NCTSN The National Child Traumatic Stress Network

Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)

Treatment Description	• Acronym (abbreviation) for intervention: SMART • Average length/number of sessions: Approximately 12 months comprised of 34 individual sessions, 40 family sessions, and 24 group sessions (number of individual/family sessions may vary based on the needs of the child and family). • Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, or addresses transportation barriers):* The family power structure, and perceptions regarding sexuality, gender roles, identity, stigmatization of mental health, and spirituality are aspects of culture that are integrated into the treatment. • Trauma type *(primary):* sexual abuse • Trauma type *(secondary):* Physical abuse, neglect, and community violence • Additional descriptors *(not included above):* The S.M.A.R.T. model is a structured, phased- based approach to treatment for sexually abused children who are exhibiting sexual behavior problems. The model has been successfully implemented with a primarily African American population since 1998. It incorporates already established practices proven to be effective in trauma treatment, such as CBT, as well as psycho-education and skill building to directly address the behavioral and emotional concerns associated with the experience child sexual abuse and the resultant victimizing behavior. The primary objectives of the model are: 1) to eliminate the sexual behavior problem; 2) to establish stability and a sense of safety in the lives of children; 3) to improve insight, judgment, and empathy; 4) increase awareness of personal risk patterns and triggers; 5) to develop coping skills and strategies that improve emotional and behavioral regulation; 6) to provide parents with the skills to meet their children's physical/emotional needs; and 7) Increasing children's connectedness to positive others and building internal objects that support future growth.
Target Population	• Age range: *3 to 11.* Child must have a history of child sexual abuse and be exhibiting sexual behavioral problems. • Gender: ☐ Males ☐ Females ☒ Both • Ethnic/Racial Group *(include acculturation level/ immigration/refugee history--e.g., multinational sample of Latinos, recent immigrant Cambodians, multigenerational African Americans):* To date the model has been effectively used with primarily African American children. • Other cultural characteristics *(e.g., SES, religion* : Majority of families are low

	income; more than 50% of the children reside in foster or kinship care; most of the children have experienced multiple traumas including physical abuse, exposure to violence, traumatic grief, and neglect. • Language(s): English • Region (.e.g., rural, urban): Urban • Other characteristics (not included above):
Essential Components	• Theoretical basis: The theoretical underpinnings of the S.M.A.R.T. model include Trauma theory, Multi-Systematic Family Therapy, and Cognitive Behavioral Therapy. The model also integrates concepts and intervention strategies of the Trauma Outcome Process Model. • Key components: The model consists of three clinically essential phases: Safety & Stabilization, Trauma Integration & Recovery, and Re-Socialization & Mastery. Each phase contains content modules that must be mastered in order to move to the next phase of treatment. Each module includes specific activities and interventions and provides indicators of mastery to inform and guide clinical practice. Care giver involvement is mandatory and a combination of individual, family, and group therapy services are provided and tailored to meet the individualized needs of the child and family. To date, the average length of stay for model completion is 12 months. The S.M.A.R.T. model includes a specialized treatment workbook that was specifically designed to address issues related to victimization, victimizing, and steps towards healthy touching and relationships. The workbook provides specific activities that address the components of each stage of treatment. It serves as a tool to assist children and their care givers to better understand the impact of the trauma, triggers, and emotional needs of the children while creating a useful dialogue for the formation of the parallel trauma narratives. Ultimately, the parallel narratives are integrated into one comprehensive narrative. Key Components: Psycho-education, Safety Contracting and Monitoring, Sexuality, and Skill Building are core components of each phase. Concepts are introduced in Phase I and the scope and intensity increase and are reinforced throughout each stage. Additional Key Concepts included in each stage are: *Safety & Stabilization* • Trauma Assessment • Risk Reduction Plan • Family and Community Engagement *Trauma Integration & Recovery* • Impulse Regulation • Affect Modulation • Trauma Triggers

