Model for Pediatric Traumatic Stress.—The Care Process Model for Pediatric Traumatic Stress (CPM-PTS)[34,35] addresses pediatric traumatic stress for children aged 0–18 within primary care settings through screening and a stratified treatment approach based on symptom severity. Based on the premise that traumatic events are highly prevalent and can lead to negative mental health outcomes, the CPM-PTS relies on screening tools, early identification, and a structured integrated-care approach to prevent ill effects of trauma exposure. Screening tools include the Safe Environment for Every Kid (SEEK) screener[36] for children aged 0–5 and the Pediatric Traumatic Stress Screening Tool[34] for children aged 6–18. When trauma exposure is identified, traumatic stress is managed by: 1) making any necessary reports to child protective services or law enforcement for suspected child maltreatment; 2) responding to suicide risk as needed; and 3) pursuing one level of a stratified array of therapeutic options matched to severity of traumatic stress reaction. The CPM-PTS can be delivered by non-mental health professionals including primary care clinic staff. The CPM-PTS as a universal approach can be implemented with all families in pediatric primary care settings. Outcomes of a pilot trial of CPM-PTS in a U.S. primary care setting are forthcoming. The CPM-PTS can be delivered in English or Spanish, and the manual outlines adaptations for special populations (e.g., refugees, homeless children).[35] A manual with screening tools, decision trees, and resources for brief intervention may be found at https://utahpips.org/cpm.

Prevention of Negative Sequelae of Traumatic Stress

Trauma-exposed youth who experience clinically significant traumatic stress symptoms are at elevated risk for a host of negative long-term outcomes, such as depression and

other mental health concerns, substance use disorders, physical health conditions, family problems, and worse economic outcomes in adulthood.[8] For trauma-exposed youth who are already showing clinically significant symptoms of traumatic stress, family-based prevention programs may prevent the negative sequelae and reduce the likelihood of long-term functional impairment.

Trauma-Focused Cognitive Behavioral Therapy.—Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)[37] is a family-based intervention targeting traumatic stress in children and adolescents aged 3–18 and their non-offending caregiver(s). TF-CBT is designed for youth who have experienced traumatic events and are already demonstrating traumatic stress reactions such as PTSD symptoms, depression, anxiety, and behavioral problems. Typically 8–25 sessions in length with a combination of individual child, parent, and conjoint components, intervention content is divided into three phases: 1) stabilization (including psychoeducation, cognitive and emotional coping skills, and parenting skills); 2) trauma narrative and processing; and 3) consolidation (including *in vivo* exposure, enhancing parent-child communication about the traumatic event, and preventing future re-victimization through safety planning).

TF-CBT has a strong evidence base and is considered a gold standard treatment for child traumatic stress including PTSD.[38] At least 13 randomized controlled trials have shown the program's efficacy in reducing children's symptoms of PTSD, depression, and behavior problems, compared to attention or waitlist controls or treatment as usual.[38,39] TF-CBT has been implemented and evaluated with families from a wide range of cultural backgrounds, in low and middle income countries and other low-resourced settings, with youth impacted by commercial sexual exploitation, with youth in foster care, and in several other populations. Cultural adaptations for TF-CBT have been documented for a number of U.S. (e.g., American Indian/Alaska Native, Latinx, Black/African American, refugee) and global (e.g., Congolese, Jordanian, Tanzanian, Zambian) populations.[40] TF-CBT is available in many communities, with a database of certified TF-CBT providers found on the program's website: https://tfcbt.org/.

Alternatives for Families: A Cognitive Behavioral Therapy.—The Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT)[41] program addresses risk factors and consequences of family conflict, caregiver physical aggression, or child physical abuse. AF-CBT is designed for families with children aged 5–17 where (a) the caregiver engages in physically aggressive discipline, physical abuse, or angry/hostile stance towards the child, (b) the child exhibits externalizing behavior problems and/or trauma-related symptoms, or (c) the family engages in coercive and conflictual interactions. AF-CBT targets factors at: (1) the parent level, e.g., parental hostility and anger, negative attributions about the child, and ineffective or harsh parenting practices; (2) the child level, e.g., child's anger, anxiety, trauma-related distress, social interaction skills, behavioral problems, and negative self-attributions; and (3) the family level, e.g., familial coercive or conflicted interactions. Progressing through three phases—namely engagement and psychoeducation, individual skill building, and family applications—AF-CBT sessions are conducted depending on topic with either the caregiver alone, child alone, or caregiver and child together. Building on

skills training throughout the program, a key component is the "clarification" session, which involves having the caregiver take responsibility for their actions in the abusive or aggressive incident(s), recognize and verbalize the impact of the abuse on the child, and plan how to prevent a future incident.

Multiple clinical trials of AF-CBT components reflect the program's effectiveness in reducing parents' use of physically aggressive discipline, parental anger problems and psychological distress, child externalizing behaviors, and family conflict.[41,42] Implementation processes have been evaluated in community mental health and child welfare settings.[43,44] AF-CBT operates in the U.S., Canada, and other countries, with program materials available in several languages, and providers are listed on the program's website: http://www.afcbt.org/whereisAFCBT.

Combined Parent-Child Cognitive-Behavioral Therapy.—Another program to prevent negative sequelae of physical abuse is Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT).[45] The program serves families with children ages 3–17 in which there is either substantiated or risk for child physical abuse, although other forms of trauma can be addressed. CPC-CBT aims to help children recover from traumatic stress reactions related to physical abuse or coercive interactions, to promote positive and effective parenting, and to enhance family safety. Delivered either in an individual family or group format, CPC-CBT typically consists of 16–20 sessions comprising four phases: engagement, skill building, family safety, and abuse clarification. Early stages of treatment rely more heavily on separate parent and child components, with joint sessions increasing in later stages.

One randomized trial demonstrated that families who received CPC-CBT demonstrated greater improvements in child traumatic stress symptoms and positive parenting compared with those in a parent-only CBT condition.[46] A pilot trial similarly showed pre- to posttreatment reductions in parents' use of physical punishment, parental anger, child traumatic stress reactions, and child behavioral problems.[47] Intervention materials are available in English, Spanish, and Swedish and additional information can be found on the program website (https://centers.rowanmedicine.com/cares/services/mentalhealth/cpc-cbt.html).

Discussion

Though the field of child traumatic stress has largely focused on treatment, there is a growing recognition of the need for a cogent public health approach emphasizing prevention.[48] Concentrating only on treatment in the face of a provider shortage in child mental health, exacerbated further by the COVID-19 pandemic, does not reduce or even contain the need for trauma services. A prevention approach is likely to have greater public health impact by a) reducing the incidence of child trauma exposure, b) preventing the onset of symptoms for recently trauma-exposed children, and c) preventing the long-term developmental consequences of traumatic stress. It is valuable to consider opportunities for preventing childhood traumatic stress across multiple timepoints: prior to PTE exposure, during the peritraumatic phase, and during the posttraumatic phase after traumatic stress

symptoms have begun to appear. The programs described here illustrate ways to reduce the public health burden of child traumatic stress at these different time points.

For children who might experience PTEs, positive family relationships are critical in protecting children from adversity exposure and from the negative short- and long-term outcomes of exposure. Each of the family-based programs discussed here targets aspects of the parent-child relationship using a variety of modalities. Several common strategies characterize many of these programs, including educating parents on common responses to trauma, increasing family communication about the trauma, using exposure-based techniques with the child and family, increasing awareness of safety and the use of safety planning, and reducing parents' coercive discipline strategies and replacing them with positive parenting techniques. Collectively, these programs have shown favorable child, parent, and family outcomes such as less harsh and coercive parenting, improved family functioning, reduced child maltreatment incidence or recidivism, child behavioral and emotional adjustment, fewer child PTSD symptoms, and less caregiver distress. The programs incorporate universal prevention (e.g., DRTP, targeting the entire population of parents of disaster-exposed children to prevent negative effects), selective prevention (e.g., SafeCare, aimed at families at risk of child maltreatment (re)occurrence), and indicated prevention (e.g., TF-CBT, designed for children already exhibiting trauma-related difficulties). Given the shortage of specialty mental health providers for children and the significant barriers to accessing those providers—particularly for youth from underrepresented backgrounds who are disproportionately affected by trauma[3,4]—it is critical to examine other settings and opportunities for the prevention, early identification, and treatment of traumatic stress. Primary care providers such as pediatricians can play a vital role in the effort to address childhood traumatic stress.

Summary

Consistent with a call to embrace a public health, prevention-focused approach to ameliorating the impact of traumatic stress,[48,49] this article described several family-based programs aimed at preventing child traumatic stress, ranging from programs to prevent exposure to PTEs, to those aimed at preventing traumatic stress reactions shortly after exposure, to those preventing the negative long-term consequences of traumatic stress. Programs in these three categories draw on universal, selective, and indicated prevention, and highlight the importance of parents and families in promoting children's health and addressing children's exposure and reactions to trauma.

Acknowledgements:

We would like to acknowledge funding from the National Institute of General Medical Sciences (P20GM130420).

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Key points:

- Most children are exposed to potentially traumatic events and some develop traumatic stress reactions including emotional and behavioral difficulties.
- Positive parenting and family support are key protective factors for children who have experienced or might experience potentially traumatic events.
- Family-based preventive interventions can address child traumatic stress by preventing children's exposure to traumatic events, preventing traumatic stress reactions following exposure, and preventing long-term negative sequelae of trauma.

Synopsis:

Most children experience potentially traumatic events, and some develop significant emotional and behavioral difficulties in response. Although the field has mainly focused on treatment, a prevention framework provides an alternate approach to reducing the public health burden of trauma. Because parents and families can affect children's trauma exposure and reactions, family-based preventive interventions represent a unique opportunity to address child traumatic stress. This article discusses family-based programs that address child traumatic stress across three categories: preventing children's exposure to traumatic events, preventing traumatic stress reactions following exposure, and preventing negative long-term sequelae of trauma.

Clinics Care Points

- Pediatric providers should educate caregivers on safety practices to prevent exposure to potentially traumatic events.
- To identify traumatic stress early and prevent its negative effects, pediatric providers should consider adopting trauma screening measures in well-child visits across all ages and stages of development.
- Pediatric providers should seek information about potential traumatic stress from multiple sources including both child and caregiver.
- When trauma is identified, pediatric providers should address immediate safety concerns, provide brief education to the family about trauma and common reactions, support parent-child communication about the traumatic event, and teach a relevant coping skill.
- Pediatric providers should familiarize themselves with the family-based prevention programs available locally and provide appropriate encouragement and referrals based on the varying needs of children and families.