

Integrative Treatment of Complex Trauma for Children (ITCT-C):
A Guide for the Treatment of Multiply-Traumatized Children
Aged Eight to Twelve Years

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Sources for this treatment guide

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How this treatment guide should be viewed

This is a summary version of *Integrative Treatment of Complex Trauma for Children (ITCT-C)*. The final ITCT-C guide, incorporating adaptations and revisions received through reviews by clinicians throughout the National Child Traumatic Stress Network and others across the U.S., will be available within the next year. Both this guide, and the final version of a related guide -- *Integrative Treatment of Complex Trauma for Adolescents (ITCT-A): A Guide for the Treatment of Multiply-Traumatized Youth*, authored by Briere and Lanktree (2008) -- are available to clinicians at www.johnbriere.com.

References to the literature

In the interest of brevity, most citations to the trauma literature are not included in this version. The revised treatment guide, upon its release, will be fully referenced. However, major sources of information relevant to ITCT-C are presented in the Appendix.

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Chapter 1

Introduction and Overview

Integrative Treatment of Complex Trauma for Children (ITCT-C) is a comprehensive, assessment-driven components-based model, integrating theoretical and clinical approaches for the treatment of complex trauma in children and adolescents. ITCT-C has been empirically evaluated in the past several years and was identified as a “promising practice” in the NCTSN by the Complex Trauma Workgroup. This model has been presented at various conferences and trainings for the past five years.

ITCT-C was developed at Miller Children’s Abuse and Violence Intervention Center (MCAVIC), an outpatient, multidisciplinary assessment and treatment center at Miller Children’s Hospital in Long Beach, California, with support from the Substance Abuse Mental Health Services Administration (SAMHSA). SAMHSA funded MCAVIC as a Category III (Community and Treatment) Services Center of the National Child Traumatic Stress Network (NCTSN) from 2001 through 2005. In 2005, MCAVIC collaborated with the University of California, Psychological Trauma Program to become the MCAVIC-USC Child and Adolescent Trauma Program, a Category II Treatment and Service Adaptation Center of the NCTSN. The mission of this Category II center is to provide nation-wide training, adaptations, and dissemination of the ITCT-C model. This treatment manual is focused on multiply traumatized children aged 8 to 12 years. An updated version, available in 2009, will include further research and information supporting the theory and interventions of ITCT-C. Another treatment manual, currently available, is designed for treatment of complex trauma in adolescents and young adults aged 12 to 21 years of age (Briere and Lanktree, 2008).

Because this is a multi-modal, comprehensive treatment model, much of the effectiveness of the therapist relies on the therapist’s skill, sensitivity, creativity, openness to the client, and actual enjoyment of the therapy process. Although specific interventions and activities are described, this is not a “how-to manual”. ITCT-C is designed to inspire therapists to approach the treatment of complex trauma with a component-based treatment model using individualized based on regular, comprehensive assessments, and allowing for adaptations related to the client’s age, developmental level, and cultural/ethnic background.

ITCT-C is a relationally based model incorporating tenets of complex trauma theory (e.g., Cook, Spinazzola, Ford, Lanktree, et al., 2005; Herman, 1992), attachment theory (e.g., Bowlby, 1988), cognitive behavioral approaches (e.g., Cohen, Mannarino, & Deblinger, 2006), and the Self Trauma Model (e.g., Briere, 2002; Briere & Scott, 2006). Types of trauma addressed with ITCT-C include child physical and sexual abuse, emotional abuse and neglect, traumatic bereavement from loss of family members and close friends, witnessed or experienced peer or domestic violence, community violence, parental substance abuse, and medical trauma associated with severe medical condition or injury.

MCAVIC provides ITCT-C or ITCT-A interventions to clients aged 2 to 21 who have experienced any of the above-named traumatic exposures, with an emphasis on comprehensive, regularly administered assessments. Results of regular, standardized evaluations of functioning assist clinicians in identifying significant problem areas and provide information about improvement or exacerbation over time. In addition, assessment data are collected to evaluate the effectiveness of ITCT-C in meeting individual clients' treatment needs, as well as documenting the overall empirical effectiveness of ITCT-C. A matrix for the selection of assessment measures for a given client, depending on his or her age, can found in Appendix 1.

ITCT-C has a variety of components, including affect regulation training, titrated exposure, cognitive therapy, and relationship processing, which are differentially utilized according to each child's specific problems or issues. In addition to individual therapy, ITCT-C often involves collateral, family, and group therapy. Parent education classes are also provided for caretakers struggling with parenting issues. ITCT-C has been adapted for school-based clients/students experiencing traumatic loss, community violence, parental substance abuse, and exposure to domestic violence. Adaptations of ITCT-C components can be made for younger children, but with a stronger emphasis on symbolic and expressive play, shorter individual therapy sessions for child clients, and an even greater emphasis on collateral and family sessions to facilitate appropriate caretaker support and parenting skills. Weekly collateral sessions with primary caretakers are integral to the ITCT-C model with younger child clients.

This model particularly targets economically disadvantaged children, many of whom are coping with additional stressors associated with unsafe communities in urban environments. It is sensitive to the needs of culturally diverse groups, including African Americans, Latino Americans, Asian Americans, and Pacific Islander Americans, as well as Caucasian/White

Americans. Frequently, ITCT-C clients are coping with stress associated with immigration (from Mexico, Central America, Pacific Islands, and Southeast Asia), acculturation challenges, separation from primary caretakers who may remain in their country of origin, and attachment/relationship difficulties associated with being reunited with family members after a period of separation. This approach especially stresses cross-cultural issues and stressors such as socioeconomic resources, racial discrimination, and unsafe communities. It has also been adapted for use in urban schools in economically impoverished areas, including alternative (e.g., storefront) school settings. Nevertheless, although developed in an urban environment, ITSC-C can also be used in rural settings and with clients who may not be as economically disadvantaged or culturally diverse. And, interventions described can be used with multiply traumatized children and adolescents who may not be facing the same extent of external stressors.

The client's history of attachment relationships and current relational schema is especially relevant in ITCT-C. The therapeutic relationship is thought to trigger the child's trauma-related reactions as well as allow for opportunities to countercondition relational trauma memories (Briere and Scott, 2006). A supportive context and trusting relationship with the therapist is key to the processing/recalling of traumatic material, where attachment issues are triggered and trauma-related feelings occur, but the child has an increasing sense of safety and security in therapy sessions.

Empirical Support for ITCT-C

ITCT-C has been evaluated in several studies, albeit none with randomized control groups. Most recently (Lanktree, 2008), 137 clinic-based clients were included in a comparison of scores on the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) at intake versus a second administration 3 or more months later. There were 90 (66%) females and 47 (34%) males in this sample. Clients were culturally diverse: 15% Caucasian, 28% African American, 46% Hispanic, and 11% Asian American and Other. The mean age was 11.5 years, ranging from 8 to 15 years. Types of trauma experience by clients included: sexual abuse (54%), physical abuse (25%), witnessing domestic violence (29%), community violence (15%), traumatic loss (31%), medical trauma (14%), and other trauma (37%). The majority of clients (58%) had exposure to two or more trauma types, based on information known to the therapist.

Results indicated that all subscales of the TSCC (Anxiety, Depression, Posttraumatic Stress, Anger, Dissociation, and Sexual Concerns) decreased significantly from Intake to Time 2. In addition, there were no cultural/racial differences in treatment effectiveness.

Clients receiving ITCT-C at school sites have also been studied. For both more mainstream schools, and alternative (“storefront”) school sites, clients reported statistically significant reduction in trauma-related symptoms such as posttraumatic stress and depression as a result of shorter-term treatment groups (11 weeks for alternative students, 13 to 15 weeks for mainstream students). For the mainstream elementary and middle school children receiving ITCT-C group treatment at school sites, other symptoms measured by the Trauma Symptom Checklist for Children-A (TSCC-A; Briere, 1996) including anxiety and dissociation also improved significantly. Students in the “storefront” program reported significant reductions in feelings of ineffectiveness, anhedonia, attention problems, and oppositional behaviors, as measured by the Child Behavior Checklist (CBCL-Youth Report; Achenbach, 1991). The adaptation of ITCT-C for this latter group also included classroom support on an almost daily basis and biweekly consultation groups for teachers and social worker throughout the school year. Chapter 14, School-Based Interventions and Other Adaptations of ITCT-C, provides further details regarding specific school-based ITCT-C interventions and protocols.

Adaptation and implementation challenges

Issues and challenges in the implementation of ITCT-C include its focus on more than a single trauma exposure. In many cases, the therapist needs to constantly assess the extent to which different traumatic exposures are having an impact on the child. In fact, in many cases it may be unclear what adverse experience or environment is responsible for what current problem or symptom. Fortunately, the approach advocated in this guide is primarily concerned with the resolution of current symptoms and problems, and is not as focused as some models (e.g., classic exposure therapy) on the client specifically processing a discrete, identified, traumatic event or memory.

An additional potential challenge for those using ITCT-C is its reliance on the therapeutic relationship as a critical component. The relational aspect of this therapy means that the clinician must be aware of his or her own strengths and weaknesses as they play out in his or her interactions with (sometimes very challenging) child clients. As noted in chapter 15, this requires constant vigilance to the ways in which the clinician is potentially triggered by the client, and

emphasizes the need for peer collaboration and supervision/consultation with more experienced therapists.

Some centers and or independent professionals may have difficulty implementing a full assessment protocol for their clients. Yet, many funding sources require these assessments to be done in order to ensure most effective treatment interventions programmatically, as well as to evaluate clinical improvement of individual clients. Others may be limited in the number of sessions they can offer clients, based on funding issues. Adaptations of ITCT-C, including a reduced assessment battery and modifications for shorter-term treatment models, can be made while still adhering to the basic assessment-based, component-oriented philosophy of ITCT-C.

Another challenge for programs providing ITCT-C -- or other trauma-focused interventions -- is the need for a positive, collaborative team spirit. On occasion, trauma therapists will find that their own histories of trauma or loss are significantly activated by the work they do, to the extent that it interferes with their effectiveness. Therapists working with traumatized children, adolescents, and families are especially confronted with the challenges entailed in regularly addressing other people's pain. Some clinicians may become "burned out" by the structural issues associated with working in an agency that is struggling with inadequate budgets, excessive caseloads, and insufficient staffing. These and other stressors can result in the clinician experiencing challenges in his or her interactions with colleagues and clients. Building a positive, mutually supportive, and respectful working environment should be a particular goal for this work. As described in chapter 15, co-therapy with groups and families can enhance sense of mutual respect and learning from others, as can regular group supervision and multiple opportunities to "debrief" with peers in an accepting, supportive environment.

Chapter 2

What is Complex Trauma and How Does ITCT-C Address It?

Complex trauma is typically defined as a combination of early and late-onset, multiple, and sometimes highly invasive traumatic events, usually of an ongoing, interpersonal nature. In most cases, such trauma includes exposure to repetitive childhood sexual, physical, psychological abuse, and/or family violence, often in the context of concomitant emotional neglect and harmful social environments. Children who have experienced medical trauma (e.g., chronic serious illness or serious physical injury) and/or traumatic loss may also have symptoms of complex trauma. As noted by the National Child Traumatic Stress Network (NCTN) Complex Trauma Working Group, “children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment...in childhood, adolescence and adulthood” (Cook et al, 2005). Among the impacts of complex trauma are anxiety and depression; dissociation; relational, identity, and affect regulation disturbance; cognitive distortions; “externalizing” behaviors such as self-mutilation and violence; sexual disturbance; and substance abuse (Briere & Spinazzola, 2005; Cook et al., 2005). A full version of the NCTSN white paper is available at www.NCTSN.net.

Cook et al. (2005) described further how the impact of complex trauma go beyond posttraumatic stress alone, typically occurring in a number of domains -- biological, attachment, affect regulation, dissociation, cognitive, behavioral control, and self-concept. Although children exposed to trauma may be diagnosed with PTSD, major depression, and/or some form of anxiety disorder, these diagnoses capture only a limited aspect of the traumatized child’s complex self-regulatory and relational impairments.

Most children presenting with complex trauma symptoms also have experienced an insecure attachment with their primary caretaker(s). Abuse and/or neglect involving a close interpersonal relationship is also especially likely. The age of onset is important and other factors also contribute to the extent of trauma. It is important that the therapist consider the following when they evaluate clients at risk for symptoms of complex trauma.

Comparison of Simple Trauma versus Complex Trauma

<u>Simple Trauma</u>	<u>Complex Trauma</u>
<ul style="list-style-type: none"> • Non-interpersonal • Limited exposure---may be a single incident • Shorter duration • Onset of traumatic exposures more likely to be at later stage of development • Support of caretaker/family • Secure attachment with primary caretaker(s) 	<ul style="list-style-type: none"> • Interpersonal • Multiple exposures of different types of trauma • Longer duration • Onset of traumatic exposures may have begun at an earlier stage of development • Less or no support of primary caretaker/family • Insecure attachment

Factors Related to Complex Trauma Symptoms

A traumatized child will present with more or less symptoms of complex trauma depending on the extent to which one or more of the following factors are present:

- **Relationship to abuser**
 - A closer relationship with the abuser has been found to contribute to increased symptomatology. Often, the child will express feeling a stronger relationship to the person who sexually or physically abused him or her than to any others in their environment. Such abusers may have provided attention, privileges, outings, etc., in order to gain access to the child. It is important to consider the child's relationship to the offender as often multi-dimensional and confusing.
- **Intensity, invasiveness, or other especially deleterious aspects of abuse or violence.**
 - Lasting physical injuries can be perpetual reminders of the traumatic experience.
 - Sexual abuse can be particularly related to complex trauma symptoms; emotional abuse and neglect are frequently associated with sexual abuse, especially when

occurring in an intrafamilial context (e.g., the perpetrator is a biological parent, step-parent, grandparent etc.). Sexual abuse can also be very difficult for a child to disclose, for a number of reasons. Younger children are particularly dependent on their caretaker(s) and may not want to upset them or lose them, or have fears of what will happen when they disclose. The abuse may have continued for a considerable period of time and the child may have tried to disclose without being heard or protected from further abuse. Children can be reluctant to disclose sexual abuse due to shame, a belief that they somehow contributed to the abuse, and/or anticipated repercussions---disruption of family, removal of primary economic support, separation from family members due to removal from their home, and anger from family members. They also may have been directly threatened with harm to themselves and/or to family members if they disclosed the abuse.

- It is important that the therapist consider (but not assume) sexual abuse as a possibility -- even when a child is not disclosing -- if behaviors are consistent with sexual abuse, and/or if the child is especially distressed and demonstrating symptoms of complex trauma. As noted, this type of trauma can be especially difficult for a child to disclose due to issues of shame, secrecy, and possibly, close relationship with abuser, and lack of protective caretaker.
- Family system issues associated with intrafamilial abuse often contribute further to the child's trauma. Emotional abuse and neglect often associated with physical and sexual abuse may be overlooked and can contribute significantly to the traumatic impacts. If a child is not supported (or is rejected) by the primary caretaker or other relevant adult family members at the time of the disclosure of child abuse, further distress for the child is likely. This aspect of the trauma may need to be addressed even before specific details of the abuse are explored. A child in these circumstances is also likely to have greater mistrust of the therapist, and may require more time for the therapeutic relationship to develop.
- **Losses associated with abuse and other circumstances**
 - Losses may include when a caretaker is incarcerated or a child is placed away from the primary caretaker. In other instances, there may be a traumatic loss of a

close family member and/or friend (e.g., grandparent who raised them, loss of a sibling in an automobile accident, witnessed shooting death of parent or friend, death of a family member from AIDS, or suicide of a parent). Many clients experiencing complex trauma have had a combination of several losses, which further exacerbates their difficulties in forming attachments and close relationships, as well as their ability to process their traumatic abuse or violence-related experiences.

- Losses experienced multi-generationally should also be considered as they contribute further to the family's stress and inability to support the traumatized child. Some families have experienced extensive traumas over many generations including severe/life-threatening illnesses, substance abuse, violence, child abuse, traumatic death or separation, poverty, and discrimination, and may be severely compromised regarding the emotional support and resources that they can offer the traumatized child.
- **Medical injury or severe medical condition**
 - In some acute medical contexts, children are brought to the Emergency Department because of physical injuries associated with shooting, stabbing, fires, physical assault, and/or sexual victimization. Children also may present with physical illness (e.g., childhood diabetes, kidney disease, cystic fibrosis, serious infection, HIV, cancer, organ transplant) and may require invasive medical procedures. The serious medical condition itself may also be further complicated by neglect and/or abuse issues. Conversely, an abused child who is also dealing with a physical disability associated with injury from abuse or violence, or receiving ongoing medical treatments for the injury or illness, may present with especially severe or intense trauma symptoms.
- **Self-blame, shame**
 - It is important that the therapist evaluate for possible self-blame or shame in the child, but not assume that they are necessarily present. Shame or guilt is more likely for children who have experienced abuse of a more interpersonal nature, (e.g., by a family member or friend), often because they trusted that person, had a relationship with them, and are trying to understand how their trust was betrayed.

- **History of multiple traumas before or after the trauma exposure that brought the child to therapy.**
 - Although a child may be presenting for treatment due to, for example, foster placement and recently reported physical abuse in their previous home, he or she may eventually report sexual abuse that is contributing significantly to complex trauma symptoms. Or, there may have been previous attempts on the child's life that he or she is not able to describe or discuss until some modicum of safety with the therapist and at home has been established. The child may, instead, initially express anger or sadness regarding the separation or loss of a caretaker before exploring previous traumas that were particularly frightening.
- **Premorbid functioning**
 - A child who had impaired social functioning, limited coping skills, or a significant psychological condition (e.g., depression or ADHD) prior to the traumatic event may exhibit more complex trauma symptoms.
- **Cognitive/developmental delays**
 - A child who appears to have cognitive and/or developmental delays may present as such because of trauma exposures that have interfered with their ability to learn and perform academically. The child also may have been exposed to prenatal substance abuse, have sustained a head injury, or may have limited capacities due to other biological factors. Psychological assessment can be very helpful in ruling out cognitive delays or neurological impacts arising from head trauma, early neglect, or prenatal substance exposure, as opposed to difficulties more directly associated with abuse.
- **Insecure attachment**
 - As described previously, caretaker-child attachment issues may compromise parental ability to protect the child, lead to (or reflect) family dysfunction, arise from unresolved trauma of primary caretaker(s), and result in a relative lack of emotional attunement and consistent, dependable nurturance of the child.

- **Age of first trauma experience**
 - Children who have experienced abuse and/or neglect especially early in life generally appear to have greater psychological or emotional difficulties, especially in the areas of identity, affect regulation, and interpersonal relatedness.
- **Lack of community safety, poverty**
 - Some children, especially those who are socially or economically marginalized, may not be able to play or move about their neighborhoods freely without threat of violence. The increased stress of always being vigilant to danger, including gang-related activity, combined with parental struggles to support their families financially, can contribute further to the traumatic impacts for the child and their family.
 - Poverty can also be associated with a greater likelihood of single parenthood, low education, and drug and alcohol abuse.
- **Cultural and gender considerations/differences**
 - In some cultures, children may be required to honor their elders regardless of their treatment of them, and males may be valued more than females. Some cultures consider children who have been sexually abused as being damaged and no longer “virgins”. In other cultures, spirituality and religion are particularly valued and those who seek therapy may feel stigmatized by seeking help outside their family and their church. For children living within ethnic cultures or subcultures who have been oppressed by the mainstream or dominant culture, traumatic experiences may have been further exacerbated by feelings of disenfranchisement and disengagement.
 - It is especially important, however, to not generalize across cultural/ethnic groups but to recognize differences within groups, including country of origin, language differences, socioeconomic factors, level of acculturation, isolation versus identification with their culture and ethnicity, and beliefs/values impacting perceptions and impacts of trauma exposures.

Case Examples Illustrating Background Factors Contributing to Complex Trauma

The following cases illustrate a number of the factors described above that may contribute to symptoms of complex trauma:

Case 1

B. is an 11 year old biracial girl who was referred to a trauma-focused outpatient treatment center by a hospital social worker due to her HIV+ status, depression, anxiety, and traumatic grief, the latter related to the recent loss of her grandmother and anticipated loss of both her mother and father from AIDS. B.'s mother also has been diagnosed with cancer but is currently in remission. Both parents are currently not able to work, creating significant financial hardship for the family. B. presents with high levels of dissociation and anger as measured by the Trauma Symptom Checklist for Children (a trauma-specific measure described in Chapter 3), and demonstrates difficulties in her attachment relationships (e.g., difficulty trusting and relating to others) and with affect regulation (e.g., becomes easily triggered emotionally, and frequently has angry outbursts).

Due to her parents' illnesses and their own trauma histories, B. has not received consistent parenting from them and, at times, was physically and emotionally neglected by each of them. She also may have been abused by others caring for her, although she has not disclosed any details. She often spent time with her grandmother and appears to have had a stronger attachment to her grandmother, than to her parents. There was considerable conflict between B.'s parents and grandmother during the past few years, especially with regard to the parenting of B. As a result, B. was not allowed to see her grandmother, who became very ill and ultimately died.

B. has medical problems associated with being HIV positive, as well as difficulties complying with her treatment regimen. She also has considerable psychological symptomatology, as described above, probably due to inconsistent and neglectful parenting, medical trauma, and abuse compounded by poverty and living in an unsafe neighborhood. B. continues to struggle in therapy with these issues, which also interfere with her ability to process her traumatic grief related to the loss of her grandmother, a primary attachment figure. Because of the complexities of her attachment relationships with her parents, she also has additional problems associated with addressing her feelings related to the anticipated loss of her parents.

Case 2

Z. is a 10 year old Latino male who was referred to a trauma-focused outpatient clinic by a school counselor following the recent murder of his father. He was apparently the victim of a drive-by shooting while standing in the family's front yard. Z. is described by the counselor as being frequently tearful, depressed, and "spaced out." He reportedly does not respond to others when spoken to and has difficulty focusing on academic tasks in the classroom. In therapy sessions, he cries uncontrollably and reports that he does not feel close to any other family members, and that his father was the person that he loved and trusted the most. Z. denies that he has any friends and has considerable difficulty engaging with the therapist----often appearing withdrawn, agitated, and sad.

His profile on the Trauma Symptom Checklist for Children reveals clinical elevations on Depression, Dissociation, Posttraumatic Stress, and Sexual Concerns. Z. appears in therapy sessions and elsewhere, per his mother and teacher, to be having problems with identity, attachment relationships (i.e., not engaging with others, and being mistrustful of family members and peers), dissociation, and affect regulation (i.e., becoming very emotionally distressed at family events and on occasions when his father would have been present in the past). Although Z. denied any sexual abuse initially, he later reported in therapy that the adolescent friend of an older brother had sexually molested him on multiple occasions, fondling him and forcing him to orally copulate the older boy. He reports that he had disclosed to his mother soon after the alleged abuse occurred, but that she had not believed him and had not told his father. Z. had not told his father because he was worried that he would blame him and no longer "be proud of me". Z. also reported that his parents did not get along most of the time, saying that they had "a lot of fights" but denied that there had been any physical violence. Z.'s mother alluded to a previous history of being hit by Z.'s father, but would not provide further details.

Z.'s traumatic grief related to the sudden violent death of his father and his ability to process his feelings in therapy is complicated by other traumatic exposures, including the alleged sexual abuse and history of parental conflict. There is also concern that he is not receiving consistent parenting or support from his mother, who reports feeling angry towards her late husband and states that Z. reminds her of him. Due to Z's relational difficulties, dissociation, and affect regulation problems, he is not yet able to fully address his grief in treatment. He also will

need to develop greater trust in the therapeutic relationship before he can process his traumatic grief and other traumatic events.

