# Multimodality Trauma Treatment (MMTT) (also called Trauma-Focused Coping)

## Treatment Description
MMTT is a skills-oriented, cognitive-behavioral treatment (CBT) approach for children exposed to single-incident trauma and targets post-traumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control. It was designed as a peer-mediating group intervention in schools. It has been shown to be easily adaptable for use as group or individual treatment in clinic populations as well.

## Target Population
Children and adolescents in grades 4 through high school who have experienced single-incident traumatic stressors (disaster, exposure to violence, murder, suicide, fire, accidents) — recognizing the fact that most children have experienced more than one PTSD qualifying stressor. MMTT can address intrafamilial violence/abuse in individual treatment or in clinic-based groups where homogeneity of group membership can be assured and the treatment adapted to the needs of the child and family members.

## Intensity
Fourteen group sessions with 6–8 members per group delivered during 1 class period a week. An individual pull-out session is done mid-protocol to introduce narrative exposure in a controlled way. (An individual assessment session is also done prior to group work). This allows the therapist to adjust treatment so that the balance between child individual and group trauma processing can be optimized.

## Essential Components
<table>
<thead>
<tr>
<th>Session</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Psychoeducation</td>
</tr>
<tr>
<td>2</td>
<td>Anxiety Management</td>
</tr>
<tr>
<td>3</td>
<td>Anxiety Management and Cognitive Training (Thinking, Feeling, Doing and Stress Thermometer)</td>
</tr>
<tr>
<td>4</td>
<td>Cognitive Training (Traumatic Reminders)</td>
</tr>
<tr>
<td>5a</td>
<td>Anger Coping</td>
</tr>
<tr>
<td>5b</td>
<td>Grief Management</td>
</tr>
<tr>
<td>6</td>
<td>Individual Pull-out Session (Narrative Exposure)</td>
</tr>
<tr>
<td>7</td>
<td>Setting Up the Stimulus Hierarchy (group)</td>
</tr>
<tr>
<td>8</td>
<td>Group Narrative Exposure</td>
</tr>
<tr>
<td>9</td>
<td>Group Narrative Exposure (Cognitive and Affective Processing)</td>
</tr>
<tr>
<td>10</td>
<td>Group Narrative Exposure (Worst Moment)</td>
</tr>
<tr>
<td>11</td>
<td>Worst Moment Cognitive and Affective Processing</td>
</tr>
<tr>
<td>12-13</td>
<td>Relapse Prevention and Generalization</td>
</tr>
<tr>
<td>14</td>
<td>Graduation Ceremony</td>
</tr>
</tbody>
</table>
### Assessment/Outcome Measures Used

The following were used in the 1998 study (research tools):

- Child and Adolescent Trauma Survey – CATS (March & Amaya-Jackson)
- Clinician-Administered PTSD Scale — CAPS-C (Nader et al., 1994)
- Children’s Depression Inventory (Kovacs, 1985)
- Clinical Global Improvement (Guy, 1976)
- Multidimensional Anxiety Scale for Children – MASC (March et al., 1997)
- Stait-Trait Anger Expression Inventory (Spielberger, 1988)
- Nowicki-Strickland “What Am I Like” Scale – (Nowicki & Strickland, 1973)
- Conner’s Teacher Rating Scale for ADHD (Conner’s, 1995)

### General Treatment Measure Recommendations for the model:

- Any measure of PTSD, depression, and anxiety can be used. An exposure to violence measure is also suggested as part of assessment and several can be recommended.
- The CATS is a screening tool that is useful in settings such as schools to identify child candidates for group membership in conjunction with teacher/counselor recommendations. Group membership may be selected via other strategies as well.

### Training Requirements

- Recommended for clinician supervisors and therapists with a master’s degree or higher.
- Readiness assessment for general CBT experience
- Basic understanding of childhood PTSD and related symptoms
- Reading the manual and select articles
- Organizational Readiness assessment for school and/or clinic intervention

Training depends on extent of training/experience with trauma-focused mental health interventions:

- (Recommend) Intensive skills based training, one to two days
- (Recommend) Ongoing expert consultation from trainers for 4-6 months (this may require longer if consultation is needed on establishing the relationship with school or school district).
- Advanced Training as requested

### Fidelity Monitoring Procedures

Minimal when used outside the research setting. The protocol lays out a components-based approach of key tasks that allows flexibility to accommodate individual and group membership needs. Adaptation to specific population needs is encouraged. Consultation can guide this if requested.

### Implementation Requirements and Readiness

- Clinical supervisors with training in trauma specific CBT & a good working knowledge of the model.
- Clinical staff with training in the model
- Established relationship with school, school personnel, & designated school staff collaborating on implementation.
| Implementation... Cont’d | - Determine if a school counselor will be co-leading group (not required but should be considered—especially in elementary school setting).
- Private rooms conducive to group treatment
- Flip boards, chalk boards
- Consideration of target population needs and if adjunct services necessary. |

| Outcomes/ Evaluation | MMTT was the first controlled study of a protocol-driven CBT intervention for children and adolescents suffering from PTSD arising in the context of a single-incident trauma (March et al., 1998). Experimental control across time and setting in a small sample (in 2 elementary and 2 junior high schools) demonstrated robust beneficial effects of treatment for reducing PTSD, depression, anxiety, and anger using an 18 session protocol. Locus of control remained external from pre-to post-treatment but became strongly internal at follow-up.

Additional studies using a shortened (14 session), developmentally enhanced protocol in 2 elementary schools, 1 high school, and a community based clinic revealed similar (published) findings. |

| Adaptations for Special Populations or Settings | MMTT was also replicated in controlled (unpublished as yet) study in a residential treatment setting. (Michael, K. D., Hill, R., Hudson, M. L., & Furr, R. M. 2002, October). Adjunctive manualized treatment of sexually traumatized youth in a residential milieu: Preliminary results from a small controlled trial. Paper presented at the Kansas Conference in Clinical Child and Adolescent Psychology, Lawrence, KS.)

The treatment is currently being replicated in Canada, India, and Africa. |


| Anecdotal Observations | This work received two awards:

1996 American Academy of Child & Adolescent Psychiatry Norbert and Charlotte Reiger Excellence in Service Award
1998 American Academy of Child & Adolescent Psychiatry Scientific Achievement Award

MMTT has been used as a model for several other empirically-supported school and clinical setting trauma-focused cognitive-behavioral treatments. |
<table>
<thead>
<tr>
<th>Treatment Developers</th>
<th>John S. March, MD, MPH, and Lisa Amaya-Jackson, MD, MPH, Duke University Medical Center, with Edna Foa, PhD and Kimberly Treadwell, PhD, consultants from University of Pennsylvania. The manual is available free of charge.</th>
</tr>
</thead>
</table>
| Contact Information  | Ernestine Briggs-King, PhD  
Director, Trauma Evaluation and Treatment Program  
or  
Robert Murphy, PhD  
Executive Director  
Center for Child and Family Health, NC  
Durham, NC  
919-419-3474 ext. 228 or ext. 291  
email: brigg014@mc.duke.edu or Robert.Murphy@duke.edu  
www.ccfh.nc.org |