

Team turns to evidence to treat childhood trauma

Teenagers today live in a shooting-gallery world,” explains Stanley Rosenberg, Ph.D. “They get beaten up by sibs, by parents, by neighborhood gangs. If you look at who is being victimized in our culture, adolescents are just up there at the top.” Up there helping them, though, is Rosenberg, a professor of psychiatry at DMS and a longtime trauma researcher.

Childhood physical and sexual abuse are the most toxic forms of trauma and can lead to post-traumatic stress disorder (PTSD). Less intense forms of trauma, too, such as witnessing a sudden death or surviving a car accident, can sometimes lead to PTSD. And early exposure to trauma can result in “very non-optimal ways of adapting to the world,” says Rosenberg, including substance abuse, academic failure, and involvement with the criminal justice system—all of which can be risk factors for poor functioning in adulthood, including mental illness.

Early: The key is to intervene early, says Rosenberg, “to limit these toxic, self-exacerbating cycles that people get into following trauma exposure.”

Rosenberg is heading a project that aims to do just that, by providing evidence-based treatments to New Hampshire adolescents and their families who have experienced traumatic events, have developed related emotional problems, and are served by the state’s 10 community mental health centers. Called the Project for Adoles-

cent Trauma Treatment (PATT), the initiative is funded by a four-year, \$1.6-million federal grant—one of only 19 given out in 2005 by the U.S. Substance Abuse and Mental Health Services Administration. PATT is operated out of the Dartmouth Trauma Interventions Research Center (DTIRC), which Rosenberg heads.

PATT will be implemented first at West Central Behavioral Health, an agency with offices in Lebanon, Claremont, and Newport, N.H. Then the evidence-based practices will be disseminated to the other nine centers. Establishing a new model of care can be tricky, since historically mental-health clinicians have chosen from a variety of treatments that haven’t been tested head-to-head.

Evidence: “We have a system where clinicians kind of do what feels right to them,” says Rosenberg. “It has a lot to do with training [and] regional variation. . . . We really want to shift that thinking, saying, ‘Look, we have to refer to the hard evidence and prioritize care based on what the science shows us is most likely to work.’” Because West Central has

worked with DTIRC from the beginning of the grant process, “they absolutely buy into the principles,” Rosenberg says. “They are great partners.”

The treatment Rosenberg’s team selected is trauma-focused cognitive behavioral therapy (TF-CBT). Thanks to the grant, DTIRC was able to join the National Child Traumatic Stress Network, which did initial training in TF-CBT for West Central clinicians. DTIRC supervisors are continuing the process, using a train-the-trainer model.

Now, adolescents who come to West Central fill out an online screening survey, developed by DTIRC, which assesses them for trauma and PTSD symptoms. “What you want to see are the cases in which [teens] aren’t going to get over their symptoms. So you want to target them first—the ones who really need help,” says Harriet Rosenberg, M.A. She is a coadministrator of the PATT grant and a longtime research partner of Stan Rosen-

berg’s, as well as his wife.

Trauma-focused cognitive behavioral therapy has two aspects: exposure therapy and cognitive restructuring. The exposure aspect involves creating a coherent narrative of the traumatic event to overcome associated painful feelings. The idea behind cognitive restructuring is that “thinking influences your feelings, and life experiences influence that thinking, and the thinking is not always accurate,” explains Kim Mueser, Ph.D., a coinvestigator on the grant.

Trust: For example, an adolescent who was physically abused five years ago may still be holding on to certain no-longer-accurate beliefs and thus feel unable to trust anyone in authority. The treatment involves “figuring out what the thinking is you’re doing, examining the evidence behind it, challenging it, and when it’s not accurate changing it,” says Mueser.

DTIRC chose cognitive behavioral therapy because “it has the most research support behind it of any other trauma treatment out there for adolescents,” according to Mary Kay Jankowski, Ph.D., director of PATT.

The grant actually has both a short-term and a long-term goal, says Stan Rosenberg—to “transform systems so that [the centers] know and use these models,” but also to transform “the whole mindset . . . such that eight years from now, when we’ve made evolution in treatment technologies and when new models come on board, that they’re also going to use those.”

MATTHEW C. WIENCKE



DMS’s Harriet and Stan Rosenberg are heading a project aimed at nipping the effects of childhood trauma in the bud.