How does ITCT-C address complex trauma?

The Self-Trauma model (Briere, 2002; Briere and Scott, 2006) used in ITCT-C provides an integrated approach to complex posttraumatic outcomes that are both cognitive-behavioral and relational. It takes symptoms beyond PTSD into account, involves titrated exposure to traumatic material, and includes these major tenets: emphasis on the therapeutic relationship, affect regulation training, trauma processing, cognitive interventions, and identity development. ITCT-C integrates interventions to address impacts and symptoms in all these areas:

- ITCT-C allows for shorter-term or longer-term therapy, ideally allowing for comprehensive and multiple modalities---individual, collateral, group, and family interventions – in order to address the particular child’s and family’s needs. Interventions also address psychological issues that are impacted by cultural background, age, gender and resources. Although this approach has been designed with inner city, culturally diverse, and disadvantaged children and their families in mind, it has also been adapted for clients in rural settings and for those who do not have the additional stressors of community violence, poverty, and discrimination, but are nevertheless experiencing the impacts associated with complex trauma.
- ITCT-C is based on components (e.g., affect regulation training, building safety, emotional and cognitive processing of trauma, increasing attachment/relationships) within a structured model, yet allows for flexibility of interventions in order to address the individual needs of the client. For example, a child may have been referred because of reported sexual abuse by her father, but may need to address relational/attachment issues and build a sense of safety and trust within the therapeutic relationship before exploring specific traumatic exposures and developing a trauma narrative. In addition, the therapist may need to work with the primary caretaker to increase parenting skills and support so that the child feels greater sense of safety at home before exploring specific details of traumatic experiences and associated feelings.

- ITCT-C allows for an individualized approach based on clinical impressions and observations, along with repeated psychological assessment, to determine which symptoms and particular traumatic exposure(s) will be addressed in therapy. It is designed to be customized for each client in a manner that targets their current concerns, problems, and symptoms. A child who has experienced multiple types of trauma is likely to be able to explore some events and impacts more easily than others. The extent to which the child can discuss trauma and its effects is also influenced by the treatment context, i.e., hospital inpatient setting necessitating shorter-term interventions, school-based with particular confidentiality issues, or clinic-based where the child may also have disclosed specific abuse experiences in a forensic interview. For example, it is often the case that children seen in school-based programs are able to disclose traumatic loss and community violence in shorter-term groups and less likely to disclose child abuse or family violence.
- As previously described, ITCT-C was developed to assist inner city, culturally diverse, and predominantly economically disadvantaged children and their families, many of whom have experienced more than one type of trauma, as well as lack of resources, economic distress, and frequently, racial discrimination. A “one-size-fits-all” treatment model that assumes family support and economic resources, and is delivered over a limited number of sessions, often is not appropriate or effective with these clients.
- Length of time in therapy and timing of interventions: For the reasons stated above, it was also important to develop a treatment model that could allow for longer periods of intervention. Many children, faced with family system chaos, inadequate support from caretakers, multiple foster placements or separation from primary caretakers, and disenfranchisement from the mainstream culture, find that trust is a significant issue. Children in such contexts may require a significant period of time to develop trust and rapport with the therapist before interventions such as emotional and cognitive processing of trauma-related feelings can be pursued. This requires particular skill on the part of the therapist to be sensitive to the client’s current emotional state and cognitive perspective. A child who has greater attachment needs will require more time before he or she can directly communicate -- through play, art therapy, or verbal expression – prior traumatic events and their associated feelings. On the other hand, it is important for the therapist

not to unnecessarily delay direct trauma-related work, so that the child's avoidance is reinforced and trauma symptoms go unaddressed. Less experienced therapists may feel more comfortable continuing the stage of "rapport-building" for longer than is necessary. Supervision is a major way for the therapist to continue to evaluate the timing of their interventions, review assessment findings, and explore the extent to which they may be either supporting their client's avoidance or pushing too fast for exploration of traumatic experiences.

Chapter 3

Assessment of Complex Trauma

Overview and Objectives of Assessment

Integrative Treatment of Complex Trauma (ITCT-C) is an assessment-based treatment model. However, regardless of what clinical approach is used, assessment is important for several reasons:

- 1) At intake, to evaluate the individual needs of the traumatized child and to suggest targets for interventions.
- 2) Over time, to track the child's progress in treatment, especially when evaluations are administered at several month intervals and at termination.
- 3) To gather aggregate data in order to evaluate the effectiveness of the treatment model or program being used, and to support the sustainability of trauma-focused treatment via future funding.

Assessment of trauma-related disturbance can guide the therapist by indicating which symptoms are responding to treatment and which may need additional attention. For example, Lanktree and Briere (1995) conducted a treatment outcome study with 105 sexually abused children being seen at an outpatient center providing trauma-focused treatment. Assessments using the TSCC and Children's Depression Inventory (CDI; Kovacs, 1992) were administered at three, six, nine, and twelve month intervals. It was found that depression, anxiety, posttraumatic stress, dissociation, and anger were significantly reduced after three months of treatment, with depression, anxiety, and posttraumatic stress continuing to decrease at subsequent assessment intervals. Sexual concerns, however, were not significantly reduced until clients had received six months of therapy. This study supported the importance of assessing children and adolescents at intake and regular, 3-month intervals, since different symptoms may require different amounts of time for resolution.

The overall targets of psychological assessment are the child's trauma exposure history and current psychological symptoms. The assessment also should be as comprehensive as possible, and include information from multiple sources: the child's self report of traumatic

exposures and symptoms, caretaker(s)' reports of the child's functioning, and reports, as appropriate, from schools, child protection agency caseworker, and other professionals (e.g., a previous therapist or a prescribing physician).

Information is generally gathered at the time of the initial assessment with the child and available caretaker(s). Collateral sources are contacted to gain further information, once consents for release of information have been signed by the legal guardian or parent. This information might include the status of the child protection case and/or forensic investigation from the child protection worker (if there is one), school functioning, and medical issues. Because therapy should be kept separate from the forensic process, it is usually not advisable for the clinician to contact the investigating detective or prosecutor directly when an investigation is underway. If new abuse-related allegations are made, the therapist - - as a mandated reporter - - is required to contact the child protection and/or law enforcement agency and file a report. However, the therapist's role is to provide advocacy, support, and an open attitude toward new disclosures without becoming directly involved in the actual forensic investigation.

Background and Current Assessment Information

The background and current assessment information required for a comprehensive assessment includes:

- Reason for referral, including trauma exposure(s), such as reported physical and sexual abuse, psychological abuse and neglect, domestic violence, community violence, and/or serious medical condition or injury.
- Family history, including major family crises; caretaker functioning, such as employment history, mental health functioning, substance abuse, incarcerations, and illnesses.
- Primary attachment relationships, evaluated through the developmental history (prenatal, delivery, milestones etc.). If the primary caretaker is interviewed and is able to provide only limited developmental information, this is usually indicative of an insecure attachment. The evaluation includes the extent to which there has been consistent, nurturing, emotionally attuned caretaking versus inconsistent and/or neglectful parenting. Also assessed is any history of multiple caretakers, abandonment, or loss of caretaker(s).

- Current reported and observed symptoms in the child.
- History of suicidal and/or homicidal ideation and attempts for the child as well as family members.
- Child protective services involvement and placement history.
- Status of criminal investigation, if known; sometimes this information is collected from child protection workers.
- School and social functioning.
- History of any losses experienced by the child and other family members.
- Medical history and current physical status (including date of last physical examination, medications, allergies, injuries, surgeries, illnesses).
- Environmental and family stressors, such as community violence, racial discrimination, poverty, unemployment, an overcrowded home, and legal issues.

Assessment of Trauma Exposure

The primary types of trauma that should be evaluated for each client are: child abuse (physical, sexual, and psychological), emotional and physical neglect, witnessing violence done to others in the family and elsewhere, community violence, accidents and disasters, traumatic loss, and serious medical illness or injury. Information should include the nature of any traumas reported, as well as their number, type, and age of onset. For some children, multiple trauma exposures (abuse, neglect, family and community violence, relational losses, and/or injuries or illnesses) may occur concomitantly, resulting in a more complex clinical picture. Based on surveys of the National Child Traumatic Stress centers, as well as with analyses of clinical data at the MCAVIC-USC Child and Adolescent Trauma Program, it appears that the majority of children being seen for trauma-related treatment have experienced more than one type of trauma exposure and many have undergone multiple occurrences of each trauma type.

In many cases, the child will not report all significant instances of trauma exposure during the initial assessment session or early in treatment. Instead, important historical events may be disclosed later in treatment, as the child engages more fully with the therapist and experiences a greater sense of trust and safety (Lanktree and Briere, in press).

Limited or lacking emotional support and the absence of nurturing care from primary caretakers compound the impacts of these traumatic exposures. Lack of caretaker support can

also contribute to delayed disclosure of traumatic events (especially child sexual abuse), as well as increasing the extent to which a child feels traumatized or stigmatized by the abuse. Even within relatively supportive, caring families, there may be some caretaker reluctance to recognize cues or hints that the child has been abused, which may be perceived by the child as evidence of caretaker abandonment and an indication that they should “keep the secret”. Even when a child has disclosed trauma exposures, if the primary caretakers minimize the trauma or deny the emotional impact, the child may feel dismissed, rejected, or uncared for. Caretakers who are invested in maintaining relationships with family members who have been abusive are likely to be perceived by the child as discounting his or her experience, and thus may contribute further to the child’s distress.

The clinician should be prepared for a number of sessions, if not months in treatment (especially with more attachment issues and chaotic or dysfunctional families), before a reasonably complete trauma history and family history can be collected. This is especially true for younger children and those who are particularly vigilant to the impacts of their disclosures on their caretakers and family members. The therapeutic relationship and the extent of trust and safety that the child experiences with the therapist will contribute to a more complete disclosure as therapy progresses. Also, the therapist’s approach to the child (i.e., not acting as a forensic interviewer but, rather, providing appropriate open-ended questions and using a clinically sensitive, yet direct inquiry style) will increase the child’s readiness to disclose trauma, especially those related to abuse, neglect, and family violence.

The therapist’s sensitivity, sense of appropriate pacing -- not pushing too hard or moving too fast, but also not avoiding asking direct questions – will facilitate the child’s ability to discuss especially embarrassing, traumatic or shame-inducing experiences. An example of a therapist setting the stage might be, “Kids come here to talk about lots of things that have happened to them, like getting hurt or sometimes being made to do things they didn’t want to do. Did anything like that happen to you?” Play, drawings, sand tray, collage work, and board games can also facilitate discussion of specific traumatic incidents.

Sometimes children feel that it was enough to disclose trauma in a previous interview with a forensic interviewer, child protection social worker, or police detective, and that the therapist should access that information rather than asking the child to talk about it further. The therapist can let the child know that it is very important for her or him to understand what

happened, and to hear it in the child's own words. At the same time, it should be conveyed that the clinician wants to understand other things going on in the child's life, e.g., school, friends, favorite music, hobbies, likes and dislikes, and to otherwise indicate a genuine interest in the child's ongoing experience. For many children, this may be the first time that anyone has expressed such nonexploitive attention or caring.

The manner in which a child is evaluated can facilitate or hinder a disclosure, especially with regard to sexual abuse. Lanktree, Briere, and Zaidi (1991) found that when clinicians were not trained to directly inquire about sexual abuse, only 7% of the children being seen in a general outpatient psychiatric clinic disclosed sexual abuse. However, when clinicians were trained to directly ask about abuse, using gentle, open-ended questions, over 30% of all children (50% of girls) reported having been sexually abused. Those who did disclose sexual abuse were considerably more likely to have been diagnosed with major depression and to have made a suicide attempt in the past – suggesting that asking about abuse not only helps establish the child's trauma status, but also identifies a potential clinical marker for serious mental health issues.

The context in which the assessment is conducted also can affect the extent of trauma-related information that is disclosed by the child and/or family, whether by interview or on psychological tests (Lanktree & Briere, in press). In school settings, the child may not feel as free to divulge information due to concerns about confidentiality, including fear that his or her trauma history or symptoms will be shared with school personnel or other students. In hospital settings, where a child may be assessed for psychological trauma following a serious medical illness or condition (e.g., HIV infection, cancer, surgeries) or traumatic injury (e.g., an automobile accident), the child and family's need to cope with urgent or chronic medical issues may lead them to overlook or suppress information regarding prior (or current) abuse or violence. In forensic settings, issues of blame, punishment, and authority may cause the child to fear a) retribution from abusers by virtue of disclosing his or her trauma, or b) maltreatment, loss, or family disruption as a result of criminal justice and child welfare system involvement in his or her life --- each of which may motivate underreporting of traumatic experiences.

ITCT-C as an Assessment-Driven Model

Evaluation of Trauma-Relevant Symptoms

A comprehensive assessment should also include the evaluation of immediate safety issues, such as suicidality, substance abuse (in older children), and involvement of high risk behaviors, as well as a preliminary estimation of current emotional functioning and potential targets for treatment. The results of this assessment will determine whether an immediate clinical response is indicated (e.g., crisis intervention, hospitalization, harm reduction activities), as well as what specific treatment modalities (e.g., play therapy, cognitive interventions, therapeutic exposure, family therapy) might be most helpful and, in many cases, what order treatment components can be optimally provided for a particular client.

As described previously in this treatment guide, a child with early, sustained, and multiple trauma experiences may evidence significant disturbance in emotional, behavioral, developmental, cognitive, and relational domains, as well as presenting with significant posttraumatic stress (Briere & Spinazzola, 2005; Cook et al., 2005). In addition, gender-related, developmental, and cultural factors may affect how any given symptom manifests. For this reason, it is usually preferable to administer multiple tests, tapping a variety of different symptoms, rather than a single measure, and to take mediating demographic, social, and cultural issues into account (Lanktree & Briere, in press).

Within ITCT-C, assessment measures are administered at three to four-month intervals and at the termination of services. In this way, interventions can be implemented for specific trauma-related problems as they are identified through assessment, and then intensified, altered, or discontinued as further assessment reveals symptom changes over time. Assessment data is collected from the child and primary caretaker(s), through therapist observations, and based on contact (as appropriate) with school personnel, medical staff (if medical trauma is involved), and the child's pediatrician (if there is one).

Child self-report measures allow the child to directly disclose his or her symptoms or problems. However, the child's report may be affected by fears of disclosure, denial of emotional distress, or – especially in younger children – inability to report on complex internal states (Friedrich, 2002). The caretaker's report of the child's symptomatology, on the other hand, has the potential benefit of providing a more objective report of the child's symptoms and behaviors, yet may be compromised by parental denial, guilt, minimal contact with the child, the caretaker's

own trauma history, his or her preoccupation with the child's trauma, or feelings of anger toward the child.

Because both child- and caretaker-reports are subject to bias, it is often useful to administer both types, and to treat the resultant data as separate, but related perspectives on the child's functioning. For example, Lanktree, et al., (2008) found that scales of the Trauma Symptom Checklist for Children -- a self-report measure, and the Trauma Symptom Checklist for Young Children -- a caretaker-report measure, correlated with each other in expected ways and both measures were predictive of child maltreatment status. However, the TSCC and TSCYC were only moderately correlated, and each was able to predict trauma in ways that the other measure did not. These data suggest that similar measures with different reporting sources (i.e., child versus caretaker) may allow the clinician to more effectively "triangulate" symptomatology in traumatized children. This study also reinforced the importance of both child- and parent/caretaker-report measures being used in the evaluation of traumatized children, so that multiple sources of information can be considered simultaneously.

Assessment Measures that can be used with ITCT-C

The number and focus of ITCT sessions offered to each client will be variable and determined to a large extent by assessment information. For example, assessment results might indicate that a child is experiencing considerable anxiety, posttraumatic stress, and dissociation, suggesting a more extended course of treatment. Complex trauma also involves attachment issues and multigenerational trauma, however, so it is also important to consider ways to accurately assess attachment relationships and family functioning. Measures for these areas are less developed, unfortunately. The assessment matrix provided in Appendix 1 shows the measures currently used by the MCAVIC-USC Child and Adolescent Trauma Program, for the ITCT-C model. In addition, the Assessment Treatment Flowchart-Children's Version (ATF-C) in Appendix 2 connects the assessment information to prioritized treatment interventions. This process will be further described later in this chapter.

Standardized assessment measures of trauma-related psychopathology are almost always preferable to those without norms or validation studies. Measures may be either *generic*, tapping symptoms that are not necessarily trauma-related (e.g., depression, anxiety), or more *trauma-specific*, evaluating symptoms commonly associated with trauma exposure, such as posttraumatic stress, dissociation, or reactive sexual behavior.

Generic Measures

- Children's Behavior Checklist (CBCL)---Youth Self Report, Parent Report, and Teacher Report Forms (Achenbach, 1991)
- BASC-II
- Children's Depression Inventory (CDI; Kovacs, 1992)
- Attachment Style Children's Questionnaire (ASCQ; reference)

Trauma-Specific Measures (self-report)

- Trauma Symptom Checklist for Children (TSCC and TSCC-A; Briere, 1996) for 8 to 15 year olds
- UCLA PTSD Index for DSM-IV (UPID; Pynoos et al., 1998) for 8 to 18 year olds
- Child Sexual Behavior Inventory (CSBI; Friedrich, 1998)

Trauma-Specific Measures (caretaker report)

- Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) for 4 to 12 year olds

Using the Assessment Measures to Design Treatment Interventions

As described previously, psychological tests are administered at 3 month intervals (e.g., at intake, 3 months, 6 months, etc.) and examined so that symptoms can be compared across time intervals -- both to evaluate the progress of clients in therapy and identify treatment priorities, as well as to determine the effectiveness of the treatment model. Ongoing assessment at regular intervals, along with ongoing therapist clinical observations and collateral reports, may suggest the need for a shift in therapeutic focus as it becomes evident that some symptoms have responded to treatment and others continue relatively unabated or have even increased in severity (e.g., Briere, 2001; Lanktree & Briere, 1995). For example, is the child less anxious and less angry with three months of treatment, but more depressed, or is he or she having less difficulty regulating affect over time, but showing no change in sexual reactivity? The therapist can document these changes on the Assessment Treatment Flowchart (ATF-C; see Appendix) and choose appropriate interventions based on the Problems-to-components grid (see Appendix).

Case example:

An eight year old boy with a history of extended sexual abuse by an uncle and physical abuse by mother's boyfriend, in a general context of poverty and community (primarily gang-related) violence, endorsed clinically elevated levels of dissociation, posttraumatic stress, anxiety, depression, and sexual concerns at intake on the Trauma Symptom Checklist for Children (TSCC). Results on the Children's Depression Inventory (CDI), and the parent's report on the Trauma Symptom Checklist for Young Children (TSCYC), as well as a high level of internalized behavior on the Child Behavior Checklist (CBCL), supported the findings of the TSCC. The test results, along with verbal reports from the child and mother, and collateral information from school personnel (subsequent to a signed consent for release of information), led the clinician to rate five areas on the ATF-C as 4s ("Most problematic, requires immediate attention"): anxiety, depression, posttraumatic stress, dissociation, and sexual preoccupations). A number of other problems were ranked as 3s or 2s. These included caretaker support issues, relationship problems, safety-environmental (i.e., unsafe neighborhood), attachment insecurity, anger/aggression, low self-esteem, affect regulation/acting out, somatization, social skills, and school adjustment. Fortunately, the child was not exhibiting behaviors or endorsing items indicative of suicidality, risky behaviors, or grief. His intake ATF-C was as follows:

Priority ranking (circle one for each symptom):

- 1 = Not currently a problem (re-evaluate at each interval): Do not treat
 2 = Problematic, but not an immediate treatment priority: Treat at lower intensity
 3 = Problematic, a current treatment priority: Treat at higher intensity
 4 = Most problematic, requires immediate attention
 (S) = Suspected, requires further investigation

<u>Problem area</u>	<u>Assessment period</u>			
	<u>Intake</u>			
	<u>5/3/08</u>			
	Tx priority	Tx priority	Tx priority	Tx priority
1. Caretaker support issues	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
2. Safety – environmental	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
3. Safety – risky behaviors	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

4. Anxiety	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
5. Depression	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
6. Anger/aggression	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
7. Low self-esteem	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
8. Posttraumatic stress	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
9. Affect regulation/acting out	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
10. Attachment insecurity	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
11. Dissociation	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
12. School adjustment	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
13. Suicidality	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
14. Grief	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
15. Somatization	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
16. Identity	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
17. Social skills	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
18. Difficulty engaging in tx	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
19. Other: <u>Sexual issues</u>	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

As treatment progressed, the client showed improvement in anxiety, depression, dissociation, and posttraumatic stress at three months post-intake, leading the therapist to reduce his ATF-C ratings for these problem areas to “2”, “3”, “3”, and “2” respectively. Further, school adjustment problems, somatization, social skills, and low self-esteem were downgraded to “2”s or 1”s. Caretaker support issues and sexual preoccupations continued to be problematic, and ranked as “3”s. However, anger, affect regulation, attachment insecurity, and identity problems increased or stayed the same during at three months. Interestingly, the therapist reports that the anger and affect regulation ratings may, in fact, reflect the child’s greater experience of safety in sessions, allowing him to express trauma-related feelings in more overt ways. Other of these problems, i.e., attachment insecurity and identity, typically require longer-term therapy, as appears to be true in this case. Finally, due to the death of the client’s much loved grandmother between the

intake and the 3-month assessment period, grief was ranked “4” and became a treatment priority for many sessions thereafter.

The client’s 3-month ATF-C was as follows:

Priority ranking (circle one for each symptom):

- 1 = Not currently a problem (re-evaluate at each interval): Do not treat
 2 = Problematic, but not an immediate treatment priority: Treat at lower intensity
 3 = Problematic, a current treatment priority: Treat at higher intensity
 4 = Most problematic, requires immediate attention
 (S) = Suspected, requires further investigation

<u>Date:</u>	<u>Intake</u>			
	<u>5/3/08</u>	<u>8/10/08</u>	_____	_____
<u>Problem area</u>	Tx priority	Tx priority	Tx priority	Tx priority
1. Caretaker support issues	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
2. Safety – environmental	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
3. Safety – risky behaviors	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
4. Anxiety	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
5. Depression	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
6. Anger/aggression	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
7. Low self-esteem	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
8. Posttraumatic stress	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
9. Affect regulation/acting out	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
10. Attachment insecurity	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
11. Dissociation	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
12. School adjustment	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
13. Suicidality	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
14. Grief	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
15. Somatization	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
16. Identity	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

17. Social skills 1 **2** 3 4 (S) **1** 2 3 4 (S) 1 2 3 4 (S) 1 2 3 4 (S)
18. Difficulty engaging in tx **1** 2 3 4 (S) **1** 2 3 4 (S) 1 2 3 4 (S) 1 2 3 4 (S)
19. Other: sexual issues 1 2 3 **4** (S) 1 2 **3** 4 (S) 1 2 3 4 (S) 1 2 3 4 (S)

This is a typical example of how a child with complex trauma issues may present with a myriad of problems, some of which may respond to treatment relatively quickly, whereas others may require additional therapy (see Lanktree & Briere, 1995 for data on this time-related differential response). In this case, it is anticipated that the client will require considerably more treatment before the majority of his symptoms remit.

Chapter 4:

Advocacy and Systems Intervention

Social and economic deprivation, as well as racism, sexism, homophobia, and homelessness, not only produce their own negative effects on children and adults, they increase the likelihood of trauma exposure and may intensify the effects of victimization. Marginalization of children and families also reduces their access to appropriate trauma-focused mental health services; a serious problem, since a majority of inner city children have been exposed to community violence, let alone child abuse and/or neglect. Yet, many treatment models for traumatized children and adolescents do not address cultural or social differences and tend to be based on more of a “mainstream” approach, without recognizing culture-specific interventions and the additional impacts and challenges when clients are economically disadvantaged.

The National Child Traumatic Stress Network Summary Recommendations for Culturally Competent Interventions (NCTSN Cultural Competence Task Force, 2007) are as follows:

- Improve access to quality care in geographically remote areas
- Ensure language access.
- Examine the costs and benefits of culturally appropriate services.
- Reduce barriers in managed care.
- Overcome shame, stigma, and discrimination in seeking mental health services.
- Develop and evaluate culturally responsive services.
- Engage consumers, families, and communities in developing services.
- Address social adversities (e.g., poverty, community violence, racism, discrimination).
- Build on natural supports (e.g., spirituality, positive ethnic identity).
- Strengthen families.

NCTSN also recommends that mental health professionals and centers providing services to culturally diverse clients and families attempt to ensure that:

- The environment is welcoming and includes books and toys for all cultural

groups as well as books and games in the languages of clients served.

- Assessment measures and treatment interventions are culturally appropriate and whenever possible provided in the client's primary language.
- The therapist team, volunteers, and support staff are culturally diverse, and as much as possible, reflect the diversity of the clients served.
- Clients, including children and caretakers, are encouraged to discuss feelings, perceptions, and belief regarding their own cultural background as well as that of their therapist.
- All staff seek consultation regarding cultural norms, beliefs, and practices of clients served. Training and supervision continue to address cultural issues and appropriate interventions, including issues related to the client's and therapist's cultural backgrounds.
- The therapist considers acculturation and immigration issues and recognizes the diversity within a given culture, i.e., Latino/Hispanic, African-American, Asian cultures etc.
- Interventions facilitate exploration of cultural identity, increased awareness of diversity issues in community, and biases that may contribute to gang-related activity or other violence directed at members of other cultural groups.
- The agency sponsors and organizes events that facilitate greater cultural identity and awareness of other cultural groups, such as a multi-cultural anti-gang violence fair, annual client holiday party, sponsored outings, parent education groups, community presentations by agency therapists (e.g., Head Start, PTA meetings). For example, the MCAVIC-USC program provided a multi-cultural event, sponsored by a local community foundation, that included food from many cultures (Asian, Latino, African American, Pacific Islander), Ballet folklorica (Latino) dance performances, storytelling, Tongan dancing, African drumming, Miriachi music, and a craft activity table and display of hats of many nations of the world, sponsored by a local multi-cultural children's museum for arts and crafts. Also available were outreach materials and education from a member of the gang violence prevention program of a local law enforcement agency. This event was held to support the cultural identities of diverse

groups in the community, raise awareness and exchange of cultural backgrounds of the community, and support families in reducing gang-related violence.

- After-school programs reinforce cultural identity and expression, as well as increase cross-cultural awareness. In collaboration with a community recreation center and the local school district, for example, MCAVIC coordinated an after-school program for high risk traumatized youth, including hip-hop dancing, arts and crafts, and basketball.
- Outreach activities include community school/agency information fairs, parent education presentations at churches and schools in the community, and presentations to community agencies serving underserved clients. These activities can increase the visibility of the trauma-focused mental health agency and increase access to services for underserved clients.
- A culturally diverse consumer/family advisory council (including former clients and community professionals), and an expert panel comprised of culturally diverse professionals who are experts in the field of child trauma, are available to provide feedback to the trauma-focused center regarding culturally appropriate interventions.

In addition, for clients who are economically disadvantaged and have limited resources, ITCT-C providers may offer:

- Transportation to therapy sessions when needed through taxi vouchers, bus passes, or an agency van.
- Food, clothing, advocacy and referrals for legal support and housing. In some cases, such financial assistance can significantly change the family's life by no longer being homeless and /or moving to a safer neighborhood.
- Emergency financial assistance for children and families when starting back to school and for holidays (Thanksgiving, Christmas).
- Referrals to families for additional advocacy and support, e.g., social service agencies that can provide financial and legal aid, especially when families are living in unsafe housing or require assistance in applying for U.S. resident status.
- After-school programs and participation in organizations such as Big Brothers and Big Sisters, as well as the Boys and Girls Club in the neighborhood. Caretakers may not be

aware of free services in their community and these resources can supplement the advantages of ongoing therapy.

- Agency-sponsored after-school programs, multi-cultural events, and holiday parties to provide opportunities for dance, sports, food, art, and gifts (at holiday time). In many cases, clients have never experienced this level of support from their community.

Occasionally, clinicians view the advocacy components of good trauma therapy as “just casework,” and perhaps not as important as formal psychotherapy. Although it is true that advocacy activities alone cannot ensure recovery from trauma, the value of assisting traumatized children and their families with system-level issues and access to basic resources cannot be overstated. It is hard to process traumatic memory when one is hungry, without shelter, lacking safety, or feeling controlled by an impersonal social system. Further, the clinician’s attempts to help in these areas often has a significant impact on the child and his or her family; not only increasing their physical and social wellbeing, but communicating a level of willingness to be involved and helpful that almost inevitably strengthens the therapeutic relationship, as described in the next chapter.

Chapter 5:

The Client-Therapist Relationship

This chapter describes ways in which the therapist-client relationship can be facilitated, not only in relation to the child's relationship with the therapist, but also with the caretakers who are involved in the therapy process. Trauma is often associated with issues in the caretaker-child relationship, as described elsewhere in this guide, and, for the majority of children presenting with complex trauma, insecure attachment with primary caretakers compounds the emotional impact they experience. This attachment dysregulation may mean that both the child and his or her family suffer from poor relatedness. The therapeutic relationship, as an alternative and example of better interpersonal connection is often crucial to the success of therapy.

A critical aspect of the therapeutic relationship involves the timing and depth of therapeutic interventions. The therapist is, at some level, "in charge" of the session, but is also there to facilitate the child's growth. For this reason, the clinician must be careful to both intervene when necessary, as well as support and encourage the child in a nonauthoritarian environment. The therapist must respect the child's need to control, to some extent, the pacing of interventions, and in that way honor the client's boundaries. The pacing of interventions should be consistent with the client's self capacities and resources, while also encouraging the client to move forward through increasingly more difficult trauma-related material. If the therapist is pushing for more detail or trauma exposure work while the client is feeling overwhelmed, for example, the therapeutic relationship is likely to be affected. The child may withdraw from the therapist, become agitated and dissociated, or otherwise disengage from the treatment process.

Alternatively, if the therapist is overly non-directive or avoidant of trauma-related material, the client may experience the clinician as not emotionally attuned to him or her and/or perceive the therapist as overwhelmed (or, conversely, unaffected) by the client's disclosures of trauma-related experiences. The correct balance between caring and objectivity, or processing and support is often difficult to discern in work with visibly traumatized children. Some therapists find that having their sessions observed (i.e., through a one-way mirror) by colleague/peers or supervisors can be beneficial in providing feedback to the therapist regarding their body language, responses to the client, apparent level of engagement, as well as the client's behaviors and symptoms. More broadly, supervision or consultation with an experienced trauma

therapist may allow the clinician to better monitor the complexities of his or her relationship with the child and family.

The use of play and humor within therapy sessions is often also important, since it communicates that the therapist is enjoying being with the client. Even in the midst of trauma, sadness, and loss, children can show an amazing capacity to engage in games, play, and share a joke with the therapist. For example, a child might play with toys or engage in conversation that is funny or playful. Once, in a therapy session, a child was having difficulty fitting a toy shoe onto a Barbie doll's foot, which kept popping off and flying in a trajectory across the room. This became a joke for both the client and therapist, who could laugh together before resuming play that facilitated exploration of traumatic experiences and related feelings. It is important that the therapist be able to communicate relational attunement -- i.e., sensitivity to the feelings that a client is experiencing, and the potential for reactivation by material being discussed -- and to provide support, safety, as well as genuine interest and appreciation for the client.

If the therapist is having difficulty feeling empathy for the child, or experiences annoyance or irritation, it is usually helpful to explore these reactions in supervision, monitor them when they arise in therapy, and use self-care strategies to manage feelings. If a child is overactive, agitated, regressed, and/or not responding to therapeutic interventions, he or she may be expressing feelings of being overwhelmed by the therapist's attempts to process trauma or emotions. At this point, the therapist may need to engage the client in some grounding, breath training, or other relaxation exercises to reduce his or her anxiety, as described more fully in Chapter 6. In addition, structuring the session by presenting further options for play activities or expressive therapy (e.g., drawings, collage work), as well as the use of books or other psychoeducation materials, can help to reduce the client's anxiety. Sometimes, just providing more structure in the session can help the child to feel more at ease with the therapist.

The therapist may experience fatigue or frustration with certain clients, especially if the therapy is progressing slowly. It is important for the therapist to be able to acknowledge these feelings to colleagues and his or her supervisor. It is often helpful when feeling "stuck" (as well as at other times) to engage the child client in discussion regarding what they like or do not like about their sessions, and invite suggestions for how sessions might be more helpful. Sometimes this means checking in with the child about whether the therapist is "doing a good job," or whether anything he or she is doing is problematic for the client. For example, upon being

queried in this manner, an occasionally suicidal school-aged child expressed irritation with the therapist for asking in each session whether she was thinking of hurting herself. The client understood that the therapist needed to monitor suicidality each week, but objected to the therapist referring to the assessment as “wanting to hurt yourself” rather than “wanting to kill yourself”. The client expressed feelings that seemed to indicate that she felt that the therapist was minimizing her feelings. In other cases, a client may be able to state “I hate you” once they feel safe in the therapeutic relationship, and thereby more freely express their anger with their situation and therapy itself.

Sometimes, the therapeutic relationship can be altered by the child’s inability to disclose important material – most typically involving problematic behaviors or demands by caretakers. If a child appears to be avoidant or agitated in the session, the therapist may need to explore the extent their caretaker(s) is being supportive, and the home environment is safe. A child also may have been threatened by a caretaker, or be fearful of losing a placement if they reveal current circumstances (e.g., being hit by a parent in the home, when they have been mandated not to be in the home), and become agitated as a result of keeping a secret from the therapist. When the therapist is attuned to a client, he or she will often observe unusual behavioral changes that may be indicative of this type of distress, and then invite the client to talk about what may be happening at home or elsewhere. As previously unexpressed material is shared with the clinician, often the tension in the session will decrease, and the connection between client and therapist is often strengthened.

The quality of the therapeutic relationship, to a large extent, depends on the clinician’s behavior in the session, as well as his her attitude toward the client. As presented in the ITCT-C- A treatment guide (Briere & Lanktree, 2008), therapist behaviors and responses that may increase the client’s sense of safety and connectedness include:

- Nonintrusiveness
- Visible positive regard
- Reliability and stability
- Transparency
- Honesty, and
- Demarking the limits of confidentiality

In addition, having the opportunity to interact regularly with someone who listens, and seems to understand, can be a powerful and -- for many traumatized children -- new experience, especially with an adult. This experience is likely to strengthen the bond between client and therapist. Therapist behaviors that may increase this dynamic include:

- Attunement
- Empathy
- Acceptance
- Understanding
- Curiosity about the client's perspective and internal experience, and
- A client-centered focus (Briere & Lanktree, 2008)

As the child develops a greater sense of trust and safety with the clinician, he or she is also able to explore further other relationships, including primary attachments. The therapist should assess this growing capacity as it changes during treatment. The therapeutic relationship will evolve over time, as well, generally serving as an increasingly secure home base from which the child can explore his or her interpersonal world.

The various relational and attachment-related aspects of working with children who suffer from complex trauma, many of which are relatively slow to change during treatment, often means that ITCT-C can involve longer-term therapy -- especially for children who have particularly significant relational difficulties. In many cases, ITCT-C individual therapy continues for 6 months or longer, whereas group therapy (e.g., in the school-based program) tends to occur over 12 to 16 weeks with less opportunity for relational/attachment interventions.

The therapeutic relationship can also be strengthened by adding other modalities of therapy to individual therapy for the child client and collateral therapy for the relevant caretakers. The child's therapist, who also may be conducting (or co-facilitating) caretaker sessions, or consulting with the therapist providing collateral sessions, will also (ideally) co-facilitate family therapy sessions, once they begin. Likewise, group therapy -- typically beginning once there has been a course of individual therapy -- can strengthen the individual therapy

relationship. One of the effects of this multi-modal approach is that the child client is able to see how involved (and hopefully) helpful his or her therapist is in multiple aspects of his or her life.

A final issue that potentially impacts the therapeutic relationship is that of therapist advocacy, as described in the last chapter. On one hand, the clinician's involvement in advocacy/system intervention activities is usually viewed quite positively by the child and family. On the other, it may be particularly challenging for the therapist who is working with a child/family involved in a forensic or child protection situation. It is important that the clinician maintain appropriate boundaries while also providing system-level assistance through letters, reports, and consultations with professionals (e.g., child protection worker), as appropriate, and after signed consents for release of information have been obtained. Although quite understandable, it is important that the therapist not become overzealous in stating or interpreting the child's needs to others, especially other professionals, judges, etc., but rather communicate what the child has directly said in sessions that might be relevant to visitation and custody issues. Such cases may reflect therapist countertransference in addition to his or her valid desire to protect the child. Supervision can assist the therapist in understanding feelings that may be contributing to difficulties with either over-involvement with a given client, or disengagement. More discussion regarding the use of supervision to monitor boundaries and manage countertransference issues to clients is provided in Chapter 15 on Supervision and Self-Care.

It is important to reiterate that concerns about countertransference in no way suggest that the clinician should not advocate for the child client. Advocacy can involve providing referrals to the family for legal assistance and additional therapy (e.g., domestic violence group, individual therapy for caretaker), which can enhance the ITCT-C-related therapy provided to the child and their family. In addition, if the agency is able to provide food, clothing, taxi transportation, bus passes or other necessities, this assistance can make an important contribution to therapeutic effectiveness.

Chapter 6

Developing and Enhancing a Safe Therapy Environment

As noted at various points in this guide, it is essential that therapy for traumatized children be conducted in a manifestly safe and secure environment. Children are vulnerable to the adults who provide their care, and cannot typically seek therapy on their own, improve their living situation, or protect themselves from an abusive or negligent family, without the support of adults. It is important that the therapist work with the child's nonoffending caretaker(s) to increase support and safety at home, and reduce the overall risk of further trauma, regardless of its source. In families where medical trauma (physical injury, severe illness) has occurred, there may be so much stress regarding treatment decisions, anticipation of loss, and management of other children in the family, that the caretakers require considerable support before any trauma-related therapy can occur. In other cases, a foster parent may resist any involvement in therapy because he or she feels that it is sufficient to attend to the physical needs of the child. On the other hand, when the family environment is more supportive, and, in some cases, when multiple caretakers are involved (e.g., grandparent, aunt, father), the child is likely to be more at ease and open in therapy with the therapist -- even when trauma-related material arises. A supportive family system also may allow therapy with the traumatized child to progress more quickly. More of this work with collaterals and other family members (e.g., siblings, extended family), in individual, group, family therapy is discussed in later chapters.

Although safety issues are most predominant and visible early on in therapy, the clinician should continue to monitor, develop, and reinforce the safety, structure, and boundaries of therapy throughout the treatment process. He or she should periodically evaluate the extent to which a child may need a greater sense of safety in order for trauma processing to continue, and whether boundaries need to be further clarified. At the same time, it is important for children to have opportunities, throughout therapy, to increase their coping skills and experience a greater sense of empowerment as they explore new and/or "deeper" trauma-related material in therapy.

The therapy office/agency

Ideally, the therapy rooms and waiting area will be welcoming, child-oriented and well-equipped with developmentally appropriate toys, art materials, and books. The therapy room should be orderly and organized, with toys returned to the same location after each session. Art

work from previous sessions with other clients is usually stored or placed on shelves. If art work is hung on the wall, no identifying information should be evident. Such art work is noticed by clients and may encourage them to also do creative expressive work in their therapy. Soothing colors and murals can enhance the therapy space and contribute to the feeling of a sanctuary from the world the child typically inhabits. Artwork, poetry, collages etc. may be displayed in communal areas (e.g., hallways, meeting rooms) at the office or agency so that children, especially new clients, can see that others like them have worked on difficult feelings.

At MCAVIC, there is a collection of drawings, paintings, and collages made by clients hung on the wall of the corridor that all clients pass through. New clients and family members are especially likely to stop and observe this wall of client art, and to express appreciation for what others have done in their sessions. This artwork display communicates the creative aspect of therapy, as well as a way to honor individual clients' drawings, art, collages, and writings (e.g., anonymous letters, poetry). It also increases the child's sense of community, demonstrating that other children have experienced similar events, and also are involved in seeking recovery.

Session consistency and safety

As much as possible, therapy sessions should occur consistently in the same office or playroom, and be scheduled on a weekly basis on the same day and at the same time. Sometimes caretakers, especially if they have limited resources or are overwhelmed with stressful circumstances (job demands, single parenting etc.), may have difficulty bringing their children to therapy appointments on a consistent basis. It is important in these situations for the therapist to call to remind caretakers of appointments, provide transportation (e.g., taxi), if possible), and in some cases, initiate a written contract with expectations for consistent appointments and cancellation policy.

Phone calls and interruptions should not occur during the therapy session unless there is an emergency that requires the therapist to intervene. Some children will also need to check that their caretaker is available (i.e., in the waiting area) during the session, if they feel the need for reassurance during therapy. In general, however, the time the therapist spends with the child client in session should be "special:" protected from intrusion by the outside world, and honored by the therapist's efforts to provide stability and consistent, uninterrupted attention.

Toys and belongings from home

Children are encouraged to bring toys and belongings from home, such as a favorite stuffed toy, a blanket, music CD, or other favorite object. One MCAVIC client who had particularly elevated anxiety in therapy, brought a large plastic garbage bag full of blankets, pillows, and toys from when she was a much younger child, as well as her current favorite toys and a piece of her mother's clothing. Sometimes, the therapist may want to give a child a teddy bear, small toy, seashell, or small stone that can act as a "transitional object" or emotional bridge between therapy and home. If the child is testifying in court, this transitional object may also help to soothe the child in that setting as well. Children may also want to bring a school project or award into therapy. This not only contributes to a positive relationship with the therapist, but also reinforces the notion that this is a place where happy things can be shared.

Neutral toys

Neutral games, i.e., those not directly involved in trauma processing, such as Checkers, Candyland, Snakes and Ladders, Operation, Uno, etc., can increase the child's engagement and sense of safety with the therapist. A therapist may want to begin a session with play, using one of these games chosen by the client, before initiating play therapy that is oriented more toward trauma processing and exploration of feelings. Neutral games may also be used later in the session, to reduce the client's anxiety following a disclosure or activation of trauma-related emotional distress.

Control and stability in the therapy environment

Many traumatized children's needs for a safe, predictable environment have not been met prior to their involvement in therapy. If a child needs to rearrange the furniture in the therapy room (e.g., creating a barricade with chairs or cushions) to enhance their sense of safety, they are supported in doing so. Some children will need to hide behind or under furniture during stressful moments in treatment. In some instances, the therapist may choose to join them there, if appropriate and requested by the child. These activities not only allow the child to "feel safe," they communicate that he or she has the right to control parts of his or her environment as needed, in order to increase his or her own safety and wellbeing. In all cases, however, there should be a ritual of returning all furniture, toys, and books to their proper place at the end of the session. This is because the consistency and orderliness of the therapy office or playroom, and the notion that everything has a place to which it must be returned after play, generally

contribute to a sense of predictability and boundaries, rather than the chaos and disorder that many children will have experienced in their home environment.

Self-control

In some cases, traumatized children may become overly aggressive during play therapy. Toys may be intentionally broken, thrown against walls or at the therapist, or an action figure may be used to beat up or kill another figure. Although toys may sometimes be played with in a more rough manner during trauma processing, it is important that the clinician remind the child that no one is allowed to hurt anyone else during the session, nor should toys be destroyed or used to hurt others, even symbolically. A child who is being aggressive in session is reminded of the need for safety and respect for others and themselves. This is typically framed as a philosophy of non-harm; that everyone, including the child, is entitled to a life free from violence. In this way, although the intervention is focused on the child not harming toys, or the therapist, the child's own right to safety is reinforced.

If the child is not able to manage his or her behavior, so that therapy can continue, the session may need to be ended. Alternatively, a child who is exhibiting aggressive or overly active behavior may need to have a brief time-out in the therapy office, in a chair facing away from the therapist, with minimal contact. If this is necessary, it is recommended that there be an initial warning, stated in a non-punitive, neutral manner, that he or she will have a time-out if the behavior continues. If the behavior is repeated, a time-out is initiated – generally for the number of minutes that is equivalent to the child's age (e.g., approximately 5-10 minutes for an 8 year old). If the child is unable to participate in the time-out, the session should be gently, but firmly, terminated. If time-out is successful, the session can resume once the child is in a calmer state. See Chapter 12 for further information on increasing behavioral self-control.

Caretaker support

On occasion, a child will feel more comfortable if the caretaker is in the room for part of the session, or outside the room with the door slightly ajar. This is fairly commonplace with younger, more traumatized children, but may also be helpful for school-aged children who, especially at the beginning of therapy, are more comfortable having a supportive caretaker in close proximity. This also can be a way to evaluate interactions between the child and caretaker.

Although the caretaker's presence may be helpful initially, the child may not be as forthcoming in the session if a caretaker is present. As the child increases his or her trust in the

therapist, it is likely that he or she will want “alone” time with the therapist, and the parent or other adult can leave the session. In some cases, the caretaker’s absence from the session may be titrated: first involving his or her continued presence, then, as sessions continue, involving longer and longer periods away from the child during treatment, until he or she is no longer required. It is always beneficial to include, at times, the caretaker(s) in therapy sessions for parent-child and family therapy sessions- - but only when the timing is right, and without these sessions replacing the individual therapy sessions with the child client.

Play Therapy Materials and Resources

In creating a safe, child-oriented environment and since therapy with children includes play and art/creative play, it is suggested that the therapy room include the following:

- Dollhouse and doll families with varied ethnicities (Latino, African-American, Asian, Caucasian etc.) and representing all members of the family (including grandparents).
- Sand tray with myriad of figures---animals, mythical/cartoon figures, human characters, dinosaurs, monsters etc. as well as trees, castles, houses, fences, and any other small objects that are conducive to telling a story. The sand tray itself is a shallow, square-shaped box containing sand. It is not necessary to have the exact sized box recommended in sandtray books, especially when space is limited.
- Animal and human puppets.
- Stuffed animals---large and small.
- Dolls for role plays, including a baby doll, adolescent and adult dolls (e.g., “Barbie”, “Ken”, “Bratz” dolls), each of different ethnicities, genders, and those representing various professions/interests such as soccer player, veterinarian, pediatrician, teacher etc., with changes in clothing possible. Anatomically-detailed dolls can also be helpful in clinical evaluation and therapy sessions, for children who need to demonstrate with dolls how they might have been sexually or physically abused. It is essential, however, that the play does not become a forensic interview regarding details of the abuse, but instead, more open-ended yet directive play. Some therapists may consider Barbie or Bratz dolls to be

sexualized or reinforcing sexual stereotypes, but they can be helpful for clients in role-plays to enact traumatic events, especially when they have difficulty verbalizing their experiences. Dolls that are more stereotypic and sexually provocative can be avoided.

- Lego, building blocks.
- Neutral games ---Operation, Checkers, Candyland, Snakes and Ladders, Battleship, Jenga, Mancala, etc. and card games ---e.g., UNO, as well as games like the Ungame to help express thoughts and feelings, and facilitate rapport-building.
- Art materials including an easel if possible, paints, markers, drawing paper, colored pencils, crayons.
- Collage materials, including cut-out pictures and words, large paper
- Plastic magic wand (containing fluid glitter)
- “Magic box” containing disguise toys (Dracula teeth, fake nose and glasses), plastic knife, gun
- Play dough and modeling clay
- Chalkboard or marker board—with letters, chalk, markers
- Play tape recorder with microphone
- Active toys---kush ball, bowling ball and pins, basketball and net, skipping ropes, hoola-hoop.
- Play food, toy refrigerator and stove (especially for younger or developmentally delayed children).
- Books that help child to identify feelings and set the stage for therapy such as Double-Dip Feelings, I Like Me, A First Book of Play Therapy, and Don’t Pop Your Cork on Tuesday.
- Projective cards with pictures and words such as Oh cards, My Ups and Downs, and feeling charts that help children to tell stories about their feelings.
- Board games to address specific trauma-related issues such as anger, loss, family issues, and self-esteem.
- Activity books, journals, and folders for art work.

Many of these games and books listed above are available through Creative Therapy Store (www.creativetherapystore.com). Other toys and play therapy/art therapy materials are available at toy stores and art supply stores. It is important to have a wide range of materials and resources available. Although a child may be chronologically 8 years of age, he or she may be most comfortable playing on the floor in a manner more consistent with a much younger child. Also, more disadvantaged children may not have many toys at home, or have had experience in playing with others. Therapy sessions can help children to learn how to play and use play to express thoughts and feelings. Caretakers may also need to be shown how to play with and enjoy being with their child.

At MCAVIC, there is also a “treasure chest” containing small inexpensive toys that children can select from and take home, after each session (limited to one per child). This small ritual seems to help children make a gradual departure from the center and reinforce that they are cared for. Center-sponsored events such as a client holiday party (for clients and family members) as well as birthday celebrations, and parties to honor their graduation from therapy also enhance the sense that they are being nurtured, cared for, and celebrated in a safe place by caring, supportive people.

Expanding the child’s sense of entitlement to identity

As mentioned previously, children are encouraged to bring belongings, favorite toys, music CDs, school projects, awards, and achievements to sessions to enhance the notion that the therapist is interested in them as a “whole person”, rather than only their problems, symptoms, and traumatic experiences. They are also asked to draw themselves, their families, and create collages focused on their favorite things, “who am I?”, “who I want to be” etc. In these ways, the client can experience the therapist as being interested in them and their uniqueness. These activities further contribute to the therapy room as a safe place to share all experiences (including those that are non-trauma-related) with the therapist. It is essential that each client feel truly appreciated by the therapist and have an opportunity to discover their particular talents and abilities. For example, some children enjoy drawing or creating a lego, play dough, or an art project, and wish to share this accomplishment with the therapist. The therapist may display the artwork, lego creation etc. in their office when the child attends their therapy session. In these ways, the client’s self capacities and sense of identity can be further reinforced, so that they are better able to address their traumatic experiences. Chapter 7 discusses further ways in which the

therapist can help the child client to increase their self-esteem, positive sense of identity, and sense of self-efficacy.

Chapter 7

Distress Reduction and the Development of Affect Regulation Skills

Children with complex trauma exposure often experience chronic and intense distress, as well as more classic posttraumatic symptomatology. Complex trauma exposure results in a loss of (or failure to develop) core capacities for self-regulation and interpersonal relatedness (Cook et al., 2005). Chapter 6 of this guide describes interventions for creating a safe, therapeutic environment, usually a necessary pre-condition for a child to gain affect regulation skills. Children who feel triggered by situations similar to their traumatic experiences may attempt to avoid similar trauma-related material in therapy sessions. This avoidance can interfere with the child's ability to process trauma. Younger children, who are particularly vulnerable and dependent on adults, also may have difficulty expressing feelings and identifying emotional states in general, and feel heightened anxiety when alone with the therapist. For example, a child may not be able to verbalize feelings of anxiety in the therapy session, but instead develop a headache or stomach ache, or abruptly need to go to the bathroom.

The interventions in this chapter have two general foci: the reduction of acute, destabilizing emotions and symptoms (distress reduction) and the development of emotional regulation capacity. This material is presented before the chapters on cognitive and exposure-based processing because, for many children, limited affect regulation capacity must be addressed before more classic trauma therapy (e.g., therapeutic exposure) can occur.

Acute distress reduction

Acute distress reduction involves techniques that reduce triggered, overwhelming states that emerge during therapy, such as upsetting memories, flashbacks, intrusive emotional states such as fear, terror, or rage, or dissociative states. Children experiencing these internal processes may easily feel frightened, if not destabilized, and may disengage from their therapists at such times. When this occurs, it may be necessary to refocus the child's attention onto the immediate therapeutic environment (with its safety and predictability) and the therapist-client relationship. A child can also use "grounding" techniques outside therapy sessions when they feel frightened or threatened, such as while on visitation with an alleged perpetrator.

Grounding

Grounding involves focusing the client's attention away from negative thoughts, feelings, and memories, so that he or she can keep from being overwhelmed. A child may become disengaged, agitated, or dissociated, and begin throwing toys aggressively, behaving in a provocative manner (e.g., self-stimulate), or expressing feeling overwhelmed e.g., saying "You ask too many questions" or "I've already talked about this". The client may shout at the therapist, or appear irritable and/or withdrawn, report that they are now "someone else", or otherwise try to avoid difficult thoughts and feelings. Grounding may assist in these situations, as well as reducing the possibility that the child will feel so overwhelmed that they need to run out of the room or otherwise abruptly end the session.

Grounding is described in greater detail in the ITCT-C-A treatment guide. The following brief discussion includes the steps that are adapted for younger children:

1. Ask the child to briefly describe his or her internal experience, either through verbalization or by drawing or engaging in other expressive play. The child does not need to describe their feeling state in great detail, as this might cause them to become more engaged in the experience or further disengage from the therapist.
2. Orient the child to the immediate, external environment. Some children may need to check the hallway outside the therapy office or the waiting area to ensure that unsafe people (e.g., alleged perpetrators) are not there, or to check that their caretaker who has accompanied them to the session is still present. This orientation to the immediate, external environment often involves two, related messages: a) that the client is safe and not, in fact, in danger, and b) he or she is here (i.e., in the room, in the session, with the therapist) and now (i.e., not reexperiencing the trauma). The therapist may make reassuring statements such as "You are okay. You're here in the room with me. You're safe," or may ask the child to describe the therapy room. The child also may be asked to focus his or her attention on the feeling of the chair or floor underneath him or her, or of his or her feet on the floor. Sometimes asking the child what he or she and the therapist were just doing (e.g., game or play) and what we are doing right now, also can be helpful.
3. If indicated, focus on breathing or other calming techniques as described below.

If it is possible, therapy may return to the earlier focus at this point, perhaps after a brief discussion that normalizes the traumatic intrusion (e.g., as a not-unexpected part of trauma

processing) and the grounding activity. It is important that the child's temporary reexperiencing or symptom exacerbation be neither stigmatized nor given greater meaning than appropriate.

Relaxation exercises, meditation, and breath training

Progressive relaxation, breath training, guided imagery, and meditation can be used to increase the child client's sense of comfort and ease in the therapy room. Sometimes, such techniques are used at the beginning of the session to help the child feel more calm and able to explore difficult feelings and experiences. They also may be used in sessions, when a child is focusing on affect regulation, dealing with dissociative symptoms, or recounting traumatic experiences, or outside the therapy sessions, when encountering distressing situations at home or at school. These techniques can be combined within a session, or used separately at different times. Some children benefit from calming exercises at the beginning and/or end of the session, as well as at times during the session when they are experiencing more distress.

Progressive relaxation

This technique involves clenching and then releasing muscles, sequentially, from head to toe, until the entire body reaches a relaxed state. Some children may wish to close their eyes during this exercise but should not be required to do so if they prefer to keep their eyes open. The child may sit in a chair or lie on the floor while doing this exercise. Although a helpful method of calming, progressive relaxation is not used at MCAVIC because of the time involved to learn and teach the procedure. The interested reader is referred to --- for further information in this approach.

Breath training

Breath training is a simple, straightforward technique that is readily learned by children and effective in anxiety control. When stressed, children and others tend to breathe in a more shallow manner, hyperventilate, or, in some cases, temporarily stop breathing altogether. Teaching the child "how to breathe" during stress can help restore more normal respiration and typically produces a calming effect on the body/nervous system.

The therapist and client can discuss times when it might be helpful to use this exercise, for example, when the child feels angry and needs to calm down, or in contexts when trauma memories are triggered. If the child has a supportive caretaker, it can be helpful to practice this exercise in a conjoint session. Below are the steps of breath training, which may be presented with less explanation and detail to younger children.

First:

Explain to the child that it is important to pay attention to breathing, and that learning to breathe in a different manner can be helpful in managing anxiety. Indicate that some people may become a little dizzy when they first start breathing slowly and deeply, but that this is a normal reaction.

Second:

1. Have the client sit in a comfortable position. Some children prefer to lie on the floor.
2. Explain that the entire exercise will take about 5 minutes.
3. Let the child know that he or she can close his or her eyes, or leave them open if that is more comfortable.
4. Ask the child to focus on his or her breathing -- if he or she start to think about other things, he or she should to re-focus on the breath.
5. Ask him or her to breathe through the nose, paying attention to each breath, for about 5 to 6 breaths.
6. It is usually helpful for the clinician to breathe along with the child, saying “in” and “out” with each breath.
7. The child is then told to focus on breathing more slowly -- to count to three with each inhalation and three for each exhalation, for 5 or 6 breaths.
8. Ask the child to stop focusing on the breath, and to tell you what he or she thinks about the exercise, and about anything that might interfere with it. Normalize any restlessness, performance fears, or feelings that the exercise is useless. Generally the message should be that the exercise is just a chance to slow down and relax – that it is not a task that must be done perfectly.

Third:

Ask the client to practice this sequence at home for 5 to 10 minutes a day. For some children, a supportive caretaker can remind him or her to do this exercise. The client is encouraged to find a quiet, safe place where he or she can practice. He or she is reminded that the goal is relaxation

and having quiet time, and that this can be accomplished through breathing. For some children, the best time to do this may be at bedtime.

Visualization

A third approach to relaxation does not involve learning to breathe or relax, but rather how to imagine a peaceful or pleasant scene in sufficient detail that relaxation naturally follows. For many children, spending time in a therapy session discussing their favorite place, then practicing visualizing that place, will be helpful. It is important that the child (not the therapist) determines what place for him or her is most relaxing. Visualization exercises may be helpful when begun at the beginning of each session, or used when discussions in therapy become especially upsetting. This approach can also be used outside of sessions, when the child is feeling distressed or has to go to sleep. It may be helpful for a child to take home a tape of this exercise, recorded by the clinician during the therapy session.

Meditation

Although therapists may hesitate to use this last relaxation technique with children, recent research has found meditation to be helpful with children to help them relax, increase their concentration, and focus. The child is asked to do the following:

- Once a day (preferably at approximately the same time every day), preferably in a quiet, safe place, sitting in comfortable position in a chair or on the floor, and closing his or her eyes if that feels safe.
- Focusing on his or her breath. This generally involves feeling the breath go in, and feeling it go out. The child is asked to specifically pay attention to the feel of the breath as it passes through the nostrils, and fills and empties the chest, and to try to keep his or her mind on the breath.
- Noticing when his or her mind wanders, and, when it does, bringing it back to breathing. Note that thoughts and feelings may come and go, which is perfectly fine, but the job/game/goal is for the child to go back to feeling the breath go in and out.
- Not criticizing himself or herself for having trouble paying attention, or for being distracted by thoughts. It is important that the child be counseled that paying attention to just breathing is very hard to accomplish – the goal is “to do the best you can,” and

not to criticize or judge himself or herself when inevitable thoughts and feelings occur. This may be phrased as a game:

“Can you just feel your breath, just feel it going in and out, and when you start thinking, say that’s OK but I have to just feel my breath? No one can do that all the time, but can you see how much you can just breath and relax, and let your thoughts go away? Just sit there and breath, watch yourself breath. See how much you can do just that. When thoughts or feelings come, that’s not bad, it’s just not the game, so try to go back to just feeling your breath go in and out. After awhile, you can get better at this game, but it takes practice.”

As implied by the above, meditation may accomplish more than relaxation, as the child learns to observe himself or herself without judgment, to “let go” of upsetting thoughts, feelings and memories, and, with practice, to enter a state of calm. It can also be a way for children with low self-esteem to learn to be more accepting of themselves and more thoughtful about their behavior. As the child is able to utilize these skills to regulate his or her affect, he or she generally increases his or her *mindfulness* -- becoming more aware of his or her thoughts and emotions, and learning to view them in a nonjudgmental way.

It is important that meditation be framed in a way that it does not appear exotic or esoteric to children or their caretakers. In fact, words like “meditation” or “mindfulness” need not even be used by the therapist if they do not appear appropriate. For example, alternative labels for this activity might be “quiet time,” “quiet attention,” or “just breathing.” Similarly, it is not crucial that the child follow any rigid procedure in doing meditation: the goal is for him or her to learn to pay attention to his or her breath, and to develop the capacity to observe internal states without labeling them or, in some cases, having to act on them. It is not uncommon for a clinician to discover that, although the child and/or parent states the child is meditating or having quiet attention on a regular basis, the actual internal behavior the child is engaging in is unknown to all – sometimes not even the child. In such circumstances, the therapist probably does not need to do more – whatever the child is doing, if calm and some level of introspection appear to be happening, the activity is probably successful!

Physical activity

Physical activity before the therapy session, outside of the therapy room, such as skipping rope, running, shooting baskets, or playing catch, can be beneficial in increasing a child's ability to relax and focus on trauma-related material during the actual therapy session. Depending on the space available, these activities can also occur within the therapy room at the beginning of the therapy session, or be incorporated into trauma exposure work. A child who is more physically-oriented may wish to demonstrate a dance move, gymnastics, or create a game that incorporates physical activity when expressing traumatic events. Often, physical activity can help a child to express feelings toward a perpetrator or about a trauma that particularly involves anger. For example, a child who has been overly withdrawn or inwardly oriented may delight in expressing his or her anger more outwardly and in a safe place, for example through creating a dance or throwing a light ball at a target representing the perpetrator. Physical activity such as role-playing that involves physical motion or dancing to favorite music can also help a child to feel more relaxed and less anxious, at which point he or she may be more inclined to explore trauma-related material and feelings.

Emotional regulation capacity

Emotion identification

Many children who have been traumatized and neglected may not have developed a language for expressing feelings. Before they can learn to reduce distress and develop affect regulation skills, they may need support and encouragement to explore feeling states. Also, due to the cognitive limitations (i.e., more concrete thinking) of pre-adolescent children, they may need some assistance in recognizing that they are having contradictory feelings simultaneously; e.g., happy that they are no longer physically abused but sad that they are living in foster care away from their family. Expressive play can enhance this exploration, for example games in which the client and therapist each take turns drawing a stated feeling, then describing a situation that may have triggered that feeling. Feeling charts and art activities can also be helpful, not only in helping the child to identify internal states, per se, but also because they convey to the child the therapist's interests in how he or she experiences sadness, happiness, anger, frustration etc. For example, a child may draw a self-portrait or abstract figure, and then color the areas of the person/figure according to the feelings that he or she is experiencing, describing to the therapist why he or she picked whatever colors and how he or she feels while coloring.

Finally, it is generally a good idea to ask child clients about their feelings and other internal experiences on a regular basis, typically several times within a session. As described in more detail in Briere and Lanktree (2008), the goal of these questions is less to determine the child's immediate experience (although that is frequently useful in order to assess the process and impacts of the session thus far), but also to give the child practice at emotional identification. Repeated gentle (i.e., casual, nondemanding) inquiries, in this regard, provide the child with multiple opportunities to discover what he or she is feeling as a regular part of his or her interactions with the therapist. The clinician should not be especially concerned with whether any given answer to these questions is "correct" – the goal is primarily for the child to learn how to access, label, and express internal states.

Trigger identification

Although also discussed in Chapters 10 (Cognitive and Emotional Processing) and 12 (Behavioral Self-control), and in considerable detail in Briere and Lanktree (2008), trigger identification is described here because it can be considered a form of emotional regulation – if the child can keep from being triggered, or can reduce the emotional effects of having been triggered, he or she has, in fact, regulated or altered the extremity of his or her emotional state.

This intervention generally involves three tasks:

- learning about the existence of triggers (sometimes referred to as "trauma reminders"), i.e., that there are times when something reminiscent in the current environment will cause the child to have the upsetting feelings and/or thoughts that he or she had when originally traumatized,
- identifying specific stimuli (triggers) in the child's environment that can activate these memories, feelings, and thoughts, and
- learning what to do when these triggering events occur.

Each of these tasks are addressed separately in treatment:

Learning about triggers. Although the cognitive ability to understand the relatively abstract notion of triggering is more available to older children, the clinician can usually teach some version of this issue to most children between the ages of 8 and 12 years. Generally, this

involves talking about the process in simple language, usually phrased as questions that progressively home in on the notion of trauma reminders. For example:

“Do you ever [remember/think about] the bad thing [describe as necessary] that happened to you?”

“Sometimes, we [think about/remember] bad things from before when something happens right now. For example, we might remember a bad thing because of something somebody said, or we saw something that was kind of like what happened then. Or maybe we saw or heard something, and then we remembered the bad thing. Has that ever happened to you?” “When has that happened?” What did you [think/feel/remember] when that happened?”

Identifying specific triggers for the child. This builds on the first step, and involves the child (with the therapist’s help) making a list of all possible triggers that he or she has encountered that have activated trauma memories. The clinician can help expand this list by asking about triggering situations that he or she imagines the client may have experienced, given other information or the clinician’s familiarity with how traumatized children are generally triggered by external events. This list may ultimately involve a large collection of triggers, since children exposed to multiple repeated maltreatment often can be triggered in a variety of ways to recall a variety of different adverse experiences. Questioning the child in this regard should be done in a gentle, nonintrusive way, however, since discussions of prior traumas memories and their associated emotional states can be upsetting. It is sometimes necessary, however, because the child’s cognitive capacity or need for avoidance may produce a small list if not assisted.

Typical questions/statements might include:

“OK, so it sounds like sometimes that has happened to you, when something made you remember [the trauma(s)]. It would be good if we could make a list of things that make you remember. Can we do that?”

“I guess one thing that you said is that when [---] happens, sometimes it makes you remember [the trauma(s)]. Can we think of any other times? What else makes you remember?”

This list is then written on a piece of paper by the therapist, using, when possible, the child's own language (sometimes this is not possible, and the clinician uses his or her own language, albeit couched in simple, child-friendly language). The paper is kept by the therapist, perhaps in the child's chart, and is brought out at times when triggered emotional responses are being discussed.

Learning what to do when triggered. This last step, also discussed in Chapter 12, involves the child and therapist working out, in concrete terms, what the child can do in triggering situations. Generally, this step includes figuring out what to do to reduce the emotional impacts of triggers, and problem-solving about how the child can keep from engaging in unhelpful or negative behaviors once he or she is triggered.

Examples of options the child may use include (adjusted linguistically for the child's verbal/cognitive capacities):

- Positive self-talk: Upon being triggered, the child tells himself or herself things like
 - “This is just a memory, it’s not happening now”
 - “I am OK, nothing bad is happening right now”
 - “I’m feeling this just because I’m remembering what happened”
 - “I am good, not bad”
 - “I am smart and strong”
 - That was then. I don’t have to feel that way now,” or
 - Ask himself or herself “What would my therapist/mom/dad/friend say to me right now,” and then repeat the answer to himself as if the other person was speaking
- Involvement in relaxation, imagery, or attention to breath, per Chapter 7. Generally this involves the child moving away from the acute trigger and using calming methods he or she has previously learned. In many cases, this does not require extended time periods – often it is enough for the child to consciously relax his or her body for a minute or two, slow and deepen his or her breath for a similar period of time, or briefly “go to a special place” in his or her mind, perhaps with the therapist, a friend, or pet. Part of teaching this trigger solution is validating for the client that it is perfectly OK to disengage from the stressor and have a few minutes of private time.

- Trigger avoidance: The child and therapist may come up with ways that the child does not have to stay in proximity of the trigger, such as
 - Physically leaving activating situations, such as walking away from arguments with peers or others, or reducing contact with an adult who reminds him or her of his or her abuser
 - Disengaging from conversations involving trauma-evocative material, such as sexual issues for a sexual abuse victim
- Distraction: As soon as is reasonably possible, engaging in a different activity that pulls attention away from escalating internal responses such as panic, anger, flashbacks, or catastrophizing cognitions, such as
 - Starting a conversation with a safe person
 - Thinking about the letter he or she might write to his or her therapist regarding the upsetting event
 - Doing something that is physically engaging, such as exercise or playing an active game
 - reading a book, or
 - going for a walk
- Increasing support systems: Initiating contact with a friend, teacher, caretaker, pet, or the therapist if one of those resources is readily available.

It is important that the child be provided with multiple opportunities to come up with solutions or options himself or herself, as opposed to the clinician doing most of the work. The more that the child can be involved in solutions to triggers, the more that it may feel like the activity is the child's idea – a process that can increase his or her sense of self-efficacy as well as increase the likelihood that he or she will actually engage in the behavior.

Chapter 8

Facilitating Positive Identity

Children who have been traumatized often present with low self-esteem that may be related to a sense of powerlessness and limited sense of self-efficacy. As noted in the ITCT-A treatment guide (Briere & Lanktree, 2008), many of the difficulties that a child might have regarding a positive sense of self are thought to develop in the first years of life, when the parent-child attachment relationship is disrupted by caretaker aggression or neglect. Children who have been emotionally and/or physically neglected or abused may present as poorly groomed and lacking age-appropriate social skills. In order for children to feel more able to address difficult trauma-related material, it is important that they have a sense of positive identity and ability to manage feelings that arise. A family that is economically disadvantaged may benefit from a therapist or agency either providing assistance to the family through advocacy to community agencies for financial support, or providing donations of food, clothing, or gift cards to relevant stores for clothing and food.

For children aged 8 to 12 years old, who are more dependent on adults than are adolescents, enhancement of relationships with adult caretakers and/or role models may facilitate a greater sense of self-esteem and positive identity. Positive relationships can not only occur with caretakers, but also with teachers, coaches, therapists, or mentors. As the child is encouraged to explore his or her particular interests and talents, while also being positively reinforced for having them, he or she may gain a greater sense of identity and an increased capacity to be assertive and self-motivated.

A child who has been emotionally abused --- told he or she is worthless, criticized, or required to meet unreasonable expectations, is likely to internalize these statements and experiences, especially in the absence of positive affirmations and appreciation of his or her uniqueness and lovability. Clients who have had these negative emotional experiences will benefit from interventions in therapy involving not only positive responses from the therapist and participating caretakers, but also support for self-affirmations such as “I am lovable and special”; “I’m a special girl (boy)”; “I can do lots of things”, “I’m great just the way I am”. When a child has particularly low self-esteem, the therapist may need to gradually incorporate these statements into therapy sessions in a way that is experienced as genuine and identifiable as the client’s own

words. It is important that the child with low self-esteem have an opportunity to experience unconditional acceptance while also learning appropriate social skills and behavior. Children who have low self-esteem may also exhibit behaviors that interfere with positive relationships with others, or that cause isolation and alienation---e.g., overeating and excessive weight gain, bullying or aggressive behavior toward others, or social withdrawal. In receiving positive feedback from significant others (including in family sessions), clients can learn and practice additional adaptive behaviors that further increase their opportunities for positive social experiences outside of therapy.

Specific interventions to enhance positive identity development, self-efficacy, and assertiveness include:

- Physical and psychological safety in treatment, so that the child is able to introspect and explore his or her feelings without fear of danger.
- Books and board games that reinforce positive identity development
- Self-exploration during verbal therapy, play therapy, and expressive therapy. Self-portraits and collages on “who I am” and “who I want to be” can be especially helpful to children with identity and self-esteem issues. Children also can make tapes in their session of who they are and what they want others to know about them. A client may also wish to keep a journal or write a book with illustrations of who they are; when completed at different times during therapy, such material also can be used to track the child’s progress over time. A child may also place pictures, drawings, and words outside a box or folder to represent how they feel they are seen from the outside; then do the same with the inside of the box or folder to represent how they feel inside.
- Support and affirmation within the therapeutic relationship---- the therapist should express enthusiasm and interest in the child and his or her interests, likes and dislikes, celebrate the client’s birthday, and provide occasional outings while maintaining appropriate boundaries (e.g., walking together to the hospital cafeteria). The therapist also might provide small objects (e.g., a shell or a toy from the agency “treasure chest”), a snack at the beginning of the session or on special occasions, journals for recording thoughts and feelings, art supplies, or other small gift (e.g., a book that is particularly relevant to the client).

- Encouragement to engage in sports, music, art, or other after-school activities where the child can have positive experiences and broaden his or her interests. Since children aged 8 to 12 are typically less able to pursue such activities without the assistance of adults, it may be important for the therapist to provide resources and encouragement to the adult caretaker----such as a referral to the local Big Sister/Big Brother agency, Boys and Girls Club, etc.
- Role-plays that enhance positive social skills and behaviors that can contribute to healthy peer relationships.
- Support for self-validity. Group and family therapy, in conjunction with individual therapy, can enhance the development of positive self-esteem and sense of self-efficacy. Over time, as the child receives positive feedback from others (peers and family members), he or she may begin to perceive himself or herself in more positive ways and experience himself or herself as more able to cope with challenging situations.
- Physical and psychological safety in non-therapy attachment relationships. As the child feels more protected and safe, whether with his or her biological family or in foster care, he or she may feel more free to explore his or her likes and dislikes and develop a stronger sense of identity. In this regard, the therapist should concurrently focus on increasing the caretaker's willingness and/or ability to protect the child and provide a safe relational environment.

Along with specific activities, effective child trauma therapy increases identity functions during the actual process of treatment. As the therapist helps the client to process traumatic memories (described in Chapter 10) in a safe, non-overwhelming therapeutic environment -- while, at the same time, encouraging him or her to move forward through increasingly more difficult material over time -- the client not only desensitizes painful material but also develops an increasing sense of emotional competence. Inherent in this process is the need to check in with the client about his or her thoughts and feelings during the session, and to solicit information on what is helpful or not helpful in the child's recovery. In this manner, the therapeutic relationship becomes stronger and the child's feelings and an sense of self-determination are validated.

Chapter 9

Psychoeducation

Psychoeducation is used in ITCT-C to meet three objectives: (1) to decrease isolation and stigmatization associated with having been traumatized, (2) to increase coping skills; and 3) to increase victims' understanding of particular aspects of their traumatic experiences.

General focus of psychoeducation

Whether through written or verbal means, or through play (e.g., role plays), clinicians often focus on several major topics when working with traumatized children and pre-adolescents. These include:

- Some indication of the commonness of abuse and other trauma;
- Debunking common myths associated with the trauma;
- Information on the usual reasons why perpetrators engage in interpersonal violence;
- Typical immediate and longer-term responses to trauma;
- Reframing “acting out” or tension-reduction behaviors as adaptive strategies that, nevertheless, may have serious negative repercussions;
- Resources available to the traumatized child and his or her family.

Psychoeducation materials, e.g., books and DVDs, are typically used within the therapy session, rather than on a take-home basis, so that the client's responses and feelings can be monitored and explored. In some cases, however, when a child has a supportive and thoughtful caretaker, both may benefit from reading a therapist-vetted book together outside of therapy. In such cases, however, the therapist should still be involved at some level, whether by reading the material with the child and caretaker beforehand, or by discussing it with the client after it has been read.

For example, a child-friendly, comprehensive, and well-illustrated book for sex education, It's Perfectly Normal, was read at home by a preadolescent sexual abuse victim and his grandmother, who was parenting him at the time. They first read it together with the therapist, and then bought their own copy to go over at home. The content of the book generated

a great deal of discussion between the client and his grandmother, as well between both of them and the therapist, to the client's apparent benefit.

It is also essential that psychoeducational materials be consistent with the cultural backgrounds of the client, and that the information or depictions be culturally appropriate. For example, a child of a racial minority is likely to identify more with a child in a story if they share a similar cultural/ethnic background. It is not usually necessary, however, that the child's ethnicity or race be the only one represented: Many books will portray children of varied ethnicity and cultural background within the same story, so that the message of cultural inclusion is communicated. Materials should also be available in the primary language of the client.

The therapist will also want to consider other issues when selecting games and written material, such as the quality of the materials, the reading and comprehension level that is required, and the risk of insufficient cognitive-emotional integration. The latter may occur when books, pamphlets, or other materials are merely handed out without sufficient discussion or application to the client's own history or current situation. Psychoeducation is more likely to be optimal when it is read or listened to by the child and the therapist together, the therapist personalizes the material to the child by linking it to the child's specific history and living situation, and the content is discussed by client and therapist – and sometimes the caretaker(s) – so that it “make sense” to the child.

Another important issue is the “fit” between the psychoeducational materials and the values of the family around issues such as sexuality, social roles, death, or loss. For example, although sexual abuse might be the reason why a child is being brought to the clinician for therapy, it cannot be assumed that the caretaker(s) or family are comfortable with discussions about sexual issues or normal sexual development. Clients can be precipitously removed from therapy if it seems that the therapist is endorsing views (e.g., the acceptability of masturbation in the privacy of one's room, especially as an alternative to touching others) that the caretakers do not hold. It is especially important to gently broach this area with caretakers of sexually abused children, and to encourage them to be supportive of sex education, since such information is often essential in normalizing the child's reactions, and even preventing further victimization. Likewise, religious and/or spiritual beliefs regarding death and loss may need to be explored before embarking on a discussion of feelings and/or presenting psychoeducation material on this topic.

Therapy sessions also can be used to provide information and teach coping skills, through role-plays, didactic information regarding the child's rights to safety and ways of reducing further traumatization (e.g., who to call or contact if someone hurts them), and practice of new self-protective skills, such as what to do if the child perceives possible danger. Clients who enjoy reading may wish to read all books that the therapist has in his or her office, including those designed for younger children. Some clients, in fact, after reading several relevant books, have proceeded to write their own "book" of feelings and experiences, with illustrations.

Some examples of books used in ITCT-C with children

Listed here are helpful psychoeducational materials, organized by problem area, that the clinician may wish to offer the child and his or her caretakers.

Expression of feelings:

- Double-Dip Feelings (Cain, 2001)
(especially helpful in illustrating that a child may have contradictory feelings about the same experience---e.g., happy that the abuse by a family member has stopped but sad that they no longer share outings with them)

Understanding what therapy is:

- A Child's First Book About Play Therapy (Nemiroff & Annunziatia, 1990)

Identity and self-esteem:

- I Like Me (Carlson, 1988)
- Don't Feed the Monster on Tuesday (Moser, 1991)

Behavior control:

- Don't Rant and Rave on Wednesdays (Moser, 1991)
- Don't Pop you Cork on Mondays (Moser, 1991)

Grief related to loss:

- When Someone Very Special Dies (Heegaard, 1988)
- When Something Terrible Happens (Heegaard, 1991)
- When Someone Has a Very Serious Illness (Heegaard, 1991)
(all involving activities and information)

Grief related to drug and alcohol addiction:

- When a Family is in Trouble (Heegaard, 1993)

Sex education and prevention of sexual abuse:

- It's My Body (Freeman, 1982)
- Something Happened and I'm Scared to Tell (Kehoe, 1987)
- It's Perfectly Normal (Harris, 1994)
- Please Tell! A Child's Story About Sexual Abuse (Jessie, 1991)
- No-No the Little Seal (Patterson & Feldman, 1986)

Many of these books are available in Spanish, and can be ordered from the Creative Therapy Store (creativetherapystore.com). It is also important to note that, although many of these books were designed for younger children, they can be very effective with children aged eight to twelve years.

Psychoeducation can also be provided verbally during the therapy process. For some children, reading materials and/or writing exercises may trigger feelings of inadequacy related to academic problems. The therapist will need to assess this issue for each client, and, when necessary, integrate psychoeducation information verbally into therapy sessions. In addition, it is important to include caretakers in this process whenever possible----in their collateral sessions, family sessions, and group parent education/support groups. Using books and psychoeducation materials, especially in the early stages of ITCT-C, can facilitate a sense of validation and of feeling less alone. Caretakers can also benefit from psychoeducation materials (as described later in Chapter 13), in their own collateral/individual sessions, family therapy, and/or group therapy.

Chapter 10

Cognitive and Emotional Processing

As noted in Chapter 2, a significant amount of the distress experienced by children exposed extended trauma consists of distorted cognitions and posttraumatic stress. In the former, the child's attempts to make sense of his early life experiences, including acts of violence and neglect can result in negative attitudes, beliefs, and assumptions about self, others, relationships, and the future. The child may view himself or herself as inadequate, bad, unlovable, unintelligent, and helpless; others as emotionally unavailable, ill-intended, and inevitably more powerful than the child; relationships – especially intimate ones -- as dangerous, and the future as relatively hopeless.

Some of these assumptions may have been developed prior to the onset of language, such that they emerge as implicitly encoded, default perspectives that are not easily revisited or updated, and that are associated with (conditioned to) negative emotions initially arising from the experience of abuse and neglect (Briere, 1996, 2002). When activated, these early relational schema or gestalts may produce extremely negative cognitive and emotional states (e.g., expectation of abandonment, terror, rage) often with attendant behavioral responses (e.g., tension reduction behaviors); most of which may appear out-of-proportion to whatever triggered them post-abuse.

In addition to these cognitive responses, early and later victimization, maltreatment, and neglect can produce posttraumatic stress, generally described as easily activatable sensory/experiential memories of trauma that, subsequently, produce flashbacks, intrusive thoughts and memories, nightmares, and other “reliving” experiences. Also present may be attempts to avoid stimuli that would trigger such responses (sometimes referred to as effortful avoidance), psychic numbing such as decreased emotional reactivity and dissociative detachment, and autonomic arousal, involving hypervigilance, jumpiness and a lowered startle threshold, sleep disturbance, attention and concentration problems, and generalized bodily tension (American Psychiatric Association, 2000).

Most modern treatments for multiply traumatized children have developed specific interventions for these cognitive and traumatic stress-related impacts. Most generally, these involve some sort of cognitive restructuring or reprocessing of trauma related beliefs and

expectations, until they no longer interfere with daily functioning, and therapeutic exposure (also called emotional processing) to traumatic memory, in safety, until the attendant emotions are desensitized, extinguished, or habituated. Like these various other therapies, ITCT-C uses a version of cognitive processing and therapeutic exposure, although the implementation of these components is somewhat different in ITCT-C.

Preconditions for cognitive and emotional processing when addressing complex trauma

As noted at various points in this guide, a child may require a relatively stable home environment and a positive therapeutic relationship before he or she is willing to “let down his or her guard” and revisit traumatic memories. Without this sense of safety and predictability, the child may be too flooded with anxiety or hyperarousal to meaningfully engage in exposure therapy, and/or may need to use so much avoidance (e.g., dissociation, tension reduction behaviors, denial, refusal to discuss traumatic events) to accommodate distress that meaningful emotional processing of trauma memory cannot occur (Briere & Scott, 2006). As well, as noted in Chapter 7, to the extent that early trauma has precluded the development of an effective emotional regulation repertoire, the child may need to learn internal methods of affect regulation before he or she can tolerate or “handle” therapy-triggered trauma-related emotions.

This problem is especially an issue for children who – as discussed in Chapter 1 -- have experienced chronic neglect and repeated traumatization early in life, as well additional traumas and (in some cases) social marginalization later in childhood. In such cases, the “trauma load” (i.e., the total amount of activatable emotional distress associated with the total amount of trauma exposure) experienced by these children, in combination with their often insufficient emotional regulation capacities, means that they may be easily overwhelmed by interventions that require exposure to trauma memories too soon, too fast, and/or without sufficient installation of safety and protection.

For this reason, ITCT-C stresses the need to assess the complex trauma survivor’s amount of triggerable distress and emotional regulation capacity before a decision is made to provide significant therapeutic exposure. Further, like more psychodynamic approaches, ITCT-C focuses on the development of a safe therapeutic relationship, where the client eventually may be willing and able to experience painful material.

This does not mean, however, that complex trauma survivors with high trauma loads and low affect regulation capacities do not receive any therapeutic exposure in ITCT-A (or ITCT-A).

Rather, the amount of such exposure is titrated to the extent that the child can tolerate it; a constraint that may mean that some very traumatized children do not undergo much intentional emotional processing early in treatment. The process of titrated exposure is described later in this chapter.

Cognitive processing

As compared to therapeutic exposure, cognitive processing is usually less activating, and thus less likely to overwhelm the client. As a result, cognitive interventions are usually more predominant early in ITCT, whereas emotional processing comes more into the fore as therapy continues. However, cognitive therapy can also be intense, especially when discussion of the cognitive sequels of trauma trigger emotionally-laden memories and, thereby, becomes therapeutic exposure. For this reason, ITCT-C uses an approach, *cognitive consideration*, that is also titrated to some extent, generally by allowing the client to have considerable say as to what and how much distressing material is discussed or encountered.

Cognitive reconsideration accomplishes the reworking of trauma-related beliefs, assumptions, and expectations not by directly confronting the child's "thinking errors," or even by labeling his or her cognitive distortions as irrational, but rather by allowing him or her to reconsider previous (originally logical) assumptions as they emerge during the recounting of prior victimization or symbolic/implicit reexperiencing of trauma issues during play. It is not a significant departure from classic cognitive approaches, except for its more permissive approach and reduced reliance on therapist feedback or interpretations.

As with other components of ITCT-C, cognitive reconsideration of trauma includes multiple modalities of individual therapy: play, that may be symbolic or representational, using age-appropriate toys and games such as puppets, the sand tray, dollhouse, and other tools in the play therapy room; psychotherapy, involving verbal processing of thoughts; and expressive therapy, including use of drawings, art, collages, and other games involving trauma-related thoughts and associated feelings. In these ways, the child is able to tell his or her story of the trauma(s) by enacting and/or verbalizing his or her experiences. Cognitive interventions in ITCT-C focus on two specific activities or tasks: reconsideration of trauma-specific assumptions/beliefs/expectations and development of the life/trauma narrative.

Reconsideration of trauma-specific assumptions, beliefs, and expectations

As the child explores the traumatic event and related circumstances through verbal accounts, play, and expressive therapy, he or she has the opportunity to relive the past trauma from the perspective of the present and come to whatever conclusions might logically follow. The child may reconsider the basis or logic for what he or she considered previously to be “bad” behaviors, or the belief that he or she deserved the abuse because of behaving badly (e.g., came home late from school, lied, or in some other manner caused his or own maltreatment), or even “asked for” the abuse or exploitation. Additionally, it may be revealed through play that a child believed that he or she should have been able to prevent or stop the abuse or the traumatic event. For example, a child may believe that he caused his sister to be run over by a car on the way to catch the school bus because he was taking too much time to get ready, causing them to hurry, not watch the traffic, and be on the street when they otherwise would not have been. As these beliefs are acted out, and then verbally explored in therapy, the child (with the assistance of the therapist) can revisit the extent to which such assumptions “make sense” in light of the facts involved.

The client may also verbally express cognitive distortions about themselves that need to be explored. The child may say, for example, that “I am stupid”, “I look ugly”, or “No one will ever love me”. It can take time in therapy for a child to be able to share abuse- or neglect-related conclusions. As children explore these views of themselves with a supportive therapist, however, they can begin to consider the possibility that they are not “bad” and can be loved and cared for by others. This happens in two ways:

- (1) by recounting and/or reenacting in play the original event(s) in enough detail, on enough occasions, that the original assumptions or interferences the child formed no longer seem tenable in light of *current conditions* (safety, support for introspection, the absence of coercion, and a more developed capacity to think independently) and *new information* (based on what the child now knows about the rights of children, the wrongness of what was done to him or her, and gentle, nonintrusive psychoeducation from the therapist regarding these issues), and
- (2) by experiencing a relationship with the therapist that contradicts the lessons of past relational trauma, e.g., that one can be vulnerable without being hurt or

exploited; that powerful people are not always mean, dangerous, or emotionally unavailable; that not everyone who matters sees the child in a negative light; that he or she is lovable and intrinsically valuable; and that he or she has entitlements as a child, as well as a human being, that cannot be abrogated just because someone else might wish it. Most basically, the client ideally learns from a positive therapeutic relationship that the conclusions he or she formed in relationship to abusive, exploitive, or neglectful others cannot always be generalized – as witness his or her current experience.

To the extent possible, it is important that the child comes to these various realizations by himself or herself, as opposed to merely being told them by the therapist. Although there is nothing wrong with the therapist stating to the child that the trauma wasn't his or her fault, that he or she is a good person, or that he or she is safe with the therapist (in fact these are good points to make, so that the client will at least hear the therapist take a stand that is the opposite of the client's perpetrators or deleterious aspects of the social system), such statements rarely change cognitions in an enduring way. Instead, the goal is for the client to have the opportunity to come to the conclusion, on many occasions, time after time, that – given current data, current experiences, a more sophisticated neurocognitive capacity, and a perspective now less limited by fear and coercion – the initial assumptions he or she made in response to trauma are invalid. These lessons are rarely successful if the client merely hears about what is true; he or she generally has to experience it – both in a supportive, caring, engaged relationship, and based on his or her own investigations and introspection during trauma processing.

Development of a life/trauma narrative

Many traumatized children require some time in therapy (the extent to which will vary from child to child) before they can develop a coherent and meaningful narrative about their life, and the role of trauma in it. Typically, the life/trauma narrative will unfold over time as a partial function of the child's sense of safety (outside and inside of sessions) and trust in the therapist.

A common ITCT-C intervention is for the child to map on a large piece of paper, different ages, where he or she lived, who lived with him or her, etc., and then add in words or drawings about what happened to them at each major time point, including both positive experiences and traumatic experiences. This then becomes a visual representation of significant

events of the child's life up to the current time. An older child may also wish to journal about his or her experiences in writing and/or drawings, then share with the therapist what he or she has written or drawn. If the child does not feel that the journal can be safe at home (i.e., without others reading it, or it being stolen or destroyed), the therapist can store it in his or her office, and the child can take it out, read it, and make additions during therapy sessions. One child who found journaling helpful also spontaneously drew illustrations to accompany her writing. Because she did not feel supported at home, this client kept her writing and drawings in a folder locked in a drawer in the therapist's office. She was eventually able to explore more fully her narrative verbally in therapy, after each time of which she wrote more and expressed herself to a greater extent on paper.

Many severely traumatized children need a significant number of sessions in order to cognitively process their various trauma exposures. In addition, it is frequently the case that the complex trauma victim needs to return to other components of therapy, such as further affect regulation training, more focus on identity issues, and greater attention to attachment issues in the therapeutic relationship before they can address all of the most relevant memories. More aspects of the narrative may be disclosed later in therapy, when the client experiences a greater sense of trust and self-efficacy, and feels less likely to be overwhelmed by the material. For example, one child who had experienced many different types of traumas, including abandonment by a parent, sexual and physical abuse, and multiple placements, was eventually able to describe several attempts on her life by her caretaker's partner – but only once she had explored and processed these other traumatic experiences. In fact, it is a common experience of therapists working with complex trauma that memories involving some of the most threatening and frightening experiences are explored by clients significantly later in therapy, when successful trauma work has reduced some of the client's traumatic stress, the therapeutic relationship has developed sufficiently, and safety has been repeatedly established.

Emotional processing

Emotional processing of trauma memories usually involves exposure therapy. Although there are many definitions of therapeutic exposure, it can be defined here as any activity that triggers (and thus exposes the client to) trauma memories in the context of therapeutic safety. Once triggered, these memories may activated additional emotional responses/memories (e.g., fear, anger) that were initially conditioned or linked to the trauma memory. As these associated

emotional states are repeatedly elicited, but not reinforced (i.e., because there is a manifest absence of danger or trauma in the session), and potentially counterconditioned (i.e., by the positive feelings engendered by the therapeutic relationship), the emotional connection to the trauma memory weakens, until the emotional response is eventually extinguished and the memory loses its ability to produce distress (Briere, 2002; Briere & Scott, 2006).

As is true for cognitive therapy, exposure therapy with children may involve multiple modalities: play therapy using puppets, dolls, and the dollhouse for younger children, and sandtray and figures for all ages; psychotherapy, which may include the use of board games, projective card games; expressive therapy through art, drawings, and collages; and, especially in older children, psychotherapy involving titrated verbal exposure to upsetting memories.

When expressive/art therapy is used, children may make a drawing or write a poem of how they felt before they were abused or experienced some other type of trauma (e.g., neglect, traumatic loss, injury, becoming seriously ill), as compared to how they felt afterwards. Exposure in this case probably involves two separate processes: exposure to memory that is required by drawing or writing about their responses to the trauma, and exposure to the experience of hurt and loss evoked by comparing the two depictions. Children may draw a self-portrait for different times when they were hurt (an example of direct exposure to the trauma memory), or make a drawing of a person or place that, in some manner, facilitates the expression and processing of feelings. Other options may include kinetic family drawings (the family doing something) or a “snapshot” of their family, both of which can elicit memories and feelings that the child has for different members of his or her family – either because the maltreatment occurred in the context of the family, because the trauma affected the family in some way or another, or because the family’s response was an additional trauma. Children may also want to bring in photo albums or pictures of themselves at different ages, as well as those of family members. Pictures are often quite evocative in terms of triggering traumatic (and nontraumatic) memories, and thus may be effectively used as a form of therapeutic exposure. They also may trigger additional, more remote or avoided memories, which may then be processed as well.

In order for emotional processing to be maximally helpful, the child must have sufficient development of expressive language skills regarding his or her internal states. The child should be able to label feelings, a process that can be facilitated by feeling charts, books, drawings, games, and so forth, as described in Chapter 7. In some cases, the client may need more

encouragement and specific activities in order to sufficiently communicate feelings and thereby process them. These may include physical activity, role playing, drawings, and collage/art therapy. It is important to remember that, for the age group addressed by this guide (8 to 12 years), art and play are crucial, if not the primary media for clients' emotional expression.

An intervention that children have found especially helpful for emotional (and cognitive) processing of their traumatic experiences is called the "hat game", which can be used in individual and group therapy sessions. For this activity, the child and therapist write down questions on pieces of paper that relate to the traumatic experiences and related feelings. The questions are then put into a hat or other container, and the child pulls a question from the hat, then responds in whatever way they can to express feelings and thoughts related to their trauma. Exposure occurs when the child writes down the questions, and again when he or she answers them. In this way, the child is provided some structure for processing emotions, including support to pace themselves regarding how much they are able to express to the therapist.

Another technique involves clients writing onto pieces of paper all the "disgusting" things that they can think of (e.g., "dog poop", "vomit", "snot") along with the things that happened to them that were upsetting. Everything goes into a "garbage bag" and is stored in the therapist's office (James, 1989). By accustoming them to descriptions of negative, unwanted, abhorrent things, this exercise seems to facilitate some children's ability to talk about trauma experiences that they had experienced as shameful or otherwise had been unable to verbalize in the therapy session. If this exercise is used, however, it is important that the child understand that it is the abuser's behavior that is repugnant, not in any way the child's own responses.

Clients also may find it helpful to write a letter to the perpetrator or the person they have identified as hurting them. Although not required in trauma therapy with children, letter writing -- if the child is in favor of it and does not feel pressured to do it -- can be a good exposure activity: the trauma memories are activated by writing about the abuse, and by the fact that the letter is to the abuser. It further allows for expression of abuse-related emotional states, which, in the presence of therapeutic safety, can be further processed. Finally, there may be cognitive benefits as the child expresses the unfairness, cruelty, or inappropriateness of the perpetrator's behavior, thereby exposing himself or herself to these statements. It is important to note that these letters are never sent to the actual individual; their function is to promote emotional and cognitive processing only. In fact, it is often a good idea to visibly destroy the letter, with the

child's permission, so that he or she can feel safe later on that the abuser was never actually aware of what the child write.

As the therapist facilitates emotional processing of trauma, it is also important to continue to evaluate attachment/relational issues, affect regulation, and safety/trust in the therapeutic relationship, especially if the child is struggling with being able to express feelings. Of these, safety may be the most pressing issue. Because exposure is just one part of the therapy process, it is quite important that the clinician express, demonstrate, and reinforce the safety of the therapeutic environment, including his own her own non-dangerousness and willingness to protect the child. In other words, although the client is exposed to the trauma memory through play or discussion, and the memory activates associated emotional states (e.g., distress), there has to be a disparity between the activated emotional state and the current therapeutic environment, so that the emotions, unreinforced, will extinguish. Exposure without safety is quite unlikely to provide emotional processing – in fact, it may reinforce the client's triggered emotional states. For this reason, the various activities outlined in Chapter 6 must be in place if the interventions described here are to be helpful.

Finally, safety and support extend beyond the therapy session. A safe and, ideally, supportive home environment can contribute greatly to a child's ability to process his or her emotions in treatment. For example, a child who expressed particularly strong – but somewhat frightening -- anger toward the adult who had sexually abused him was able to process his feelings more directly and explicitly in sessions when supportive family members were also in the therapy room. His play involved a game that he created, wherein a target drawn with concentric circles (like a dart board) representing body parts of the perpetrator was placed on the wall of the therapy room. He, his family members, and the therapist took turns throwing a soft ball and winning points with each turn. During the course of the game, the client and family members expressed their feelings explicitly, while also engaging in a game that was fun for them. Although it is not a good idea to support aggressive behavior in any client, child or otherwise, the primary focus of this exercise was not, in fact, the child's expression of an actual desire to hurt the perpetrator, but rather for him to express anger in a less threatening game context, and to experience the support of other family members and the therapist in doing so.

Addressing avoidance and dissociation: Feedback from the system?

As noted in Chapter 2, avoidance and dissociation are often used by the traumatized child as a way to reduce his or her direct experience of trauma-related distress. Although such responses can be adaptive on some occasions, when they intermittently occur in therapy they may signal that the client is overwhelmed by activated trauma material. Further, as noted earlier, significant dissociation, by definition, means that the client is disengaging from activated emotional distress, and thus is reducing the extent to which trauma exposure and processing can occur. Ultimately, it may indicate that he or she is not feeling safe in treatment.

For these reasons, the therapist should keep track of whether the child is dissociating during treatment i.e., is appearing “spacey”, seeming more detached or disengaged, or engaging in verbalizations or behaviors that are not typical for him or her. When significant dissociation is present, the next task is to determine if therapy stimuli are producing the response. The therapist should explore with the client possible sources of danger or threat outside of therapy, including the possibility of additional abuse or neglect at home or elsewhere. It is possible that a child who appears to be in a safe home environment is, in fact, being threatened or actually abused by the very person who is bringing him or her to therapy. Or, the child may be being harassed, threatened, or victimized by peers, gang members, or other adults in his or her environment.

If external reasons for increased dissociation can be ruled out, or if dissociation notably occurs at certain points in treatment, it is possible that the therapy, itself, is motivating the client’s avoidance. In “Self-Trauma” (Briere, 2002) jargon, it is possible that the therapist is “overshooting the therapeutic window”, i.e., exposing the client (or allowing the client to expose himself or herself) to too much trauma material relative to the his or her existing emotional regulation capacities. If so, it is a good idea for the clinician to re-evaluate his or her opinion of the child’s trauma load and capacity to tolerate the activation of that material. The therapist may want to reduce direct exposure activities to some extent, and/or offer options for the child to engage in activities that provide more indirect emotional processing, such as drawings or sand tray work. Most basically, he or she must evaluate how successfully he or she is, in fact, titrating the client’s exposure. It may be that the therapist needs to proceed more slowly, focus less on the details of the trauma, move strategically into less evocative activities, such as cognitive reconsideration or temporary discussions of less trauma-related things, or otherwise reduce the intensity of the client’s emotional activation. Perhaps the child’s work in therapy would be facilitated by having a play period at the beginning of the therapy session, so that he or she has

an opportunity to gradually enter trauma processing at his or her own speed. Finally, it may be that the child needs more attention to the further development of emotion regulation skills, as outlined in Chapter 7.

An exposure philosophy

The reader will note that the exposure activities outlined in this chapter are characterized by a significant level of permissiveness on the part of the clinician. He or she rarely takes the child through preconceived exposure hierarchies, spends considerable time ensuring that the client is not overwhelmed by the process, and, in fact, generally encourages the client to help determine what and how much traumatic material should be addressed in any given session. As a result, it is often the case that a variety of different traumas are discussed or processed within or across sessions, rather than the client being restricted to just one or two. Finally, instead of hypothesizing “resistance” or “oppositonality” in a client who is avoiding certain exposure activities, or conversations about especially painful historical events, the therapist using ITCT is more likely to wonder if he or she is making a process error – perhaps pushing the client too hard, or focusing on emotional processing activities when emotional regulation or therapy relationship issues are more relevant. This does not mean that the therapist does not encourage the child to engage in exposure activities to the extent they are indicated, only that the client has real say in how much exposure he or she is willing to undergo.

Although this approach may be somewhat inefficient at times -- for example when the client is more avoidant than he or she needs to be, or when there is really just one major trauma that requires therapeutic attention, yet the client discusses many -- the ITCT therapist is willing to accept this slight downside in order to ensure safety and reinforce client self-determination. Many child victims of complex trauma suffer from insufficient affect regulation skills (Cook, et al., 2005), often are difficult to engage in treatment (Friedrich, 1995), and may have a number of traumas that require processing before significant clinical improvement can occur. As a result, ITCT-C promotes careful, titrated exposure to any number of traumas or hurtful processes (e.g., neglect), at a pace that is tolerable to the child, and that is, to a large extent, directly or indirectly under his or her control.

Chapter 11

Relational/Attachment Processing

As described in Chapter 10, ITCT-C not only focuses on the child's explicit memories of abuse, neglect, and other traumas, as they present as posttraumatic stress, cognitive distortions, negative emotional states, etc., but also on the maltreated child's very early experiences of attachment failure and their associated effects. In this regard, Cicchetti and Lynch (1995) note that "complex trauma arises when a child is exposed to danger that is unpredictable and uncontrollable while attachment with a caregiver who reliably and responsively protects and nurtures the child is disrupted or has not occurred at all."

Using the general theoretical perspective articulated in the Self-Trauma Model (Briere, 1999, 2002; Briere & Scott, 2006) and specific elements of attachment theory (Baldwin, et al., 1993; Bolby, 1989; Cicchetti & Cohen, 2006), the relational component of ITCT is based on the assumption that children exposed to early and sustained neglect and relational chaos typically encode these experiences as negative schemas or gestalts (preverbal memories of disattunements, abandonments, losses, and intrusions associated with disrupted or inadequate attachment responses of caretakers) along with the cognitions (inferences and conclusions) the child formed in the context of these experiences, and the co-existing emotional states that were conditioned to these memories. The relational schemas associated with attachment dysregulation appear to involve

- Expectations of being abandoned, rejected, betrayed, or otherwise emotionally hurt
- Assumptions by the child that he or she must be bad/unacceptable/unlovable in order to have been treated in this manner, and
- Beliefs that others (especially attachment figures) are uncaring, rejecting, disattuned beings who either must be protected against in order to reduce the likelihood of relational injury, or pursued in order to remain in proximity to them and avoid abandonment (Allen, --; Friedrich, --; Pearlman & Courtois, 2005).

The emotions, in turn, associated with these memories and cognitions are usually some variants of:

- Depression/despondency
- Terror
- Desperation
- Emptiness, and/or
- Anger/rage.

Because most of these phenomena unfold and are encoded prior to the onset of language (i.e., in the first years of life), they are largely implicit – involving experiential, sensory, and emotional memories, as opposed to narrative, verbal, autobiographical ones. Like other implicit memories, they cannot be recalled, per se, but they can be triggered by interpersonal stimuli in the child’s environment that are in some way similar to the abandonment, disattunement, rejection, or loss that characterized their attachment experiences. When triggered, these gestalts of preverbal memories, thoughts, and emotions are frequently reexperienced as current perceptions (much in the manner that flashbacks [another form of implicit memory] are), and motivate sometimes dramatic responses and behaviors that reflect the child’s original reactions to negative attachment experiences (Briere & Scott, 2006).

The net result of these negative attachment effects is often that the child has considerable difficulty in (and ambivalence about) forming stable, positive interpersonal relationships. He or she is often distrustful of emotional connection, and yet is preoccupied with unmet relational needs. Intimate connections with other people are often perceived as dangerous by the complex trauma victim, because relational stimuli trigger the early memories described above, which are highly negative in content and which are, by their implicit nature, misunderstood as representing data about current relationships (referred to as “source attribution errors” in the Self-Trauma Model). Yet, at the same time, the child also reexperiences the intense desire to attach, sometimes indiscriminantly seeking proximity to relational figures.

This amalgam of responses may variously present as:

- Authority issues
- “Borderline” dynamics
- Poor self-other boundaries

- Inappropriate attachments to harmful individuals and/or avoidant responses to helpful/caring ones
- Anger outbursts and, in some case, aggressive behavior in response to perceived rejection or abandonment (sometimes referred to as “rejection sensitivity”)
- Problems with peers, including isolation, fighting, and difficulties forming enduring friendships, and
- School problems associated with interactions with teachers and student

Given the significance of these problems, ITCT-C, like ITCT-A, attempts to address the relational (and, thus, attachment) difficulties of children exposed to complex trauma. This component is referred to as *relational processing*.

Relational processing refers to the use of the therapeutic relationship to activate, process, and help resolve attachment-level interpersonal disturbance. As aspects of the client-therapist relationship inevitably trigger memories, cognitive schema, and emotions associated with the child’s negative attachment relationships, he or she will experience the negative schema and emotions associated with those early events. However, because these cognitions and emotions are triggered implicit memories, they are not experienced as memories, per se, but rather as perceptions of the therapist and the client-therapist relationship¹. Much in the manner that explicit memories of abuse are treated, as per Chapter 10, these memories are repeatedly activated and then repeatedly not reinforced in the context of a positive, caring therapeutic relationship.

For example, the closeness of the relationship and the age and power status of the clinician may trigger in the child implicit memories of his or her original experiences with an attachment figure, which may then activate associated cognitions (e.g., that the therapist is harsh or rejecting) and conditioned emotional responses (i.e., the original experiences of anger, fear, and desperation). However, these thoughts and feelings are specifically and carefully not reinforced by the therapist, in that there is a disparity between the activated attachment gestalt and the child’s current relational experience: the clinician is visibly not rejecting; he or she is, in fact, warm and accepting, and the therapy environment is safe. Over time, in the face of no

¹ Note that this process is akin to the psychodynamic notion of *transference*, although the Self-Trauma Model views it as memory activation and source attribution errors.

objective support for his or her activated negative model of the therapist, and in the absence of danger or rejection in the session that would reinforce fear or anger, these responses tend to fade away through extinction and cognitive reconsideration (per Chapter 10). Eventually, relational stimuli such as power imbalance, closeness, relatedness, intimacy, vulnerability, and authority lessen in their ability to activate abuse and neglect-era cognitions and emotions, meaning that they are less likely to trigger relational difficulties – first with the therapist, and later in other interpersonal contexts.

In ITCT-C, however, as opposed ITCT as it is applied for some older adolescents and adults (i.e., ITCT-A and the Self-trauma Model), relational and attachment processing does not occur just with the therapist; it is most effective if it also involves work with nonoffending parents or caretakers. In fact, the clinician must be careful to insure that his or her work with the child does not cause the child to form a greater attachment to the clinician than to the parent(s), assuming that nonoffending parents are physically and psychologically available. Too much attachment to the therapist can lead to an inevitable source of suffering for the child: because treatment must necessarily end at some point, termination may reenact abandonment and loss. For this reason, the clinician should be careful to modulate the client's proximity-seeking – allowing enough relational connection that the child has the chance to work through attachment-related difficulties in treatment, but not so much bonding that the child will be retraumatized as therapy ends. Unfortunately, some therapists lose track of this reality, and are surprised when their seeming re-parenting of the child leads, in the end, to significant termination related distress.

Even more important than avoiding the risk of attachment retraumatization, efforts to increase or strengthen caretaker-child attachment reflect the need for the child to continue (and possibly have repaired) the basic parent-child relationship. Unlike the therapeutic relationship, the caretaker/parent-child attachment system ideally will continue for many years, and will serve as an ongoing source of support and nurturance for the child -- or, if not repaired or assisted, may be the source of continuing relational issues. Further, this attachment relationship extends – in most cases – considerably into the past, often to the moment of the child's birth, and thus is probably affects the child's current functioning. This is definitely true for the neglecting parent, but also holds for the more attuned caretaker. Repairing, if possible, the effects of past breaches in the parent-child attachment can be very important to the child's present and future wellbeing.

Improving the quality of the current attachment relationship, above-and-beyond repairing the effects of previous attachment lapses, is obviously quite important as well.

For this reason, ITCT-C includes parent-child and family sessions, often in the context of co- occurring parent education sessions and, in some cases, parent individual therapy (described in Chapter 13).

In these sessions, several potentially reparative things may occur:

- the child has opportunities, in a safe environment, to share with parents or caretakers any concerns he or she regarding the quality of previous and current attachment experiences
- parents/caretakers who have had problematic attachment relationships with the child can interact with him or her in ways that, based on the effects of education and therapy, foster a new and more positive attachment relationship with the child, and
- nonoffending and nonneglecting parents have an opportunity to interact with the child in ways that emphasize their support and caring

In order for these sessions to be maximally helpful, however, the caretaker(s) must, in fact, be ready and willing to respond in new ways and evidence overtly supportive responses toward the child. When parents or caretakers are not prepared to reevaluate their approach to the child, and learn new, more attachment-supportive behaviors, family or conjoint sessions may be less successful. In fact, the ITCT-C approach suggests that family or conjoint therapy with a manifestly nonsupportive caretaker is often inappropriate. In such instances, parents or caretakers must make significant progress in their own, separate, attachment-fostering sessions before the child can benefit from their presence in the child's treatment.

Chapter 12

Behavioral Self-control

Because a substantial proportion of multiply-traumatized children struggle with anger, depression, negative relational schema, and emotional dysregulation, the prevalence of “acting out” or externalizing behaviors -- ranging from self-mutilatory or suicidal behaviors, or overeating, to tantrums, aggression towards others (e.g., fighting, bullying) or property (e.g., fire-setting, vandalism), sexually reactive behavior, substance abuse, rule/law-breaking, and truancy and disruptive behavior at school – is considerably more common in this population. ITCT-C seeks to reduce this behavior; not necessarily by increasing environmental control (although that may sometimes be required), but rather by intervening in the underlying conditions that support such activities, and by encouraging new, more positive behaviors. The general goal is for the child to learn behavioral self-control, rather than solely trying to avoid (or suppress) behaviors that lead to punishment.

The major interventions for negative externalizing behaviors focus on:

- The internal emotional states that drive externalization
- The child’s repertoire of emotional regulation behaviors
- Greater awareness of thought-feeling-behavior linkages
- Trigger identification, and
- The child’s capacity to delay tension-reduction behaviors
- Parental/caretaker education

Reducing the internal emotional states that drive externalization

The literature on externalization behavior in children suggests that this symptom cluster arises from posttraumatic stress, as well as trauma-related dysphoria such as anxiety and depression. ITCT-C addresses this aspect through the titrated exposure procedures outlined in Chapter 10. As these underlying emotional states are desensitized, extinguished, or counterconditioned during treatment, the compelling need to immediately reduce the internal experience of these emotional activations is diminished. It is a common clinical observation that although emotional processing of trauma memories may, on occasion, temporarily result in an

increase in externalizing behaviors, the end result is often a reduction in aggression, sexually reactive behavior, and related phenomena.

Increasing the child's repertoire of emotional regulation behaviors

Many externalization responses are, in fact, tension reduction behaviors (TRBs), as described in Chapter 2. Because TRBs, in turn, reflect attempts to down-regulate trauma-related distress, the interventions outlined in Chapter 7 are often helpful with “acting out” children. These techniques may be used by the child not only to generally reduce hyperarousal, but also specifically to de-escalate triggering situations. On such occasions, the child may invoke previously learned techniques that “change the moment” (Linehan, 1993) and thus reduce the need to engage in externalization. For example, the child may be counseled to stop for a second when triggered, slow his or her breathing, and consciously allow himself or herself to relax. He or she may also choose to engage in grounding exercises, noticing the surrounding environment and focusing on the “here and now” of the moment rather than internal activations of the past. He or she may employ self-talk, reminding himself or herself that triggering stimuli are just that, and not a representation of reality.

As noted in Chapter 7, a critical component of these various options is trigger identification. This involves the client's growing capacity to observe his or her situation -- to recognize the cascade of events that lead to tension reduction:

- A stimulus that is reminiscent of a traumatic event or process (e.g., provocation by a peer; rejection, abandonment, or empathic disattunement; a major stressor, or negative contact with an authority figure)
- Associated anger, fear, or self-derogation that in some way is overwhelming, sometimes accompanied by strong somatic reactions, and
- Involvement in a behavior that distracts, soothes, externalizes anger (i.e., aggression), or punishes self to relieve self-hatred (e.g., self harming or endangering behavior).

As the client is more able to identify these triggers, the thoughts and feelings they engender, and the reason for his or her desire to engage in a TRB, he or she can potentially gain some control over his or her subsequent behavior. Although this learning is facilitated by session-based work on the “trigger grid” (see Appendix), the child will be less behaviorally

reactive and self- or other-endangering if he or she can ask (at whatever linguistic level is age appropriate) the following questions at the time of the triggering event:

- Is this feeling or these thoughts based on the present, the past, or a little bit of both?
- If the past is involved, on any level, what is triggering me? What memory is pushing this?
- Since my reaction is at least partly about "then," not just "now," is it a good idea to do whatever it is I want to do right now? Will it actually change the situation (i.e., that I am remembering something bad that happened to me)?
- Can I take a moment to
 - relax
 - slow my breathing
 - notice my immediate environment
 - and remind myself what's really going on, so that I can
 - keep from doing something that I might regret later or get in trouble for.

Delaying tension-reduction behaviors

Somewhat akin to using the emotional regulation approaches above, "acting out" behavior can also be reduced by teaching the child to delay or forestall tension reduction when the desire to externalize first occurs. Initially, the possibility that one can pause before acting may be difficult for the traumatized child to accept: in many cases, tension-reduction behaviors (TRBs) are experienced as uncontrollable impulses that cannot be resisted. In actuality, however, most trauma survivors who use this avoidance strategy actually have some control over when and to what extent they engage in it (Briere & Scott, 2006). Forestalling TRBs has two benefits:

- (1) Not engaging in an acting out response for a short period of time may reduce the need to engage in it. As time passes, the underlying triggered emotional state may fade (many triggered emotions have very short half-lives, often measured in seconds or minutes), thereafter no longer motivating the behavior. As well, this brief "time out" may give the

child the chance to momentarily consider the wisdom (or lack thereof) of the TRB, and its potential negative consequences.

- (2) Repeated delays in what would otherwise be relatively automatic actions may increase the child's affect tolerance capacities. By not immediately engaging in the behavior, the child is exposed to a brief period of sustained distress. However, this negative internal experience -- although experienced as overwhelming -- does not, in fact, do more than just feel bad; no catastrophic outcomes ensue. Repeated exposure to nonoverwhelming distress in this fashion can both increase the child's ability to "feel bad without going away," as well as providing an important cognitive lesson about the survivability of directly experienced emotional pain.

It is important that the notion of delaying TRBs be introduced in a supportive, nonpunitive way. The communication should be that the clinician understands why the child has used externalizing in the past, i.e., to distract, express, or otherwise address negative affective states. It should also be expressed that the behaviors in question, although helpful on one level, have a significant "downside" in terms of potential self-endangerment, harm to others or property, social unacceptability, or likelihood of other negative consequences, including some sort of punishment. Finally, the therapist should discuss with the client whether the behavior can be terminated altogether, or, failing that, whether the client can try to delay engaging in the behavior for a short period of time. When discussing this last point, the clinician should stress the benefits of stopping the behavior, but also his or her understanding that some behaviors cannot be easily terminated.

Obviously, behaviors that harm others, or significantly endanger the child, must end, if at all possible. Other behaviors, however, that are less injurious, may be negotiated to some extent. Often, the child can only forestall certain behaviors for a few seconds, or a minute, when he or she first attempts to do so. Later, however, as the child becomes more adept at delaying TRBs, the time period may extend to longer intervals. The child is asked to report back to the therapist on any occasions when he or she engaged in an externalization behavior, as well as any successes he or she had in delaying such behavior. Importantly, all instances when the child can forestall "acting out," even for a few seconds, should be reinforced, as opposed to being criticized for having occurred at all.

Parental/caretaker education regarding the basis for externalization and appropriate responses

When the traumatized child behaves inappropriately in school or in other environments outside the home, his or her parents or caretakers are often confronted with the child's "bad" behavior. In other cases, the child's aggressive or disruptive responses at home may present serious challenges for parents. In either context, the caretaker may resort to punishment of various types, and may become more disciplinarian over time. Unfortunately, punishment is rarely very successful in controlling trauma-related behavior in children. In fact, the child and parent may enter a vicious cycle, wherein the child's externalizing behaviors may lead to increased parental punitiveness, attempts at control, and familial discord, which may lead to further problematic behavior. Angry, seemingly out of control children are obviously a very difficult situation for parents, who often do not have significant support from outside systems, and who may not fully understand the reasons for the child's responses.

ITCT-C provides information and support to parents or caretakers so that the likelihood of further exacerbation of the child's behavior is minimized, and a more helpful, supportive environment can prevail. In this regard, the ITCT approach to externalizing behaviors is always positive, non-punitive, and growth-oriented for both the child and the family. The emphasis is on the child learning new, more adaptive behaviors, and parents are encouraged to use rewards – as opposed to punishment -- whenever possible, including praise and earning privileges at home. When consequences are necessary, they are structured to be consistent, reasonable, and nonpunitive, and generally accompanied by support and reward for more positive, alternate behaviors. Especially in the case of younger children, it can be very important for the therapist to engage the supportive caretaker in determining when externalizing behaviors might occur, discovering alternative ways for the child to manage anxiety, and -- when possible -- for the caretaker to encourage the child to verbally express his or her feelings. In all cases, a primary goal of working with parents of traumatized children is to provide new information, including:

- The reasons why the child is doing what he or she is doing (e.g., tension reduction, sexualization by abuse, externalization of anger or fear)
- Developmental issues that may be complicating the child's behavior or parents' understanding of that behavior, and

- Specific ways of relating to the child's dysfunctional behavior that is not punitive, but rather caring and supportive – while still establishing clear boundaries and rules.

The following chapter outlines the various specific components involved in working with the parents or caretakers of maltreated children.

Chapter 13

Interventions with Caretakers

Caretaker interventions within the ITCT-C treatment model occur concurrently with individual treatment of the child. For some children, caretaker interventions primarily involve teaching otherwise supportive and caring parents how to address the child's ongoing issues as they present at home. For others, the child-caregiver relationship is the source of trauma and/or related other sources of trauma, e.g., a parent does not provide supervision and is neglectful so that their child is sexually abused by family members. When this happens, the attachment relationship is often severely compromised (Cooke et al., 2005). According to Friedrich (2002), 80% of maltreatment children develop insecure attachment patterns. Caretakers often have their own traumatic history and may need support from a therapist in collateral sessions before they can be more empathic, protective, and supportive with their child.

Individual therapy for the caretaker(s) may be recommended, especially if the caretaker's own trauma history is impeding the progress of his or her child's therapy. Given the multi-generational aspects of many instances of complex trauma, many caretakers require considerable support and opportunity to explore their own feelings and reactions before family therapy can be conducted (see Chapter 14, Family Therapy for more discussion). Sometimes, especially when it is difficult for a caretaker to seek individual therapy elsewhere, an agency may assign a therapist solely for the purpose of providing individual therapy to the caretaker. The primary goals of collateral interventions with caretakers include:

- Support
- Parenting skills development
- Psychoeducation regarding impacts of trauma, and
- Exploration of their own feelings and reactions to their child's traumatization – especially in relation to their own trauma history.

Groups for caretakers are especially helpful. At MCAVIC, two different groups interventions (“Phase 1” and “Phase 2”) are offered to parents.

Phase 1 didactic parenting group

Didactic groups are typically held weekly for 12 sessions. The format focuses on parent education and training, with materials (videos and manuals) provided as required to support the parent training model, Structured Training and Education for Parents (STEP). Classes are adapted to the needs and background of culturally diverse parents, and Spanish-speaking caretakers, in particular, are provided with Spanish-speaking (bilingual) therapists. Parenting classes are also provided in the community for (a) teen parents and (b) adult parents residing in a residential treatment center for substance abuse.

The Phase 1 parenting group consists primarily of caretakers who have children who have been abused. Typically, however, they also may have other issues, such as partner violence or exposure to community violence. Caretakers receive and discuss materials on parenting, work to increase their coping skills, explore feelings related to their experiences with child-relevant systems (e.g., legal, child protection), receive and discuss information related to the impact of trauma on their child, and create their own trauma narrative. Psychoeducation materials, such as The Mother's Book and videos or DVDs on different types of trauma are often used.

It is important that group members have similar issues and concerns, and, for the most part, similar levels of insight, motivation to explore difficult issues, and self-capacities. Whenever possible, the sessions should be co-facilitated by two therapists who have had some previous contact with the caretakers, either through collateral or family therapy sessions. If, however, the prospective group members are not known to the therapists, it is especially important that the clinicians meet with each candidate for the group individually, to discuss their goals for participating, as well as some background regarding their child's traumatic experiences. Initial assessment, including completion of the Trauma Symptom Inventory (TSI; Briere, 1995) and "self-portraits" prior to the beginning of the group -- or in the initial session -- can be helpful in identifying group members' own traumatic reactions and experiences..

An example of group sessions for the first phase group model, designed by two MCAVIC-USC co-therapists, Hodges and Farrell, is provided below. This group model has thus far been used for biological mothers and grandmothers only, but could be adapted for fathers groups as well.

Phase One Group Model: Sessions for Caretakers of Sexually Abused Children (Hodges & Farrell, 2007; Farrell & Hodges, 2007)

- Meeting 1: Introductions and planning
- Meeting 2: Information Regarding Sexual Abuse
Dealing with systems (Criminal Court, Dependency Court, Family Court, Child Protection Agency)
- Meeting 3: Impact of Sexual Abuse on Children
Symptoms, feelings, behaviors: Short and longer term effects
- Meeting 4: Impact of Sexual Abuse on Children
Impact on relationships (i.e., with mothers, siblings)
Impact of sexual abuse disclosure on mothers
- Meeting 5: Understanding Dynamics of Sexual Abuse and Abusers
How did this happen?
Why did this happen?
- Meeting 6: Dynamics of Sexual Abuse and Abusers
Grooming, excuses
Grief and other feelings related to the offender
- Meeting 7: Personal Narratives
Sharing our stories, getting support
- Meeting 8: Personal Narratives
Sharing our stories, getting support
- Meeting 9: Parenting After Abuse – Family of Origin Issues
Self esteem and coping
Communication with our children
- Meeting 10: Self Care & Safety
Trust issues
Goals for the future
- Meeting 11: Celebration and Planning for the Future

Phase 2 parenting group

This second group is only available to non-offending caretakers after they have had a successful course of parenting classes, and are more able to address their own trauma issues. Although sessions include some didactic material, the focus is more on exploration of parental

trauma history and family of origin issues, and discussion and support among group members. Sessions for this group involve exploring gender issues, increasing their sense of self, developing relaxation skills, further exploration of trauma experiences, relationships with partners, and sexuality. Group members also may journal their experiences throughout the time of the group.

This group is less commonly provided at MCAVIC, since many parents or caretakers are struggling with multiple trauma exposures, social stressors, and the multiple impacts of poverty, and, as a result, may feel too overwhelmed to explore their own complex trauma in a group setting. For those who have “graduated” from Phase 1, however, and can tolerate the focus on more personal issues, Phase 2 groups provide opportunities for more in-depth exploration, and sometimes are more gratifying for higher functioning caretakers.

Chapter 14

Family Therapy

Family therapy is often an important component of ITCT-C, because there are typically family system issues that significantly influence the child's psychological functioning and trauma-related responses. The number of sessions will vary according to the family, their concerns, and their motivation and availability, as well as whether they are dealing with orders associated with criminal, dependency, juvenile, or family court. If individual therapy for caretakers is occurring concurrently, they may exhibit resistance to attending family treatment as well. Nevertheless, weekly family therapy is probably best. If this is not possible, bi-weekly sessions can still be helpful.

When should family therapy be considered?

Because it is relatively labor intensive, not always welcomed by all family members – some of whom may be disengaged from the child, and involves, in some cases, significant scheduling issues, the clinician should ascertain when family treatment is likely to be helpful. Among the necessary conditions are the following:

- The caretaker(s) exhibits at least some emotional support for the child and has some potential to develop empathy for him or her
- The child is able to express feelings and process trauma in individual therapy, and exhibits sufficient trust in the therapist to engage in a potentially more challenging therapeutic modality
- Caretaker(s) and children who will be attending family therapy sessions are able to tolerate activation of feelings within sessions and exhibit adequate coping skills and/or ability to respond to therapist to reduce anxiety
- The family is able to commit to regular sessions and in some cases, is willing to sign a contract stipulating the number of sessions, appointment time, and cancellation policy.

When more than one therapist has been involved in providing therapy to the child or caretaker family members, the individual/collateral therapist will need to co-facilitate in the family therapy sessions. Briefing time for the co-therapists prior to sessions, as well as de-

briefing time after each session, is essential. Sessions generally include a significant amount of practice of skills and role plays specific to the family's needs, so it is especially helpful to have the therapists present who have been working individually with family members. Therapists should make a concerted effort to engage with all family members (especially those who may not have attended collateral sessions previously) and avoid being over-allied with whomever they have been working with in individual sessions.

The following is a 6 to 8-session family therapy module that might follow a course of individual therapy for the child and weekly collateral therapy sessions for the caretakers. Each session is briefly summarized regarding the primary topic, goals for the session, and sample interventions. The order of sessions might vary, but the following are topics typically considered important in order for the family system to recover and heal from trauma, as well as to function more effectively and safely in the future. If child abuse and/or family violence has occurred, additional attention will need to be directed at increasing caretaker protectiveness and reducing the risk of further victimization. Six sessions of family therapy would be considered a minimum in most cases; for some families, additional sessions might occur at a later date, if further trauma exposures occur or are disclosed, or the family is better prepared to do further work.

The primary topic areas for family therapy, which are interwoven across sessions, include:

- Effective communication
- Appropriate caretaking, including safety and protection of the child and age-appropriate expectations
- Affect management
- Boundaries and roles
- Attachment/relationship issues, and
- Parental empathy, support, and emotional attunement.

Session 1: Assessment of Family Functioning, Family Therapy Goals, and Planning

- Each family member has an opportunity to describe areas they would like to see addressed in the family sessions, and goals they would like for treatment. It is important

that the family begin sessions with a sense of hope and optimism that they can feel better, more supported, and cared for in their family. Although each member (regardless of age) should have an opportunity to express concerns about the sessions and how their family is currently operating, it is beneficial if a general consensus can be reached regarding goals for family sessions.

- The therapist(s) begins to engage all family members in the family therapy process, ensuring that all feel welcome.
- The therapist(s) reviews with the family, plans for future sessions, taking into account their stated goals.
- The therapist begins to gain a sense of how the family is functioning (if this is not already known) by reviewing a typical day -- routines, mealtimes, bedtimes, assigned chores, after-school activities, how homework is completed, etc., as well as problems that have arisen and how traumatic events have affected family functioning. For example, if a family member is dealing with a chronic, debilitating illness or traumatic injury, it is important to know how this is affecting family relationships and functioning. Family members also have an opportunity to briefly describe how they have been traumatized, and why they are at the agency receiving treatment -- e.g., a son witnessed a shooting of a friend, a daughter was sexually abused by stepfather, a mother was battered by a boyfriend. By briefly stating what they have experienced, at the onset of therapy, it is communicated that difficult things will be talked about in a safe place. This is especially important when there may be family members (e.g., a caretaker or sibling) who have not attended any therapy sessions previously.
- Cultural beliefs and practices, as well as the role of religion/spirituality, will need to be assessed and integrated into the plan for family therapy. Respect for cultural differences is essential, while also reiterating the mandating reporting responsibilities of the therapists.

Session 2: Effective Communication and Expression of Feelings

- Each family member is encouraged to express feelings that they are having regarding the traumatic event(s) that brought them to treatment.

- Communication among family members is facilitated by the therapist re-directing family members to express feelings directly to the person concerned. Family members often express blaming statements, typically beginning with “You.....”. Instead, they are encouraged to use “I.....” statements instead, to convey how they feel in a way that others can hear. Often, role plays are helpful at this stage to describe situations at home, and for the therapist to coach better communication skills (e.g., expressing feelings and developing listening skills).
- Better communication can be an ongoing challenge throughout the duration of the family therapy sessions. But communication should be especially focused upon at the beginning of treatment, in order to create an environment of safety for later processing of trauma and more difficult material.
- Caretakers are encouraged to be more empathic toward their children -- initially, it may only be possible to begin this process, which will continue throughout family therapy. For those caretakers who have particular difficulty understanding their children emotionally, regular individual therapy sessions may be required concurrently, throughout the time that family therapy sessions are conducted.

Session 3: Roles and Boundaries (may require more than one session)

- Following intrafamilial abuse, but also as a result of other types of trauma (e.g., community violence, medical trauma), there may be a reversal of roles and/or inappropriate expectations of children vis a vis their caring for parents. An example of this is parentification, whereby a child is required to perform duties and tasks beyond their developmental level and is expected to care emotionally care for adults and other children, rather than having their own emotional needs cared for in an age-appropriate manner. Emotional abuse and neglect by caretakers may also lead to the child experiencing himself or herself as devalued except in terms of what he or she can do for others. A goal at this point in family therapy is to attempt to re-orient the adult(s) toward taking better care of themselves and nurturing their children in a consistent, emotionally attuned manner. For more dysfunctional families, a number of sessions may be necessary for roles and boundaries to be significantly re-aligned. Most typically, more traumatized

caretakers are likely to have greater difficulty being less demanding and more nurturing of their children.

- Family drawings and collages can facilitate clarification of roles and boundaries. For example, having each family member draw their family regarding how they currently perceive it, and how they would like their family to be in the future. Such drawings can convey roles of family members as well as relationships, connections, expectations, and emotional status. For example, a child may draw himself or herself as isolated from the rest of the family, or much larger than adult members, or with very little attention to detail for family members while the background is elaborate and highly detailed. Family drawings can also reveal feelings that family members have toward each other.
- Role plays can also be used whereby, for example, all members can reverse roles, or enact a situation at home (e.g., discipline situation or child wanting emotional support), and, with coaching by the therapist(s), learn alternative, more age-appropriate, and role-appropriate ways of managing situations that arise.

Session 4 Exploration of Trauma Exposures (may require more than one session)

- Once communication, roles and boundaries, and increased support of children by caretakers, are evident, it is important that each member of the family have an opportunity to describe the traumatic event(s) and how they were impacted.
- As events are described, which can be mapped out on paper, as a timeline or lifeline (described earlier) with associated feelings, for each family member, they are able to gain a better understanding of how each other has experienced shared and/or separate traumatic events.
- Family members can participate together in creating a genogram, showing multiple generations, relationships, and trauma exposures throughout the family system. This can help the family to understand their family history and context for traumatic experiences, and may even help them to prevent further trauma in the future.
- It is also helpful at this stage for family members to engage in drawings, board games, and other play-oriented means of describing traumatic events.

Session 5: Enhancing Family Relationships, Increasing Support Network, and Further Trauma Processing

- Most families will require further opportunity to process their traumatic experiences and express associated feelings.
- It is also important for children to experience their primary caretakers as being more empathic, supportive, and emotionally attuned to them.
- At this point, when adequate communication skills have been acquired and the adults are expressing more empathy for their children, it may be appropriate and helpful to family members to have extended family attend the session. For example, if family members are dealing with a recent loss or new traumatic event (e.g., incarceration of a family member) or require additional support which appears to be available, this larger family session can be very beneficial. Another example is when support by the extended family can counteract emotional abuse or neglect by the primary caretaker, who continues to struggle with adequately emotionally supporting his or her children.
- Because the formation and continuation of more secure attachments is important for the child's healing, family therapy can be focused, at this stage, on developing further and reinforcing the primary attachments in the child's (and other family members') life. This work may also extend to further development of peer relationships. With some families, more sessions will be required to further explore and develop attachment relationships.
- Caretakers may also benefit from attending concurrent group sessions for themselves, wherein they can explore further their own traumatic experiences, receive support from other adults who have had similar experiences, and become more emotionally available to their families.

Session 6: Goals for the Future, Reinforcing Treatment Gains

- At this point, all family members review with the therapist(s) their progress thus far, and the possibility for further therapy.

- Family members might share their feelings regarding how they experience family therapy, what was helpful, what was difficult, and what they would like to have happen in the future for their family to function even better.
- Family members and the family may decide to continue at this point or take a break, and re-evaluate in the future whether more sessions might be useful.

If indicated or desired, family therapy sessions may be resumed again at a later time, while the child client and collateral(s) continue in individual therapy sessions. If further safety or protection issues arise, new trauma disclosures occur, reunification or visitation with an alleged perpetrator is possible, or clients are exhibiting or expressing heightened anxiety, requiring further relational processing within the family context, further family sessions may be helpful. As the structure for family therapy sessions presented here is flexible, it is possible that the therapist(s) and family members may decide that the family needs more weekly sessions to practice skills. Similarly, if further traumatic events occur (e.g., death in family, sudden hospitalization of chronically ill parent or child), a decision may be made to extend current sessions in order for the family to process this new material. Finally, during the process of ongoing family therapy, it may become clear that additional issues must be addressed in family therapy, such as:

- Cultural factors that involve identity and communication issues for members of the family, acculturation, and generational differences in beliefs regarding acceptable parent and child behaviors
- The need to broaden the family's social network, including the possibility of increasing interests and support for the family, identifying respite resources for the caretaker(s), and increased contact with external systems, such as involvement in church or community groups
- Issues arising from the needs and issues of foster parents, as well as the impacts of the child's history of multiple placements and multiple caretakers on his or her response to the current family milieu.

It is important for the therapist to balance the needs of the family system, while not overlooking the needs of the primary child client, who, in most cases, is also undergoing ongoing individual therapy. There may be, for example, things that he or she had to say to other family members, requests he or she wants to make, or explanations he or she wants to hear regarding ways in which the family may have mistreated him or her. Or, the rest of the family may be outspoken or preoccupied with issues relatively unrelated to the child's concerns. In such instances, the clinician should be careful to include the child's desires or specific goals for treatment when working with the family as a whole. Information on the child's specific family-related issues will not always arise in the context of the family session – it may come from his or her work in individual therapy, in which case the therapist should communicate this material to the child's family therapist(s). In other cases, information on the relative needs and issues of children and their caretakers as it relates to family therapy may become apparent in during the assessment phases of treatment, and the Assessment-Treatment Flowchart – Children (ATF-C) may be helpful in determining the treatment priorities of family treatment.

Chapter 15

School-Based Interventions and Other Adaptations of ITCT-C

School-based interventions and adaptations of ITCT-C are particularly essential in communities where families may be less inclined to seek services for their traumatized children due to lack of resources, social disenfranchisement/disengagement or fear of community agencies, or because they are unaware or for some other reason unable to access services. ITCT-C-related services are provided at numerous school sites to increase the access and quality of trauma-related services for traumatized children and youths.

Prior to any school-based trauma intervention program being initiated in the community, it is essential that the agency professionals meet with key staff of the local school district such as the lead school psychologist, social workers, school counselors, and administrators. The agency offering trauma-focused interventions should be receptive to the needs of the school district, while also describing the program goals and activities. MCAVIC staff spent much time in the early years of the school-based program in Long Beach establishing strong collaborative relationships with key school personnel, including principals, counselors, and teachers at schools identified by the school district as being in greatest need, as well as having space and receptive staff. These relationships have expanded during more than 10 years of MCAVIC's school-based program with continued training, outreach, and consultation. MCAVIC also includes school personnel on its Consumer/Family Advisory Council to ensure that coordination of services is effective and meeting the needs of the community for traumatized children.

MCAVIC has provided ITCT-C-related, school-based interventions: consultations, individual therapy, group therapy, and training for school personnel at 18 school sites, including elementary, middle, and high schools, as well as alternative ("storefront") school sites. ITCT-C involving individual therapy tends to occur more at the high school-level mainstream sites where the clients require more intensive therapy and school schedules are more difficult to coordinate to conduct group sessions. Group therapy models for school-based programs focus primarily on domestic violence, community violence, traumatic loss, and parental substance abuse, with the focus being determined by the traumatic exposures of the selected group members. ITCT-C was further adapted for the alternative ("storefront" sites) where more intensive services were needed for highly traumatized, at risk children and youth. Treatment often involved combinations of

individual and group therapy, as well as crisis interventions (when necessary), and daily visits by therapists at the school sites to check in with the students and teachers, as well as assist with behavioral management issues and academic support. Because this model requires intensive services and daily contact at the school sites, it can be more challenging for clinicians and agencies than more typical school sites. On the other hand, this program can do much good for disengaged, multi-problem children, and is rewarding for staff.

Referrals, screening, and assessment in the school-based program

Referrals are accepted at school sites for school-based services (assessment and individual therapy or group therapy) and at MCAVIC for clinic-based treatment, primarily from school counselors, psychologists, and social workers. Referral forms are completed by school personnel for school-based services which are then reviewed and screened by school-based therapists. When referrals are made directly to the clinic, they are reviewed and screened just as any other referrals from other sources are screened. General criteria include trauma history, child's and family's interest in participating in treatment, no imminent suicidality or psychotic disorder, and no involvement of the child in treatment elsewhere. The initial assessment is conducted once the child's legal guardian or parent signs the consent for services, which is sent home with the student and returned signed to the school. School-based clients are assessed using the TSCC-A (TSCC without the Sexual Concerns subscale), the CDI, and the UPID. See chapter 3 for information on these measures. At the alternative school sites where ITCT-C services were provided previously², high risk students were screened and assessed, then received individual therapy with group therapy as needed and appropriate.

When trauma exposure is very extensive, involves sexual abuse, or the child presents with severe posttraumatic symptomatology, it is recommended that the child receive clinic-based treatment, where the family can also be involved in treatment. Clients are assessed after 3 months of treatment, as they are with ITCT-C based at the clinic. If it is found through this second assessment that the child remains symptomatic, they are either referred for follow-up therapy at the clinic, encouraged to attend another series of school-based group sessions (if there is time remaining in the school year), or continue with individual therapy sessions while at school (at the high school sites, only).

² This program is not currently being offered at MCAVIC due to funding and personnel constraints. It is anticipated that it will resume as a MCAVIC program in the future.

ITCT-C school-based group model

If referred at high schools, children receive individual therapy, usually in a staff office where confidentiality is maintained. At elementary and middle schools, however, children receive ITCT-C through group therapy sessions, conducted on a weekly basis during the school day. Group therapy sessions can be difficult at high school settings, where scheduling can be difficult given academic demands. As well, high school students sometimes disclose extensive, repeated trauma exposures that exceed what is possible in group therapy.

For most groups, cohesion is enhanced when child clients in the group share similar trauma histories and are no more than two years apart in age. Culturally diverse groups can be quite helpful, because they offer the child the opportunity to share his or her cultural beliefs and identities in the context of their trauma histories, and, as well, learn more about other cultures/ethnicities. Groups for sexually abused children are not conducted on school sites due to confidentiality issues, but when such disclosures occur in the context of trauma groups, the child's experience is reported to the appropriate legal or child protection agency (if disclosed for the first time) and, if the child desires, he or she is referred to MCAVIC or another agency that can provide specialized treatment for child sexual abuse. Sessions are consistent with ITCT-C components and can complement individual therapy if necessary.

The following is an example of a protocol for school-based group therapy sessions that are conducted on a weekly basis for 12 weeks, with children aged 8 to 12 years who are presenting with trauma histories involving community violence, domestic violence, parental substance abuse, and/or traumatic loss. Group sessions always begin with members checking in and then sharing a small snack. A relaxation exercise and/or breath training is often used at the beginning of the session to help children regulate affect and feel more focused, and may be repeated at the end of the session to allow de-escalation before they return to the classroom. It is also helpful for clients to express positive statements about each other at the end of each session. Sessions are typically conducted during the school day at a time that is most conducive for the children's participation and in a room (e.g., school counselor's office) that is private.

Protocol for School-Based Group Sessions

Session 1: Introduction to the Group

Addresses the components of creating a safe environment and reducing stress.

- Introductions, overview of the group, group rules and guidelines (which are posted at each group). Clients may be encouraged to make a brief statement about why they are attending the group (e.g., “ I saw a cousin get shot” or “I told my teacher that my Dad hits me.”).
- Introduce the use of a behavioral chart (if being used) to monitor positive behaviors for each member and means for reinforcement, e.g., stars or stickers for behaviors then pizza party for the group when their goal is reached.
- Discuss confidentiality and trust-building
- Members agree on a group name and make a banner that will be posted at each session.
- Children may “interview” each other in pairs, then describe to the other members what they learned about the child they interviewed.
- Self-portraits and assessment measures are completed
- Group members describe and/or write their goals for participating in the group
- “Ice-breakers”: Play such as a board game, art therapy, or physical activity such as role-playing favorite place, animal, or person can be used at the beginning of the session to increase connection and comfort with other group members.

Session 2: Identifying Feelings and Emotions

Addresses the component of processing emotions.

- Identify the feelings and explore how they are normal reactions to an abnormal situation.
- Explore experiences/situations that are frightening, exciting, upsetting, make them happy or sad etc. -- drawing exercises to express feelings (e.g., color a gingerbread character according to feelings they have, represented by different colors), and writing exercises to enhance expression of feelings.
- Role plays where children act out how they express and/or manage feelings in particular situations -- beginning the process of learning more adaptive ways to express and manage feelings.

Session 3: Building Cohesion and Trust

Addresses the ITCT-C components of self-identity development, relating to others.

- Activities---art, collages, writing, to describe who they are and their interests, likes and dislikes
- Positive statements/impressions about each other.
- Group and individual goals re-visited and revised as needed.

Session 4: Anger Management and Non-Aggressive Expression of Anger

Anger is especially crucial to explore due to the relationship to trauma and high risk of aggressive behavior (Song, Singer, and Anglin, 1998).

- What makes them angry? Collages, exercises
- Impacts on others. Consequences
- Assertive expression of feelings.
- Relaxation and guided imagery exercises
- Role plays; videos of athletes fighting----discussion of consequences, alternative behaviors

Session 5: Staying Safe (if there are immediate safety issues with group members, this session may need to be scheduled earlier in sequence)

- Building a safety plan, identifying situations of risk and danger.
- Role plays and discussion re: preventing gang-related and tension-reduction behaviors.
- Seeking help and support from others.
- Problem-solve safety strategies.

Session 6: Building Self-Esteem

- Improving self image and increasing self-capacities.
- Art therapy, role plays, physical activities, after-school program.

- Positive feedback to each other.
- “I am good at.....”
- “I can help others by.....” More severely traumatized children may have difficulty forming relationships with others and having empathy for others’ feelings. As they are able to process their traumatic experiences, feel more supported by others, and gain more positive self-identities, they are likely to be more available to others, have greater empathy for others, and be able to form stronger relationships, which then also increases their self-esteem.

Sessions 7 and 8: Specific Exploration of Trauma Events

- Trauma narratives, drawings, collages.
- “Hat game” with questions about specific experiences. This intervention has been especially effective with groups that are processing more violent or intrusive experiences, and are having difficulty with verbalizing directly these experiences.
- Letter to perpetrator or person who did not protect them.
- Connecting experiences with feelings and behaviors.
- Occasional use board games, such as the Ungame, to facilitated discussion of specific experiences and feelings.

Session 9: Cognitive Processing

- Relating cognitions to trauma experiences---cognitive restructuring/reconsideration, exploring beliefs and distortions about the trauma, the child’s reaction to it, why it happend.
- Feedback from other group members.
- Addressing feelings of self-blame, guilt, powerlessness.
- Role-plays

Session 10 and 11: Building Positive Coping Strategies and Support Systems

- Learning to combat negative thoughts, develop positive self-awareness and self-efficacy.
E.g., “I am.....” collage

- Reviewing trauma narrative in the context of strengths and skills learned
- Brainstorming an expanded repertoire of positive coping skills
- Exploring family and friend relationships

Session 12: Celebration and Making Plans for the Future

- Putting it all together-----trauma experiences and related feelings/behaviors, increasing self-esteem and self-capacities.
- Increased safety and sense of empowerment.
- Review initial goals and achievement of goals----feedback to each other.
- Goals for the future.
- Sharing of journals, music, accomplishments.
- Post-treatment assessments.
- Celebrate----pizza party.

On school-based programs

Although centers providing trauma-focused services may feel that it is too difficult and time-consuming to develop and establish school-based programs, such programs provide trauma-focused services to children who otherwise might not be receive services directed at reducing the impacts of their trauma experiences. In addition, behavior that is often considered “bad” or “acting out” in school may, in many cases, reflect the effects of trauma that have gone untreated. For these reasons, it may be important for agencies to consider ways in which interventions can be adapted for the school environment. ITCT-C was especially designed to incorporate interventions in the community at school sites. By being on-site in schools, staff can field referrals not only for school-based groups, but also for clinic-based services to children who need more extensive and intensive treatment. In addition to school-based therapy, consultations and training for teachers and counselors, school personnel can result in school staff being more optimistic about what can actually be done for their students.

Chapter 16

Supervision and Self-Care

Using ITCT-C, the therapist has an opportunity to develop an ongoing relationship with his or her clients and their family members – in many cases for many months – and experience the gratification that accompanies true change and significant healing. (See Leichsenring & Rabung [2008] for a new meta-analytic study that indicates the preferability of extended, as opposed to short-term, treatment for more complex psychological difficulties].

Despite these benefits, there can be significant challenges for the therapist who provides extended interventions to traumatized children, often in the context of relatively rigid and distressed family systems. The work, itself, involves hearing about repeated violence and cruelty directed toward the most vulnerable segment of the human population. In addition, government funding for therapeutic services to abused and neglected children is often unreliable and insufficient, leading to stressful working environments for therapists and others. Finally, therapists may have their own trauma histories, which may be activated by working with clients in this area. These issues are seemingly more likely to emerge when the clinician forms longer-term therapeutic relationships with traumatized children, probably because the sense of relational intimacy is greater, and the intensity of the trauma work is more sustained. For these reasons, it is crucial that therapists receive continuous support, validation, training, and supervision. It is also important that the entire treatment team work to create and maintain a positive working environment, one characterized by mutual support, frequent discussions, peer feedback, and collaboration.

Supervision

In many cases, clinicians working in child maltreatment are relatively new to the job, often having just recently completed their education, and frequently needing post-degree “hours” for state licensure. For these clinicians, especially, training and supervision is of great importance. Other, more experienced clinicians may not require licensure hours, but still may benefit from the support, ongoing training, and consultation that occurs in effective child trauma treatment centers. In the best contexts, beginning and experienced clinicians all provide support, feedback, and new information to one another, realizing that the complexity of the work and the

sometimes extremity of the challenges means that no one knows it all and everyone has something to offer anyone else.

It is essential that therapists undergoing supervision feel sufficient trust and safety in the supervisory relationship that they can address issues that may arise, both in terms of the quality of their interventions and in the daily functioning of the agency or organization. It is often only when trust and respect have been established in the supervisory relationship that the clinician can present his or her work in an open and non-defensive manner. This openness is essential to good clinical practice, since the clinician must be aware of any issues or responses that are being triggered in his or her work with a particular client, or that may emerge as he or she seeks to engage with a particular caretaker.

The art of effective clinical supervision in such contexts involves the ability to support and validate while, at the same time, offering feedback to the therapist about his or her errors, “blind spots,” or activated issues. The supervisor must also (a) provide the institutional support and structure necessary for effective practice in stressful environments, (b) ensure that the supervisee receives the training and information that he or she needs to work with traumatized clients, and (c) assign an appropriate workload – one that is appropriately challenging and involves a range of clients with varying trauma histories, but also that is not so large or clinically acute that the therapist is “burned out” and clinical care is compromised. Therapists should be encouraged, if not required, to stay “up to date” by reading clinically relevant books and articles, and attending training/education sessions that can enhance their skills. Whenever possible, additional training or conference attendance should be funded by the agency or organization, not the clinician.

Although peer support and collaboration is important, it generally does not replace supervision -- even for experienced and licensed therapists. On occasion, therapists may rely more on each other than on their supervisor for information or advice, sometimes because they fear revealing assumed weaknesses or gaps in their knowledge, or because they respect colleagues more than their supervisor. However, this decision may mean that the clinician receives inadequate and/or insufficient information, and, as a result, his or her clients may suffer. Clinician avoidance of supervision must be addressed directly by the supervisor. This should involve one or more sessions where the clinician has the opportunity to discuss his or her issues, concerns, and, perhaps, authority issues in the context of supervisor support and nonjudgment. It

should also represent an opportunity for the supervisor to consider possible aspects of the supervisory environment that may discourage help-seeking by the supervisee, including systemic power dynamics within the agency, and the possibility that the supervisor is insufficiently engaged or supportive of staff.

In order for supervision to be optimally effective, it is crucial that the supervisor-supervisee relationship (like the therapist-client relationship) is based on trust and safety. The supervisor (in the absence of observing all therapy sessions, which typically is not possible) must base their supervision input, information, and support on what the supervisee has told them. Similarly, even the most astute and knowledgeable therapists can overlook important aspects of the client's presentation, the therapist-client relationship, and their own countertransferential reactions, and thus can benefit from the advice and feedback of a clinician whose job involves dealing with such issues.

Training

Information on child trauma and its treatment has burgeoned, even just within the last decade. More than in some other areas in mental health, ongoing research and new clinical approaches to child maltreatment require that the clinician devote considerable time to updating his or her knowledge of advances in the field. Further, interventions such as ITCT require competence in a variety of different approaches, since complex trauma often requires a variety of different intervention components.

There are a variety of sources of information on ITCT-C and ITCT-A, as well as the literature upon which it is based. The reader is referred to the Appendix for the most core of these sources. ITCT-C trainings and follow-up consultations are also available at conferences throughout the U.S. As well, web-casts and educational materials on complex trauma and ITCT are available at the website for the National Child Traumatic Stress Network, www.nctsnet.org. The NCTSN-sponsored speaker series, Complex Trauma Speaker Series, includes webcast presentations and associated materials on

- The bio-neurological basis of complex trauma (Bessel Van der Kolk, M.D.)
- Assessment of complex trauma (John Briere, Ph.D.)
- Conceptualization and treatment planning for complex trauma (Joseph Spinazzola, Ph.D.)
- ITCT-C for school-aged children—principle components (Cheryl Lanktree, Ph.D.)

- The ARC intervention model for complex trauma (Kristine Kinniburgh, M.S.)
- The SPARCs group treatment model for adolescents with complex trauma (Mandy Habib, Psy.D.), and
- The Real Heroes intervention model for complex trauma (Richard Kagan, Ph.D.).

It is likely that another speaker series on topics related to complex trauma will be available through the NCTSN website during the coming year.

Team-building and support

Ongoing team/staff meetings are essential to the creation of a positive working environment for those who treat child trauma. These events should be scheduled on a weekly basis, and should include training or guest presentations, celebrations of life events (birthdays, marriages, births, departures), and the sharing of food (ideally paid for by the agency). The goal of these meetings is thus not only to facilitate the ongoing functioning of the agency, but also to engender and sustain collegiality and positive morale. It is also important that members of the team have an opportunity to support each other through traumatic experiences, such as deaths and losses, while also maintaining vision and working together toward common goals. Open discussion of and respect for each other's perspective, regardless of experience, also helps to build a sense of trust and collaboration among team members. Challenging each other and mentoring the less experienced is also ideally part of the support system that should be built in.

Self-care

Because work with child trauma victims is so evocative, and draws so deeply on the internal resources of the therapist, it is important that those working in this area especially attend to their own positive functioning. Although there is an element of sacrifice entailed in listening to hurt children for a living, it is not healthy -- nor, ultimately, good for clients -- for the therapist to sacrifice his or her well-being to his or her occupation.

This chapter ends with some suggestions for how those working with child trauma victims can take care of themselves, both emotionally and physically. Although some activities involve separating oneself from the accumulating tension of the therapeutic day, others reinforce the notion that being a therapist, under the right conditions, is a good thing. It is an occupation that can promote joy, meaning, and the opportunity to witness wonderful things -- a child's laughter, the beginnings of a suddenly improved future, and the capacity of even the most

maltreated to heal. As someone working with abused children once said to one of the authors of this guide (CL): “I love going to work. I love working with the people I work with. It makes me happy. I’m having fun”.

The following are some of the ways that therapists can take care of themselves as they work with traumatized children:

At work:

- Maintain a mixed caseload, involving children and adolescents with varied trauma histories and varying levels of psychological functioning; try to include a few clients who have not been severely traumatized.
- Try working in various settings, e.g., clinics, schools, hospitals
- Seek supervision, consultation, and collaboration with other therapists, even if you are experienced
- Take breaks during the day -- including walks, debriefing sessions with colleagues, coffee or lunch with friends and colleagues, or a brief meditation/relaxation session. Don’t work nonstop through the day.
- Continue your education and training -- attend workshops and conferences in your community, as well as national-level conferences and meetings
- Provide outreach, consultation, training to others
- Develop and expand your working relationships with other professionals in the community

Outside of work:

- Maintain a balance of work and play -- avoid over-extending yourself
- Intentionally pursue fun things – see it as recharging that part of yourself depleted by the work you do
- Consider social or political action: helping with the “big picture” may be a partial antidote to the “small picture” of a child’s tragic experience.
- See if you can further develop your sense of humor
- Take vacations, travel to other countries, experience other cultures and people
- Intentionally take time to connect with friends and family

- Engage in regular physical exercise
- Spend time with children and pets (your own and/or those of friends and family)
- Develop and sustain other interests and hobbies -- gardening, photography, cooking, yoga, dance, music, art, reading non-work related books, movies, theatre

Personally:

- Consider psychotherapy for your own issues, or as a way to maximize your growth
- Consider meditating, or engaging in some other contemplative activity
- Expand your spirituality: including retreats, reading, and engaging with spiritual communities
- Consider writing a journal
- Consider writing professionally. A treatment guide, for example, might be great!

Appendix

The following pages contain forms and information the therapist will need when providing ITCT-C, as well as handouts to distribute the child client.

MCAVIC-USC CLIENT ASSESSMENT MATRIX

Measures to be administered at the beginning of treatment, at three month intervals, and at the end of treatment.

	Age Ranges	8	9	10	11	12
Requirement for NCTSN	TSCC – A	*	*	*	*	*
	UCLA-TRI (E/S)	*	*	*	*	*
	CBCL (E/S)	*	*	*	*	*
Other Measures as Needed	TSCC	*	*	*	*	*
	TSCYC (E/S)	*	*	*	*	*
	CSBI (if applies)	*	*	*	*	*
	CDI	*	*	*	*	*
	TRF	*	*	*	*	*
	YSR (E/S)				*	*
	ASCQ	*	*	*	*	*

*Blue = Clinic client Green = Caregiver Purple = School client Orange = Teacher
(English version/Spanish version)*

ASCQ: Attachment Style Classification Questionnaire
TSCYC: Trauma Symptom Checklist for Young Children
CBCL: Child Behavior Checklist
TSCC-A: Trauma Symptom Checklist for Children A version
CDI: Children’s Depression Inventory
UCLA TRI: UCLA Trauma Reaction Index
CSBI: Child Sexual Behavior Inventory
YSR: Youth Self Report-CBCL
TSCC: Trauma Symptom Checklist for Children
TRF: Teacher Report Form-CBCL

Assessment–Treatment Flowchart: Child version (ATF-C)

Client name _____

Priority ranking (circle one for each symptom):

- 1 = Not currently a problem (re-evaluate at each interval): Do not treat
- 2 = Problematic, but not an immediate treatment priority: Treat at lower intensity
- 3 = Problematic, a current treatment priority: Treat at higher intensity
- 4 = Most problematic, requires immediate attention
- (S) = Suspected, requires further investigation

	<u>Intake</u>			
<u>Date:</u>	_____	_____	_____	_____
<u>Problem area</u>	Tx priority	Tx priority	Tx priority	Tx priority
1. Caretaker support issues	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
2. Safety – environmental	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
3. Safety – risky behaviors	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
4. Anxiety	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
5. Depression	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
6. Anger/aggression	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
7. Low self-esteem	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
8. Posttraumatic stress	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
9. Affect regulation/acting out	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
10. Attachment insecurity	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
11. Dissociation	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
12. School adjustment	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
13. Suicidality	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
14. Grief	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
15. Somatization	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
16. Identity	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
17. Social skills	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
18 . Difficulty engaging in tx	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
19. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

PROBLEMS TO COMPONENTS GRID

<u>Problem (from ATF)</u>	<u>Treatment components that may be useful</u>
Caretaker support	Collateral sessions, family therapy, parent training/therapy, parent psychoeducation, caretaker group
Safety (environmental/social)	Play and expressive/art therapy, safety training, system interventions, psychoeducation
Risky behaviors	Psychoeducation (including sex education), safety training, cognitive processing, emotional processing, trigger identification, harm reduction
Anxiety and hyperarousal	Play and expressive/art therapy, grounding, relaxation/breath training, emotional processing, psychoeducation, cognitive processing, relational processing, medication
Depression	Play and expressive/art therapy, cognitive processing, psychoeducation, relational processing, medication
Anger	Play and expressive/art therapy, grounding, breath training, trigger identification, anger management, cognitive processing, relational processing, mindfulness training
Low self-esteem	Play and expressive/art therapy, cognitive processing, relational processing, group therapy, group therapy, self-exploration, support
Posttraumatic reexperiencing	Play and expressive/art therapy, grounding, emotional processing, cognitive processing, psychoeducation, mindfulness training, support, medication
Affect dysregulation and acting-out behavior	Play and expressive/art therapy, tension reduction, grounding, breath training, trigger identification, emotion identification, safety training, psychoeducation tension, behavioral charts, reduction behaviors “What I can do”), mindfulness exercises
Attachment insecurity	Play and expressive/art therapy, relational processing, relationship building, group therapy, family therapy
Dissociation	Play and expressive/art therapy, grounding, relaxation/breath training, emotion identification, emotional processing, trigger identification, relational processing
School adjustment	Emotional processing, affect regulation training, advocacy/consultation with school personnel, trigger identification

Suicidality	Safety training, grounding, cognitive processing, psychoeducation (“what can I do”), systems intervention
Grief	Play and expressive/art therapy, psychoeducation, cognitive processing, emotional processing, support, family therapy, mindfulness training
Somatization (trauma related)	Emotional processing, cognitive processing
Identity issues	Play and expressive/art therapy, relational processing, self-exploration, group therapy
Social skill deficits	Play and expressive/art therapy, psychoeducation, group therapy
Difficulty engaging in tx	Play and expressive/art therapy, relationship building

Materials for Non-Offending Caretakers Group
(Hodges, 2007)

Part One

Effects of child sexual abuse by family member
Symptoms, Feelings, Behaviors

- I. Child sexual abuse within the family is a negative experience for many reasons
 - A. Occurs within an important relationship
 - B. Child can't effectively say "no"
(Power, parental authority, child dependent on adults,
adult vs. child, parent vs. child, male vs. female)
 - C. Inappropriate for age
 - D. Painful, frightening, upsetting, confusing
 - E. Changes the relationship with perpetrator, especially in cases of incest
 - F. Loss of trust, safety
 - G. Impacts development

- II. How kids react depends on several things
 - A. Gender
 - B. Age/Development
Language
Cognitive development
Identity-experiences, role models, comparing self to peers,
 - C. Security of attachment to caregiver(s)
 - D. How important people in child's life respond to the abuse
 - E. Intrusiveness, severity of the abuse, aggressiveness
 - F. Duration of abuse

- III. Some effects of incest
Attachment, Biology, Emotion regulation, Dissociation, Behavioral Control, Cognition, Self-Concept
Cognitive distortions, emotional pain, avoidance, impaired sense of self, interpersonal difficulties, posttraumatic stress
 - A. Short term Effects
 1. External/Observable behaviors
Nervousness, jumpiness, changes in arousal
Difficulty managing emotions, trouble naming feelings experienced
Difficulty expressing needs
Physical complaints (stomach trouble, headaches)
Memory problems
Concentration problems
Excessive compliance
Defiance
Aggressive behavior
Sleep problems
Running away
Substance use
Binging/purging (Bulimia)
Age Inappropriate sexual behaviors
Upset at mention of sexual topics and other reminders of the abuse
Problems at school (grades, peer interactions, etc.)
Self injurious behaviors

Toileting disturbances
Withdrawal

2. Internal effects
 - a. Wrong thinking...trying to make sense out of what happened...
 - Self Blame*: This is my fault...I must be bad and deserve to be punished
 - Lowered self esteem*: I can't do anything well, I can't protect myself, I am helpless
 - Feelings of worthlessness* : I am worthless and do not deserve good treatment, no one values me
 - Avoidance of thinking* : too upsetting, overwhelming
 - Delays resolving the experience, "getting over it"
 - b. Emotional pain...impaired psychological functioning, negative thinking, losses
 - Guilt*- It's my fault
 - Shame*- Something is wrong with me, everyone knows what happened, I am different from others, I am damaged,
 - Fear, anxiety*- Decreased sense of personal safety and ability to trust, expectations that people are dangerous
 - Fear that will others will leave, fear of being abandoned
 - Hopelessness*- Suicidal thinking, planning, behavior
 - Anger*
 - c. Self problems
 - Body image problems
 - Lowered self worth
 - Social problems
 - Poor sense of separateness from others
 - Inappropriate help seeking
 - Difficulty managing strong emotions
- B. Long term
 - Depression
 - Anxiety,
 - Increased susceptibility to stress
 - Inability to regulate emotions
 - PTSD/Complex PTSD
 - Sleep disturbances
 - Addiction (substances, behaviors)
 - Eating Disorders
 - Physical symptoms (ex. chronic pelvic pain, migraines)
 - Suicidal behaviors
 - Interpersonal problems
 - Problems with intimacy, trust, self esteem
 - Sexual problems
 - Decreased awareness of risks to self

Part Two

Developing Our Personal Narrative

(Farrell, 2007)

Chapter One:

“What my life, my family’s life, was like before I found out about the sexual abuse...”

Chapter Two:

“How I felt toward the offender, myself, my child, when I found out about the abuse...”

“The worst moment was...”

“Something I never thought I would tell anyone is...”

“Other memories, thoughts, feelings I’ve experienced are...”

Chapter Three:

“How I am different now...”

“Advice I would give to other mothers who have the experienced sexual abuse of their child...”

“How I have grown...”

“What I want for my family...”

Whenever possible, describe in detail how your body felt, what your mind was doing, how you were feeling

Which memories keep coming back to you?

Being aware of your anxiety:

1.....2.....3.....4.....5
 Not upset Most upset ever

****We try to go at just the right pace in encouraging you to tell your story so that it never hurts more than you can handle. You can let us know at any point if we are going too fast for you, and we will slow down.****

Part 3**GRIEF LOSS & MOURNING OUR LOSSES**

(Farrell, 2007)

The Stages of Grief:

- **D**enial (this isn't *happening* to me!)
- **A**nger (why is this happening to *me*?)
- **B**argaining (I promise I'll be a better person *if...*)
- **D**epression (I don't *care* anymore)
- **A**cceptance (*I'm ready* for whatever comes)

The Grief Guide

- **N**umbness (mechanical functioning and social insulation)
- **D**isorganization (intensely painful feelings of loss)
- **R**eorganization (re-entry into a more 'normal' social life.)

The Tasks of Mourning

1. Accept the Reality of the Loss
2. Work through to the Pain of Grief
3. Adjust to an Environment in which what is Lost is Missing
4. Emotionally “Relocate” and Move on with Life.

What Have I Lost?

- 1.
- 2.
- 3.
- 4.
- 5.

Where am I at in the Stages of Grief? (Where have I been?)

How can I Mourn my losses?

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