	• Cognitive Processing • Trauma Narratives *<u>Re-socialization</u>* <u>& Mastery</u> • Stress/Relaxation • Healthy Intimacy • Self-esteem • Relapse Prevention
Clinical & Anecdotal Evidence	• Are you aware of any suggestion/evidence that this treatment may be harmful? ☐Yes ☒No ☐ Uncertain • Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time). 3* • This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group. ☐Yes ☒No • Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? ☒Yes ☐No If YES, please include citation: There are annual Program Evaluation Reports for the period December 1999-December 2003 submitted to the Jessie Ball duPont Foundation who provided foundation support for the development and piloting of the model. • Has this intervention been presented at scientific meetings? ☒Yes ☐No If YES, please include citation: The model was presented as a poster presentation at the annual APSAC conference in 2003 and as a 3 hour clinical intensive session at the 15th Annual Child Abuse and Neglect Conference in 2005. • Are there any general writings which describe the components of the intervention or how to administer it? ☒Yes ☐No If YES, please include citation: The preliminary findings and descriptive features of the pilot administration are currently being written for submission for publication. In addition, a treatment manual and specialized workbook will be completed by January 2007. • Has the intervention been replicated anywhere? ☐Yes ☒No Other countries? *(please list)* • Other clinical and/or anecdotal evidence (not included above): Preliminary findings from data collected during the pilot are favorable and indicate that the model improves emotional and behavioral regulation in the home, school, and in the community. Data collected specific to the sexualized behavior indicates a significant reduction and in many cases the elimination of sexualized behaviors. Details of the pilot and preliminary data analyses are in the process of being written up for submission for publication. Plans to implement clinical trials with control groups are being explored.

Research Evidence

		Number of Participants	Sample Breakdown	Citation
Published	☐Yes	N =	By gender:	

	Case Studies	☒No		By ethnicity: By other cultural factors:	
	Pilot Trials/ Feasibility Trials (w/o control groups)	☒Yes ☐No	N = 62	**By gender:** Male=34 Femal=28 **By ethnicity:** African American=38 Multi-racial=8 Hispanic=2 Caucasion=16 **By other cultural factors:** Foster Care=26 Kinship Care= 18 Natural Family=16	In Progress
	Clinical Trials (w/ control groups)	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	
	Randomized Control Trials	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	
	Studies describing modifications	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	
	Other research evidence	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	

Outcomes	What assessments or measures are used as part of the intervention or for research purposes, if any? During the pilot phase of model development beginning in August of 1998, the following outcome measures were utilized to assist in the formulation of clear treatment goals, inform practice, and to measure the program's success: SMART Symptom Checklist (a 26 item checklist monitoring the frequency of behaviors) was administer at intake and every month thereafter, the CAFAS/PECAFAS was administered at intake and every three months thereafter, and the Child Sexual Behavior Checklist was administered at intake and every 6 months. Follow up administration of the measures was completed at 6, 12, and 18 months post discharge for each patient.

	Effective October 1, 2004, a decision was made to change the assessment/measures protocol. Measures are administered at intake, 6 months and at discharge. Current measures include: UCLA PTSD Index Trauma Symptom Checklist for Children Child Behavioral Checklist Child Behavior Checklist- Teachers Report Form Child Sexual Behavior Inventory Parent Stress Index • If research studies have been conducted, what were the outcomes?
Implementation Requirements and Readiness	• Space, materials or equipment requirements? Large enough space to accommodate group treatment for between 8-10 children Private treatment rooms Treatment manual and workbook. • Supervision requirements (e.g., review of taped sessions)? 1-2 day intensive training in the model. 6-month on-going expert consultation from trainers. On-going Weekly individual/bi-monthly group clinical case consultations at the completion of the expert consultation. • In order for successful implementation, support should be obtained from: Funding stream that allows for the provision of intensive services.
Training Materials & Requirements	• **List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** The treatment manual and intervention workbook are in progress and anticipated to be completed by January 2007. • How/where is training obtained? Contact developer: Betsy Offermann at the Kennedy Krieger Family Center • What is the cost of training? Determined by the training/on-going supervision needs of the site. • Are intervention materials (handouts) available in other languages? ☐Yes ☒No If YES, what languages? • Other training materials &/or requirement (not included above): Workshops at national conferences
Pros & Cons/	• What are the pros of this intervention over others for this specific group (e.g., addresses stigma re. treatment, addresses transportation barriers)?

Qualitative Impressions	• The intentional incorporation of cultural beliefs and influences promote family strengths and the development of adaptive coping responses to problematic sexualized behavior. • The model is not based on Juvenile or Adult offender models and reduces stigmatization. • The parallel formation of victim and victimizer narratives reduces shame, instills hope, and provides a supportive, non-threatening framework to address painful affect and content. • What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)?: Lack of consistent caregiver participating in treatment. The inconsistency often triggers regressions in emotional and behavioral regulation and can lead to placement disruptions. • Other qualitative impressions:
Contact Information	Name: Betsy Offermann, LCSW-C Address: Kennedy Krieger Family Center 2901 East Biddle Street Baltimore, MD 21213 Phone number: 443-923-5907 Email: offermann@kennedykrieger.org Website: