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Supporting resilience in chldren and youth impacted by complex trauma

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ABSTRACT

Exposure to repeated traumatic events, including abuse, neglect, and domestic and community violence is often referred to as complex trauma. This research was conducted to better understand the developmental impact of complex trauma on children and adolescents, and to consider what treatment approach might best serve this population. The author first examined the impact of repeated victimization on child neurobiological development, with particular attention to the areas of attachment, affect regulation, behavioral control, cognition, and self-esteem. Complex trauma treatments that are more individually focused and grounded in cognitive-behavioral theory were then compared to those that are more systems-focused and stem from attachment and intersubjective theories.

This author found that most of the literature agrees on the following core components of treatment for youth with complex trauma histories: safety, self-regulation, self-reflective information processing, traumatic experiences integration, and relational engagement. An area that seems to be getting increasing attention is treatment directed at fostering strengths and building competencies. The author concluded that including a caregiver in as much of the treatment as possible can support attachment and lead to longer-term positive gains. The author found that both approaches offer potentially effective interventions, and combining components from both can result in a more comprehensive treatment approach. This study includes a case example and a

discussion of implications for clinical social work practice with a focus on cultural considerations as well as recommendations for further research.

SUPPORTING RESILIENCE IN CHILDREN AND ADOLESCENTS IMPACTED BY COMPLEX TRAUMA

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I

Introduction

The National Child Traumatic Stress Network (2013) defines complex trauma as "exposure to multiple traumatic events of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure." These events are severe and pervasive and include physical, emotional, and/or sexual abuse, witnessing domestic and community violence, separation from family members, and re-victimization by others. Recent research on the impacts of complex trauma, particularly its effect on development and attachment, has been monumental in helping clinicians understand the needs of children and youth who have past or current exposure to recurrent trauma in their families and/or communities. This body of research includes studies demonstrating that well over half (66%) of youth in the United States report at least one traumatic event by age 16 (Copeland, Keeler, Angold, & Costello, 2007), and many of these youth are exposed to multiple traumatic events (Finkelhor, Ormrod, & Turner, 2007). Further illustrating childhood trauma impacts, a study by Jaycox et al. (2002) found that 49 percent of students in an urban pubic school sample (n= 61) reported more than one violent victimization, and thirty-two percent had clinical levels of PTSD symptoms.

The DSM-V (2013) outlines a number of distressing symptoms that children and youth with PTSD can experience that include categories of extreme avoidance, intrusions, negative alterations in cognition and mood, and alterations in arousal and

reactivity (American Psychiatric Association, 2013). Left untreated, these conditions make it very difficult for children to function and can lead to poor academic performance, disciplinary issues, including high rates of suspensions and expulsions, and chronic truancy (Adelman & Taylor, 2010). Research by the Substance Abuse and Mental Health Services Administration (2009) on the developmental impact of complex trauma highlights the importance of early identification and access to mental health resources in order to provide the social and emotional foundation necessary for subsequent developmental success**.** The Adverse Childhood Experience Study was a study of over 17,000 individuals aimed at examining correlations between experiences of childhood trauma and the development of serious physical and mental health conditions (Felitti & Anda, 1997). Initially conducted in the U.S. from 1995-1997, this study showed that young people who have experienced complex trauma are more likely to develop emotional, behavioral, cognitive, and relationship difficulties. Similar studies are currently being conducted internationally. As reported by Hussey, Chang, and Kotch (2006) studies of abused children who did not receive mental health treatment show increased academic and other school problems, including a dropout risk two-and-a-half times higher than for their non-abused peers. Moreover, studies have demonstrated the association of childhood trauma exposure in the development and progression of drug use and dependence in adolescence and early adulthood (Anda et al., 2006).

The extensive research on the pernicious effects of complex trauma has resulted in numerous approaches to treating children and youth presenting with these symptoms. The purpose of this study is to help inform clinicians' decisions about the appropriate intervention when working with this highly vulnerable population from a theoretical

perspective. This study is designed to answer the overarching research questions: What is the most effective approach to the treatment of children and adolescents impacted by complex trauma? As such, the study will examine clinical approaches that fall within two theoretical perspectives underlying childhood trauma treatment, namely individual-focused treatment and systems-focused treatment. These two theoretical perspectives are selected because they represent the two key clinical approaches utilized in treatment. The individual-focused treatments I will review stem from cognitive theory, while the systemic-focused treatments take root in attachment theory. Further, these theoretical frameworks were selected because evidence supports the effectiveness of treatment models from both, but little is discussed about why one may be more appropriate than another given a specific case. I will examine the pros and cons of both therapeutic approaches, and discuss important clinical considerations when choosing one over the other. I will also examine cultural differences reflected by the literature and areas in need of further study. This study will build on previous studies by examining how therapeutic models from these two theoretical camps differ in how they address the individual's system. After reviewing current literature on treatment models and their corresponding theoretical frameworks, I will include a discussion of developmental and systematic considerations relevant to complex trauma that can assist clinicians in determining how to approach a particular case.

CHAPTER II

Complex Trauma

As the aforementioned studies show, it is imperative that children and adolescents impacted by complex trauma receive early and ongoing intervention. A number of such interventions exist, but not all incorporate the same elements. Some are more individually focused, while others place more emphasis on including members of the child's system. Within both of these categories, models vary in their specific components, length of treatment, therapeutic relationship, and bio/psycho/social/developmental considerations. Many of these models are relatively new and still gathering an evidence base, and it can be hard for clinicians to choose among them. The overall goal of this theoretical study is to build upon previous studies, such as Eric Eichler's *Talking Through the Body: A Comparative Study of Cognitive-Behavioral and Attachment-Based Treatments for Childhood Trauma*, by further illuminating the phenomenon of complex trauma and ways to promote resilience in affected children and adolescents. Eichler (2012) notes the need for further analysis of the many emerging forms of treatment. While this study is limited in that it is theoretical, and therefore does not add to the empirical research, it will add to the existing literature by conducting an in-depth examination of several individually and systemically focused treatments. To do this, this chapter will first trace the history and development of our current definition of complex trauma. I will then explore the associated domains of impairment, including recent neurobiological research on the

effects on complex trauma on the developing brain. After this I will discuss treatment considerations, highlighting theoretical considerations, clinical controversies and points of agreement, and the ways various cultures and populations respond to treatment. I will end this chapter with a discussion of my chosen approach. Subsequent chapters will draw upon the information in this chapter to examine specific treatment models.

The Definition and Prevalence of Complex Trauma

Freud's Seduction Theory is understood to be an early incarnation of what we now classify as stress response syndromes in the Diagnostic and Statistical Manuel of Mental Disorders (Wilson, 1994). Seduction Theory, the original model of neurosis, emphasized the role of external stressors and traumatic events in psychopathology. In 1897, Freud began to include intrapsychic fantasy as the focus of analytic treatment for traumatic neurosis; however, in his early 20th century lectures he continued to uphold the relevance of external stressors and it could be argues that he set the foundation for our current stress response diagnostic categories. These categories were not officially codified until the early 1970's, when Vietnam War veterans consistently began returning to the U.S. with seemingly bizarre symptoms such as flashbacks. Prior to this, such symptoms were disregarded or attributed to the earlier paradigm of traumatic neurosis. Realizing just how great an impact such symptoms were having on functioning, the healthcare system began to study and formulate ideas abut what soldiers were experiencing once removed from combat (Andreasen, 2010). In 1980 Posttraumatic Stress Disorder (PTSD) became a formal diagnosis that helped to explain symptoms including avoidance, intrusions, and hypervigilance.

This early research and the diagnostic construct of PTSD both have some clear limitations. For one thing, the diagnosis of PTSD was normed and studied primarily among white men. Also, early studies of PTSD were limited to survivors exposed to a situational trauma who were treated once they were fully removed from traumatic situations. Contrarily, the majority of trauma exposure in the U.S. is ongoing and includes various co-occurring types, which we now refer to as complex trauma (Pynoos et al., 2009). In addition, the majority of those affected by complex trauma are also those affected by chronic poverty and oppression, and in the U.S. this is predominantly people of color (Lanktree et al., 2012). Finally, because this early research is on adults, it fails to account for the important considerations that are important to consider when assessing and diagnosing children and adolescents.

The prevalence of complex trauma is difficult to obtain because a majority of incidents are unreported (Finkelhor, Ormrod, & Turner, 2007). In a study involving a national representative sample, Hazen, Connelly, Roesch, Hough, and Landsverk (2009) concluded that one in eight youth ages 12-17 have endured some form of ongoing maltreatment. A study by Silverman et al. (2008) found that of the youths exposed to trauma, the estimated prevalence of sexual abuse is as high as 40% among females and 13% among males. Findings also indicated that as many as 85% were exposed to community violence, with 66% direct victims of this violence. Findings from another nationally representative sample of 1,467 youth conducted by Finkelhor, Ormrod, and Turner (2010) indicate that 86% of youth who had experienced any type of sexual victimization and 77% of youth who experienced physical abuse by a caregiver had also undergone four or more types of victimization during the past year. Such trauma is

particularly pervasive in the child welfare system. In 2009 The Illinois Department of Children and Family Services conducted a study of 8,131 children and youth in state custody and found that while nearly all (97%) had experienced at least one traumatic event, the majority were found to have had five or more, including at least two types of trauma (Griffin, Martinovich, Gawron, & Lyons, 2009).

Not surprisingly, research indicates that individuals who have experienced continuous trauma throughout their development are much more likely to endure prolonged psychological distress when compared to individuals who experience a single incident of trauma (van der Kolk, 2005). Briere and Spinazzola (2005) discuss how the effects of psychological distress are more easily contained among individuals who experience single-incident trauma. They add, though, that when an individual is exposed to one traumatic event, the corresponding psychological distress can impede their ability to protect themselves from further exposure. van der Kolk (2005) documents significant distinctions in psychological impact when comparing an adolescent who has experienced a car accident to an adolescent who has experienced long-term trauma such as physical abuse, sexual abuse, emotional abuse, and neglect by caregivers. Such ongoing interpersonal trauma tends to be correlated with persistent psychological disturbance, whereas single incident trauma symptoms are usually more contained (van der Kolk, 2005).

Despite what is known about the difference between single incident trauma and complex trauma, much of the current research on trauma has continued to focus on the sole diagnostic construct of Posttraumatic Stress Disorder (PTSD). This is problematic because as van der Kolk (2005) points out, the domains of complex trauma-related

impairment are so significant that PTSD cannot fully account for all of them. Children and youth therefore often carry additional diagnoses such as Oppositional Defiant Disorder, Conduct Disorder, Major Depression, Bipolar Disorder, Anxiety Disorder, Borderline Personality Disorder, and Dysthymia in an attempt to account for psychological symptoms that are not incorporated in the traditional PTSD diagnostic construct (Luxenberg, Spinazzola, & van der Kolk, 2001). Each diagnosis represents just a small piece of the psychological impairment caused by exposure to the continuous and prolonged experience of trauma.

van der Kolk has led the movement to create a diagnostic construct that gives justice to the multifaceted domains of impairment experienced by survivors of complex trauma. In his extensive work studying the implications of complex trauma, he introduced the diagnostic construct of DESNOS: Disorders of Extreme Stress Not Otherwise Specified. van der Kolk (2005) and Ford (2005) emphasize that the biological development of children and adolescents is a significant factor impacting how trauma is experienced and expressed. Cook et al. (2005) categorize the psychological distresses experienced by these children and youth into the following domains: attachment, biology, affect regulation, disassociation, behavioral control, cognition and self-concept. A recent study by D'Andrea, Ford, Stolback, Spinazzola, and van der Kolk (2012) attempted to examine another potential diagnostic construct introduced by van der Kolk, Developmental Trauma Disorder (DTD). This construct aims to help distinguish children with histories of complex trauma from other trauma-exposed children by accounting for chronicity of exposure and the caretaking environment. The study included a sample of urban children in the United States (N=214) from age 3-17 who received services at a

child treatment center after experiencing one or more of the Criterion A stressors outlined by the diagnosis of PTSD. The sample was relatively homogenous with regards to race as nearly 80% of the participants were African American. The results showed that children who had experienced complex trauma were much more likely to meet the proposed DTD criteria than those with a history of only one traumatic event. Klasen, Gehrke, Metzner, Blotevogel, and Okello (2013) conducted a similar study using a sample of former Ugandan child soldiers, all of who had experienced severe ongoing trauma. They found that 78.2% met criteria for DTD while only 33% met criteria for PTSD. Most strikingly, only 1% of this sample met criteria for PTSD alone, which is further evidence of the limitations of this diagnosis.

Although van der Kolk and others set the stage for a revised and formalized understanding of complex trauma, the DSM-V (2013) still does not include a diagnosis specific to complex trauma. The new version has, however, expanded the criteria for PTSD and reclassified it under a new category called "Trauma and Stressor-Related Disorders." The three major symptom clusters in the pervious DSM has been expanded to the following four:

- Re-experiencing the event—For example, spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.
- Heightened arousal—For example, aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-□vigilance or related problems.
- Avoidance—For example, distressing memories, thoughts, feelings or external reminders of the event.

- Negative thoughts and mood or feelings—For example, feelings may vary from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

Also, the DSM-V includes two new PTSD subtypes. The first is called *PTSD Preschool Subtype*, which is used to diagnose PTSD in children younger than 6 years. The second new subtype is *PTSD Dissociative Subtype* to describe those who experience significant dissociative symptoms. Perhaps the change most aligned with the research on complex trauma is that diagnostic thresholds for PTSD have been lowered for children and adolescents, which makes the diagnosis more developmentally attuned given that children tend to be impaired by fewer symptoms than older individuals.

Domains of Impairment

Attachment. As we know both from observation and now from MRI scans, infancy and toddlerhood are critical periods of brain development. Babies' brains grow and develop as they interact with their environment. As evidenced by the early research on attachment by John Bowlby (1973) and Mary Ainsworth (1978), when babies cry and their physical and emotional needs are subsequently met, they internalize the message that *people will take care of me,* and are able to form secure attachments with their caregivers. As this research has advanced from observation to include brain imaging, we now understand that this pattern actually leads to structural changes in the brain, the strengthening of neuronal pathways that link call and response (Lieberman, 2005). If, on the other hand, these cries are ignored or responded to with abuse, these negative conditions lead to a pruning of the neural connections. These babies then begin to stop

trusting that others will meet their needs, which may impede their ability to respond to nurturing and kindness even if it becomes available (Belsky & de Haan, 2011). Recently, researchers have also drawn attention to a process called epigenetics, wherein not only the neural pathways but also the genes that control bodily systems associated with self-regulation, cognition, and interpersonal connection may be altered by repeated incidents of trauma (Skelton, Ressler, Norrholm, Jovanovic, & Bradley-Davino, 2011). Moreover, research on children who have suffered early emotional or physical abuse or neglect shows that this may begin to inhibit the brain's ability to use serotonin, the chemical that promotes feelings of well-being and emotional stability (Healy, 2004). Of course, all of this can have a lasting effect on the ways an individual understands and interacts with his or her environment.

It is not problematic for babies and young children to experience occasional periods of moderate stress; in fact, this is necessary to help them develop the ability to regulate stress independently, which is imperative for survival (Hesse & Main, 2006). This stress become detrimental, however, when it is prolonged and unpredictable, such as in cases of abuse and neglect. Hesse and Main (2006) explain how this becomes particularly damaging if the source of the stress is the caretaker, the one who is looked to as a safe haven and a secure base. When threatened, children are biologically programmed to seek the caregiver for safety and comfort, but if the caretaker is a source of threat, or unable to provide protection, the child is placed in an unresolvable situation. This leads to the development of what Ainsworth (1978) called insecure attachment. She initially identified two types of insecure attachment: anxious-avoidant and anxious-ambivalent. Main and Solomon (1986) later added a third type, disorganized attachment, which is

considered the most problematic because it is associated with the greatest number of developmental problems, as well as symptoms such as dissociation, depression, anxiety, and behavioral dysregulation (Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006). Morton and Browne (1998) reviewed 13 studies and found that overall 76% of children who were abused and/or neglected by their caregiver were insecurely attached, while only 34% of controls fell into this category.

Behavior and Cognition. With all three types of insecure attachment, the brain begins to focus its energy on survival in the face of danger, and these areas of the brain begin to dominate other functions, such as those associated with complex and abstract cognition (Kolassa & Elbert, 2007). This is particularly true during early childhood and adolescents because both are formative periods of brain development. Just before puberty, adolescent brains undergo a growth spurt in the frontal lobe, the part of the brain in charge of planning, impulse control, and planning. Neurobiological research demonstrates that adolescence marks a developmental phase during which individuals move from basic levels of cognitive processing to more complex and sophisticated processing**.** As discussed by Kolassa and Elbert (2007), normative development during adolescence leads to a more thorough integration of thoughts, emotions, and past experience for the purpose of controlling behavior and regulating affect. Adolescents begin to move away from immediate emotional reactions to more calculated decisions about their behavior. In a similar discussion, Schore and Schore (2008) add that such changes are not linear, however, and often lead to a certain level of confusion and frustration characteristic of an adolescent's life.

Exposure to complex trauma greatly impacts the neurobiological systems associated with normative development. According to Lyons and Lopez (2000), chronic exposure to intense stress has a detrimental effect on prefrontal functioning, the part of the brain responsible for executive functioning. When danger is detected, the subcortical regions of the brain fire signals that incite immediate emergency response, thereby decreasing activity and blood flow in the frontal cortex, which is more discerning and would slow down these impulsive reactions. If the frontal region is repeatedly turned off in the face of ongoing threats, the limbic system becomes the default response system and illogical cognitive patterns develop that can then lead to irrational behavior.

Complex trauma can also result in physical and functional changes in the amygdala, the part of the limbic system responsible for processing sensory material, regulating anxiety, releasing stress hormones, activating galvanic skin responses, elevating blood pressure, lowering pain sensitization, and modulating hippocampal function (Lyons & Lopez, 2000). The amygdala identifies the intensity of an emotional experience and then initiates a comparable action response. Kolassa and Elbert (2007) discuss how chronic traumatic stress has been shown to increase the size of the amygdala when compared to individuals not exposed to such stress. The enlarged volume of the amygdala suggests that individuals perceive a greater percentage of external stimuli as threatening and dangerous. For example, an individual may interpret a crowded room or a random person on a bus as threatening despite no evidence to support this. In such situations, the amygdala dominates the functioning of the prefrontal region responsible for decision-making. When this happens again and again over time, individuals become perpetually caught in a state of fight, flight, or freeze.

The cognitive and behavioral changes that can result from the neurobiological impact of exposure to complex trauma has been termed alexithymia, the inability to recognize, react to, and regulate emotion by giving it meaning (van der Kolk, 2005). Alexithymia occurs when the body converts overwhelming emotional experiences into muscle activation. Individuals with this condition therefore experience somatic symptoms, such as headaches and stomachaches, rather than the emotions associated with trauma. Research by Perry (2002) indicates that the specific effects of this maltreatment and the extent of damage hinge on the following: the age of onset, the relationship to the abuser (i.e. parent or other adult), the presence or lack of a dependable and nurturing individual in the child's life, the type and severity of the abuse, the intervention (both the type and when it occurs), and how long the maltreatment lasts**.**

Crozier and Barth (2005) trace specific types of maltreatment to a common deficiency in cognitive development. Hypothesizing that cumulative trauma of any type predicts poor overall cognitive performance, they drew upon research done comparing survivors of neglect to survivors of physical and/or sexual abuse. In the case of neglect, caregivers have inadequately met their physical and emotional needs and they have therefore been under-stimulated and/or malnourished, both of which have been shown to result in cognitive delays. Likewise, research shows that psychological trauma associated with physical and/or sexual abuse often impairs normative cognitive development. A study by Carrion, Garrett, Menon, Weems, and Reiss (2008) examined fMRI scans of youth exposed to complex trauma for neurological alterations affecting attention and other cognitive functioning. (It is worth noting that none of the youth in their sample met criteria for PTSD but did meet criteria for numerous other psychological diagnoses,

which supports the need for a revised diagnostic understanding of complex trauma.) As they hypothesized based on the manifest symptoms, Carrion et al. (2008) found increased maladaptive neurological functioning as the result of chronic stress exposure. When compared to a control group, the youth in their sample consistently displayed decreases in attention and frontal cortex functioning, both of which are likely connected to their problematic behavioral and cognitive performance. Following this study, Webster et al. (2009) used neuropsycholocial testing to compare youth exposed to complex trauma to a control group. They administered the Woodcock-Johnson Test of Cognitive Ability, Third Edition (WJ-III) to both groups and found that the trauma-exposed youth scored much lower in the following areas: cognitive efficiency, cognitive fluency, broad attention, and working memory. Like Carrion et al.'s study, Webster et al. (2009) point to the connection between chronic psychological distress and cognitive delays.

It is important for clinicians to be aware of the results of such studies and to consider the potential cognitive impact of complex trauma when approaching treatment. Evidence from this research suggests that treatment models that primarily focus on cognitive processes may fall short when it comes to working with these children and youth. This evidence also points to the importance of providing psychoeducation about the possible cognitive effects of complex trauma to the adults involved in the lives of these children and youth so that they are do not risk such pejorative labels as rebellious, crazy, slow, or lazy.

Affect regulation, a cognitive process of monitoring, evaluating, and modifying internal emotional states in order to effectively and successfully interact with the external environment (Ford, 2005), directly influences the way in which one interacts with his or

her environment. Hovanitz, Hursh, and Hudepohl (2011) describe the process of affect regulation as the ability to reflect on one's mood, referred to as meta-cognition, in order to identify and manage emotions. A number of psychological disorders associated with experiences of complex trauma impede an individual's ability to regulate his or her affect (Ford, 2005). Individuals who are unable to regulate and control their emotional state can be easily become overwhelmed and dysregulated. Dysregulated individuals often use behaviors such as substance abuse and self-harm in order to fend off the discomfort of internal chaos. Briere and Spinazzola (2005) discuss how victims of interpersonal trauma in childhood are prone to severe avoidance states such as disassociation, substance abuse, and other tension-reduction activities such as cutting.

Thus far I have explored research pointing to the ways disruptions in neurobiological development influence behavior and cognition, including affect regulation. Not all researchers, however, point to the neurobiological deficits as the source of impairment, but rather to a lack of modeled behavior. Walsh et al. (2007) views affect-regulation as a learned behavior, and attribute deficits in this area to unhealthy environments in which children do not learn how to appropriately express emotion or experience positive validation for early expressions of affect. Specifically, they contend that maltreated children are never taught how to identify, differentiate, and label emotions. They also suggest that it is possible that children who do not have enough environmental safety to express emotional states may internalize their fear of invalidation, rejection, and abuse and then experience these feelings as authentic emotional expression (Walsh et al., 2007). For example, a child who was physically reprimanded for crying may have never developed the ability to express her emotions in a developmentally appropriate way, and

may subsequently internalize a fear of expressing any emotion.

Self-esteem. Self-esteem, or one's sense of self worth, relates to the way one either accepts or rejects his or her existence. Not surprisingly, especially in light of all of the impairments discussed above, research supports that childhood maltreatment, especially interpersonal victimization, often leads to profoundly low self-esteem (Amstadter et al., 2011). Amstadter et al. (2011) assert that this diminished self-esteem and the process of internalizing abusive events contribute to an elevated risk for future victimization. This makes sense given that one's self perception has a strong influence on his or her thoughts, decisions, behaviors, and relationships (Reynolds et al., 2010). For example, an adolescent who has a negative view about him or herself may be more likely to act without considering longer-term impacts, thereby putting him or herself in danger by using substances, engaging in self-harm, or continuing abusive relationships believing that this treatment is deserves. Reynolds et al. (2010) take this one step further by exploring how the concept of self-agency, a sense of control over one's experience, relates to self-esteem. They point out a correlation between low self-esteem in adolescents with a history of trauma-exposure and a diminished sense of self-agency. This results in individuals feeling as if their life is out of their control, which can lead to intense feelings of hopelessness, anger, and sadness.

Because exposure to repeated trauma can have such a deleterious effect on self-esteem, many treatment models maintain a focus on promoting resilience by supporting and individual's existing strengths and on building new competencies. Resilience is a term used to describe an individual's ability to withstand adversity and move forward with life tasks and quality of life (Coatsworth & Duncan, 2003). This will be discussed in

more detail in later chapters. In the next section I will discuss treatment considerations connected to the impairments reviewed in this section.

Treatment Considerations

Theoretical Considerations. This study will examine complex trauma first and foremost in light of attachment theory, which I view as the most relevant lens with which to understand this presentation because, as discussed in the previous section, attachment disruptions permeate all forms of childhood maltreatment. A mother's attachment style has been shown to be the best predictor of a child's attachment classification. According to research by Main and Cassidy (1988), a birth mother's attachment classification before the birth of her child can predict with 80% accuracy her child's attachment classification at 6 years of age. An interesting addition to these findings was made by Dozier, Bick, and Bernard (2011), whose research on foster children reveals that this attachment style is not set in stone. They found that when placed in foster care, a child's attachment classification becomes similar to that of the foster mother after 8 months in placement. These findings strongly suggest that the transmission of attachment patterns across generations is not genetic but rather a social construct. It also supports the idea that effective treatment involves facilitating an affectively attuned relationship between the child and his or her primary caretaker (Becker-Weidman, 2006). As Siegel (1999), who has done extensive research on the neurobiology of attachment, puts it

> As parents reflect with their securely attached children on the mental states that create their shared subjective experience, they are joining with them in an important co-constructive process of understanding how the mind functions. The inherent feature of secure attachment – contingent, collaborative communication – is also a

fundamental component in how interpersonal relationships facilitate internal integration in children. (p. 333)

Like Siegel, Flores' (2010) research promotes the idea that the brain can be altered through healthy and secure relationships. His research specifically tracks metabolic changes within the brain that consistently occur in the context of therapeutic interventions explicitly focusing on attachment. Such results reflect Dozier, Bick, and Bernard's (2011) research indicating that a foster parent's attachment style can influence that of her foster child in less than a year's time. Siegel (1999) notes that the need for external regulation through attachment is biologically significant at all stages of development, it is therefore not surprising that a secure base for attachment predicts positive treatment outcomes (Flores, 2010). Thus far, though, most therapeutic interventions that target the relationship between child and caregiver have been limited to young children. This may be attributed to the process of individuation in which adolescents are beginning to rely less and less on their caregivers. As indicated by the neurobiological research on the effects of complex trauma laid out in the previous chapter, however, age does not necessarily indicate developmental stage. It is therefore possible that an adolescent may still need the support of a caregiver in order to facilitate developmental milestones normally met in younger years. Another reason these treatments have focused on younger children may be that caregivers have not been as consistently available to participate in therapy with adolescents, particularly those in the foster system. Finally, it may simply be that this relatively new approach is yet to spread beyond young children, who may be seen to be at the greatest risk. Whatever the case, this research highlights the benefits of

therapeutic interventions that involve a primary caretaker for both children and adolescents.

Assessment. The unique systemic construct of complex trauma and the corresponding domains of impairment have important implications for accurate diagnosis and effective treatment. Clinicians must have a comprehensive understanding of the domains of impairment in order to address the long-term underlying grief and psychological pain alongside the cognitive and behavioral symptoms. As discussed above, complex trauma can impair development, regulatory capacities, interpersonal relationships, and result in patterns of revictimization. As Ford and Courtois (2013) note, "The core goal of treatment—*enhancing actual and perceived safety and resilience by enhancing the ability to self-regulate in the affective, somatic, cognitive, behavioral, and self/identity domains*—provides a context for screening and assessment" (p. 120). There are now a number of scales clinicians can use to assess for trauma. The most recent of these is the newly revised Symptoms of Traumatic Stress for Children-Revised, which screens for intrusive re-experiencing, avoidance, emotional numbing, and hyperarousal symptoms. Briere and Spinazzola (2005) remind us, however, that even scales designed specifically for complex trauma may not cover the complexity of an individual's issues and ongoing assessment is therefore immensely important.

Along with the use of scales, a thorough bio-psycho-social-developmental assessment at the outset provides the foundation for efficacious treatment. Clinicians must gather information on the duration, type, and subjective experience of the trauma (Perry, 2001). Perry (2001) and Spinazzola et al. (2005) emphasize the importance of understanding the type of trauma in addition to the developmental age of each individual

seeking therapeutic services in order to administer appropriate interventions. The assessment should screen not only for past trauma, but also for current and potential future retraumatization. Post-traumatic reenactments and triggers must also be taken into consideration (Spinazzola et al., 2005). Developing an understanding situations, people, or activities that are a reminder of abuse, and the ways they are experienced (i.e. through intrusive memories, avoidance, emotional numbing, or hyperarousal), is essential to establishing safety in the initial phase of treatment.

When conducting this assessment, clinicians must stay attuned to any signs of destabilization to ensure that this process does not re-traumatize the child or adolescent (McCrea, 2010). Clients should only divulge what they're comfortable sharing, and these disclosures should be followed with support and services. Involving members of the child or adolescent's support system (caregivers, family, peer, school, and/or community) could be considered one of the most important measures of support. Research by Ford & Hawke (2012) confirms that when trauma history and symptom screenings in juvenile detention centers led to access to trauma-informed services, there was a marked decrease in violent incidents. These trauma-informed services included informing staff of the youth's triggers and coping strategies, and providing psychoeducation about the potential effects of trauma on functioning and development. Because complex trauma can cause clients to explicitly avoid relationships and to reenact alienating behaviors, providing psychoeducation helps caregivers and service providers understand rejecting, noncompliant, emotionally abusive, and even physically threatening behaviors in the context of trauma. This new understanding can facilitate a more compassionate response and it will be less likely that such behaviors will be taken personally, which could lead to

anger and resentment and a perpetuation of the cycle of avoidance and reenactment. Also, Osofsky (2009) discusses the risk of vicarious trauma for caregivers and service providers and advocates for the need for trauma-focused psychoeducation along with intensive and ongoing support (supervision, support groups, etc.) to prevent burnout resulting from vicarious trauma.

Finally, throughout assessment clinicians must consider presenting symptoms from a number of angles. Ford, Fraleigh, & Connor (2010) provide the example of a child who seems highly oppositional and defiant, and the importance of distinguishing between these behaviors and proactive aggression during assessment. They note that in cases of complex trauma such an oppositional and defiant presentation is often a defense mechanism and the individual's best understood way of coping with his or her environment. Palardy, Vonk, and McClatchy (2009) further add that it is important to maintain an awareness of what may *not* be able to be expressed. For example, they point out that there is often and inextricable link between grief and trauma, such as when a child witnesses the loss of a family member due to violent death. The subsequent complex trauma symptoms of numbness and avoidance can significantly inhibit mourning. McCrea (2010) mentions another possible impediment to verbalization: victims may be reluctant to speak about what they have endured due to fear of triggering distress or getting others in trouble.

Treatment Protocol and Limitations. Following the initial assessment, phase-based treatment is a well-documented best practice across models of complex trauma treatment. Ford (2005) discusses the history of phased-based treatment for complex trauma in both the adult and child literature. The three most agreed upon phases are: (1)

engagement, safety, and stabilization, (2) recalling traumatic memories, and (3) enhancing daily living. The first phase focuses on simultaneous alliance building and the development of techniques for affect regulation including mindfulness, yoga, biofeedback, and/or stabilization on medication. This is essential and should continue as long as needed to ensure that individuals have the capacity to tolerate later stages of treatment.

Although the overall above-mentioned phases continue to be relevant, there has recently been more movement toward flexibility when it comes to approaching treatment for complex trauma. In an evaluation of the Child STEPs program, Weisz et al. (2012) found that an approach that allowed the clinician to change the sequence of the treatment components was associated with better treatment outcomes than adherence to a highly structured fixed-session manual. Amaya-Jackson and DeRosa (2007) discuss how in a study conducted by the National Center for Child Traumatic Stress of clinicians working with children and youth presenting with complex trauma, the majority report the need for more freedom to use one's own clinical judgment to determine the pacing and specific technique used for a particular case. They offer a number of approaches they've found helpful in working with clients with complex clinical presentations such as expanding the treatment modules to incorporate other elements that may be necessary, continuing to apply model components well beyond the processing of the trauma itself and its immediate consequences, and adding/integrating other empirical treatment models into the treatment plan. These clinicians also described success with pairing complimentary models by beginning one specific evidence-based model before the application of another model. For example, completing attachment-focused work or a parent management

model prior to implementing a cognitive model such as TF-CBT. Amaya-Jackson and DeRosa (2007) note how Nock et al. (2003) describe such necessary adjustments as similar to physicians' selective use of off-label medications; they agree that this can be helpful in certain situations but emphasize the importance of follow-up assessment when modifying treatment protocol. Not all agree with a flexible care-by-case approach, however. O'Connor and Zeanah's (2003) advocate close adherence to the protocol set by a particular evidenced-based treatment. This, they contend, is the most ethical approach because it provides a type of quality control that ensures that this highly vulnerable population receives consistent treatment with standardized outcome measurement. One point all of these authors agree upon is the need for ongoing assessment regardless of modification of the standard protocol. While research can help inform clinical decision-making, it is ultimately subjective and it is therefore critical that clinicians remain open to change and to feedback throughout the process. Both informal observation and formal assessments, such as the Partners for Change Outcome Management System (Duncan, 2013) can help monitor outcomes and inform progress.

McCrea (2010) also places great emphasis on tailoring treatment according to specific community and cultural constructs. By definition complex trauma involves specific community and cultural forces for which treatment efforts must appropriately account. As McCrea (2010) states,

> Therapeutic and community change efforts must be 'glocalized,' applying general and even global knowledge to local cultural conditions. Helping a child prostitute in Thailand who believes that her prostitution is the only way to save her family from

starvation clearly requires different efforts than helping a victim of trafficking in Lithuania or a neglected child terrorized by gangs in the urban United States. (p. 9)

In order to do this, Zeanah et al. (2006) discuss the importance of building close partnerships among service providers, community leaders, and mental health providers that respectfully draw from the strengths of particular community and/or cultural traditions.

Another contentious treatment consideration has to do with the length of treatment. On average, evidence-based trauma treatments typically provide 12–16 sessions (Cohen, Mannarino, & Deblinger, 2012), even though many presenting with complex trauma have experienced years of abuse and neglect. Amaya-Jackson and DeRosa (2007) expresses concern that short-term interventions cannot adequately address attachment disruptions and relational difficulties. Similarly, according to McCrea (2010) the stated goal of short-term treatment, providing treatment to a greater children and youth, runs the risk of prioritizing quantity over quality; she states,

> We need much more fine-grained understanding of the nature and impact of complex trauma for individuals and its impact on the treatment process. For instance, it is very likely that short-term models tend to not be sufficient for people suffering from complex trauma, precisely because the trauma is not only ongoing but also anticipated to continue into the future. Until such persons can permanently extricate themselves from the traumatizing conditions, they need intensive, gentle, and empowering ongoing support to be able to develop psychologically. The services needed would give victims refuges where their physical and emotional safety are ensured, help them voice their experiences and provide he comfort of an enduring

therapeutic partner in overcoming the effects of trauma, and support the professionals rendering those services. (p.10)

While numerous empirically supported treatment models exist for trauma, there are far fewer available for children and adolescents with multiple trauma issues and more complex clinical presentations **(**Amaya-Jackson & DeRosa, 2007). The most commonly studied form of trauma therapy for children is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, & Knudsen, 2005**).** TF-CBT has been studied primarily with sexually abused children and randomized control studies reflect its efficacy in reducing PTSD, internalizing, and externalizing symptoms (Cohen, Mannarino, & Knudsen, 2005). Ford and Cloitre (2009) reflect, however, that therapies developed to treat PTSD following a specific type of trauma (in this case sexual abuse) may not be as helpful in treating complex trauma. Moreover, Amaya-Jackson and DeRosa (2007) highlight the fact that not all of these treatment models emphasize the importance of the therapeutic relationship, yet interpersonal problems are almost universal in complex trauma presentations. Ford & Cloitre (2009) likewise contend that a therapeutic relationship that both activates these difficulties and provides the context for their processing and resolution is an essential component of effective treatment.

Finally, research shows that multiple and severe traumas are especially common for children and adolescents in socially marginalized communities, where many report exposure to repeated violence in their homes and communities (Singer, Anglin, Song, & Lunghofer, 1995). Individuals living in these communities not only face frequent exposure to traumatic events, but also limited social and economic resources and racial discrimination. Ford and Cloitre (2009) explain that despite this, most empirically

validated interventions are not especially suited to meet the complex and individualized needs of child and adolescents in such contexts. They also discuss how studies of many treatment models for traumatized children and adolescents have multiple exclusion criteria, including suicidal thoughts or behaviors, an absence of specific memory for the traumatic event, acute or severe behavioral or psychosocial problems, unstable or fragmented family and caregiver support systems, substance abuse in the child or caretaker, aggression toward others, psychotic symptoms, mental retardation and pervasive developmental disorder, and sexual behavior problems. As we know from the previously discussed domains of impairment, these criteria would eliminate many clients with complex trauma. Due to this lack of representation in clinical studies, it is all the more important that clinicians engage in ongoing refection not only about the current research on complex trauma, but also about what they're noticing with clients in their day-to-day practice.

Method

Results from several studies have identified the following four primary precipitants of multiple traumatization: (1) residing in a dangerous community, (2) living in a dangerous (violent) family (3) living in a nondangerous but chaotic and multiproblem family environment, and (4) having emotional problems that increase risk behavior (Finkelhor, Ormrod, Turner, & Holt, 2009). As can be seen, three of these four primary precipitants are embedded in the system. Because complex trauma is a systemic problem, effective treatment must address more than just the individual's symptoms. The Child Welfare Information Gateway (2013), administered by the Department of Health and Human Services, sums this up nicely

> Because brain functioning is altered by repeated experiences that strengthen and sensitize neuronal pathways, interventions cannot be limited to weekly therapy appointments. Interventions must address the totality of the child's life, providing frequent, consistent replacement experiences so that the child's brain can begin to incorporate a new environment—one that is safe, predictable and nurturing.

Trauma treatment models incorporate caregivers and the larger system to different degrees and in different ways. As Lieberman et al. (2005) notes, most current evidence-based models are time-limited and focus on very specific goals and objectives, which makes a comprehensive approach and that would include self-reflection, affective and behavioral regulation, and relationship navigation skills (Lieberman et al., 2005). She goes on to add that the models specific to complex trauma presentations in children and adolescents are apt to have the stabilizing, emotion-regulating, often dialectical or alternatively attachment-oriented components that usually require a longer duration. Some of these models focus heavily on clinical work with members of system, while others focus more on individual clinical work but provide case management and psychoeducation to the adults in the system. Subsequent chapters will examine how the theoretical basis of representative models from cognitive-based trauma therapies and attachment-based trauma therapies approach the treatment not only of an individual's symptoms, but also how they foster a safer and more nurturing holding environment both within and outside of the therapy room.

CHAPTER III

Individually-Focused Models

Introduction

In this chapter I will explore in depth one of the two major areas of focus in my research, individually-focused therapy models for complex trauma. This will lay the groundwork for comparing these models to the systems-focused approaches that I will discuss in the next chapter. I have chosen to examine Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) and Dialectical Behavioral Therapy (DBT) because there is extensive literature documenting their use for treating the symptoms associated with complex trauma. I will first review the history and key features of the theory behind these models, cognitive-behavioral theory, and will then discuss the related literature. Within this discussion, I will include clinical, cultural, and population considerations, as well as research on their efficacy. Additionally, this review will include divergent points of view and debates within the profession regarding use of this theoretical approach in application to working with clients who present with complex trauma. While cognitive-behavioral theory is central to both of the models I will cover in this chapter, several additional theories are relevant to DBT and will thus be included in that section.

Foundational Theories

Learning theory is the basic foundation of cognitive-behavioral approaches. In the early 1950's, some psychologists began to feel that psychoanalytic talk and play therapies

fell short with certain clients. This lead Skinner (1953) and others to begin to research learning principles through experimental work with animals. They observed the ways animals become conditioned by their experiences, leading to predictable reactions and patterns of behavior (Maren, 2001). Horses, for example, may be frightened by a tree whose branches often snap on windy days, and begin to tense whenever they come near this tree, regardless of the weather, or may even avoid the area altogether. Similarly, when children experience abuse, they often instinctively experience negative emotions such as fear, shame, or anger when triggered by reminders of this trauma (Bromberg, 2003). From a learning theory perspective, this is the result of classical conditioning, a process whereby otherwise neutral cues, such as a tone of voice, a smell, or a facial expression, present at the time of the abuse become conditioned so that they too elicit negative emotions (Maren, 2001). Bromberg (2003) discussed how along with external triggers, internal triggers in the form of abuse-related memories and thoughts may also become conditioned stimuli that automatically elicit negative emotions. Operant conditioning occurs when children learn to avoid these abuse-related cues in order to reduce the likelihood of experiencing fear or other difficult emotions. Children may come to believe that avoidance is effective because it leads to an immediate reduction in anxiety, and it may become their best-understood coping mechanism. Unfortunately, not only is avoidance not always practical, but also research has shown that it prevents the overall reduction of symptoms (Foa, Hembree, & Rothbaum, 2007). Gradual exposure, a cognitive-behavioral technique, is therefore used to help these individuals gradually confront the anxiety-provoking reminders of the abuse. Through gradual but repeated attempts to confront abuse-related cues, children learn that thoughts, memories, and

reminders of the abuse are not harmful and do not need to be avoided.

Patterson (1982) used operant conditioning as a framework for his observations of interaction between parents and behaviorally-dysregulated children. He noticed a frequent relationship between inconsistent parenting and this disruptive behavior; more specifically, he observed that when would parents scold, threaten, and/or use corporal punishment, the child's disruptive behavior would increase. The parents would then back off, thereby reinforcing this dysregulated reaction. Patterson's research led to cognitive-behavioral interventions focused on consistent use of more effective parenting practices (Reid, Patterson, & Synder, 2002).

Following these behaviorally-focused parent and child interventions, research by Beck (1976) and Ellis (1962) led to the integration of the cognitive process into this therapeutic approach. They examined how cognitive distortions and irrational thinking propel maladaptive behavior and/or negative moods. Skills directed toward changing one's thoughts therefore began to be taught and practiced, leading to the formal classification of Cognitive Behavioral Therapy (CBT) in the late 1970's (Meyers & Craighead, 1984). CBT aims to modify behavior through the use of cognitive skills, or self-talk. Like Beck and Ellis, child development theorist Lev Semenovich Vygotsky proposed that children could learn to control their own behavior and feelings through the use of this self-talk (Kendall, 1977). Building on this, Bandura (1977) later introduced the notion of self efficacy, the belief that individuals can control their own responses and reactions to a situation that is now a major part of the lexicon of CBT.

Like all mainstream psychotherapeutic theories, cognitive-behavioral psychology continues to evolve. Donald Meichenbaum (1995), who published one of the formative

CBT texts in 1977, *Cognitive-Behavior Modification,* and Hayes (2004) discuss the changes over time in these basic concepts. According to both of them, cognitive-behavioral concepts have evolved in three major ways. First, the idea of conditioning has expanded from its original definition in which change was initially understood as the result of external alterations in learning process. Early behaviorists even viewed cognitive events as a form of conditioning. While this initial understanding gave rise to some invaluable therapeutic tools that continue to be used, the concept was unable to encompass the broad range of individual differences seen and the complexity of factors that were causing change (Hayes, 2004). As these inadequacies became more apparent, cognitive events began to be understood as computational, such that the brain is viewed as computer that interprets objects and events based on its multilayered programming. Another change these authors note is one that has heavily influenced Trauma-Focused Cognitive Behavioral Therapy, which I will discuss in more detail later in this chapter, and has to do with the cognitive process involved in the interpretation of events and meaning making. An appreciation began to develop for how individuals generate more complex sets of cognitive patterns, or stories, through which they understand, express, and create their own lives. This conceptualization led to the idea that these narratives could be rearranged to enable individuals to resolve difficulties and adapt to changes, and this laid the groundwork for a number of therapeutic interventions (Hayes, 2004). The third and final evolution of the cognitive behavioral approach that they discuss began in the 1990's and reflects the emphasis of psychological acceptance and mindfulness principles. Rather than striving to change one's distressing thoughts and feelings, focus shifted to cultivating an attitude of nonjudgmental acceptance of the full range of

experience (Hayes, 2004), a key component of Dialectical Behavioral Therapy.

There is some debate as to whether the theoretical underpinnings of CBT have actually changed since its development, or if new interventions have simply been applied that don't in fact deviate from the original theory. Meichenbaum (1995) and Hayes (2004) identify specific additions to the original theory, and talk about the creation of new generations of cognitive behavioral theory. Arch & Craske (2008) and Hofmann (2010), on the other hand, believe that contemporary CBT models are not distinct from the original conceptualization. While these scholars agree that mindfulness techniques have become more popular over the past decade, they contend that they've always been intrinsic to cognitive-behavioral theory. Whatever the case, CBT has been gaining in popularity since its inception, and is at the root of a number of highly regarded treatment models. I will now discuss two of these models that have become popular approaches for working with children and adolescents presenting with symptoms of complex trauma.

Therapeutic Models

Trauma Focused Cognitive-Behavioral Therapy. Although there is significant empirical support for using cognitive behavioral interventions to treat traumatized youth, as mentioned in the previous chapter few of these studies are specific to cases of complex trauma. Despite this, many continue to advocate for the use of cognitive behavioral interventions with traumatized children and youth regardless of the type or duration of the trauma (Cohen, Deblinger, and Mannarino, 2004). One CBT approach, however, Trauma-Focused Cognitive-Behavioral Therapy (TF- CBT), has demonstrated promising outcomes for reducing symptoms associated with complex trauma in children. TF-CBT focuses on the following components: psychoeducation about trauma symptoms,

affective regulation skills, the cognitive triangle (the connection between thoughts, feelings, and behaviors), development of a trauma narrative, and safety skills training. The majority of treatment takes place in individual sessions with the child, but caregivers are invited to meet with the therapist for psychoeducation and skill building (Cohen, Deblinger, and Mannarino, 2004).

TF-CBT is a short-term treatment model that consists of once-weekly, 60 to 90 minute sessions lasting 12-18 weeks (Cohen, Mannarino, Kliethermes, & Murray, 2012). While the developers recognize some need for flexibility with this format in response to the needs of the child, they emphasize that a specific sequence must be followed. These authors use the acronym PRACTICE to describe this particular sequence. The first component, *Psychoeducation and Parenting skills*, includes an explanation of common emotional and behavioral reactions related to trauma as well as some behavioral intervention techniques caregivers can use. *Relaxation* strategies are next, and include breathing techniques, muscle relaxation, and thought-stopping. The third component in this sequence is *Affect* expression and regulation, wherein the child and caregiver learn to regulate their affective reactions to trauma triggers and practice activities that promote self-soothing. Following this is *Cognitive* coping and processing, during which the trauma is examined and the therapist corrects any erroneous ascriptions about the cause, responsibility, and consequences of the traumatic experiences. The *Trauma* narrative is the next component in the protocol and involves gradual exposure to trauma related triggers through words or writing. The sixth component is *In-vivo* exposure to nonthreatening triggers in the child's environment, such as darkness, with the objective being that the child learns to better regulate his or her affect. *Conjoint* sessions with the

child and his or her parent, the next step, focus on communicating with one another and fostering therapeutic discussion about the abuse. The final segment is *Enhancing* personal safety and future growth, which entails providing knowledge about ways to help ensure safety. This component also promotes the utilization of newly learned skills for regulating stress and traumatic triggers in the future (Cohen, Mannarino, Kliethermes, & Murray, 2012).

There are a number of factors that can complicate the implementation of TF-CBT. Cohen, Mannarino, and Deblinger (2012) point out that many children who have been victimized are often a part of unstable surroundings, such as living in poverty, having a mentally ill caretaker, or a caretaker involved with the criminal justice system. The authors note that TF-CBT can be effective without the participation of the caretaker if he or she is unable or unwilling to be an active part of the treatment process. They do, however, emphasize the importance of caretaker involvement for the success of the behavioral interventions. When a parent does participate in the therapy and a child's behavior does not get better, the authors suggest that this is usually because of the caretaker's failure to correctly or consistently implement the behavior strategies. Initial evaluation of exposure and reactions to trauma are conducted to determine if TF-CBT is appropriate, and self-report measurement tools are used to assess symptoms throughout treatment (Cohen, Mannarino, & Deblinger, 2012).

Much controversy remains about the use of TF-CBT to treat ongoing trauma, as opposed to past and primarily single-incident trauma for which it was originally created. The developers have recently published several articles on ways to tailor this approach to the needs of children and adolescents experiencing continuous trauma. I will discuss this

a more at the end of this section, but first will focus on the existing empirical evidence on using TF-CBT for cases of complex trauma. Such research has been conducted both in the U.S. and internationally, and includes a somewhat diverse array of participants.

Most recently, O'Callaghan, McMullen, Shannon, Rafferty, and Black (2013) conducted a randomized control trail study of 52 Congolese girls aged 12 to 17 years who had been rescued from brothels or from military sexual violence and had either witnessed or directly experienced repeated sexual abuse including rape. Compared to the control group, results showed that the TF-CBT group experienced significantly greater reductions in trauma symptoms after 15 sessions, including 3 sessions of psychoeducation with caregivers. The TF-CBT group also showed a highly significant improvement in symptoms of depression and anxiety, conduct problems, and pro-social behavior. Several cultural adaptations were made to make this model a better fit for use within the Democratic Republic of the Congo. To support efforts to make TF-CBT more culturally sensitive, researchers in Zambia recently conducted a number of community-based focus groups to gather information on specific TF-CBT adaptations for communities in this country, specifically with youth exposed to domestic violence and/or sexual abuse (Murray et al., 2013).

Silje, Jensen, Wentzel-Larsen, and Shirk (2013) recently concluded a study in Norway that was developed to specifically assess the value of the therapeutic alliance in TF-CBT with youth impacted by complex trauma. This was the first study to examine the contribution of the therapeutic alliance to treatment outcome. 156 Norwegian youth ages 10-18 were randomly assigned to TF-CBT or TAU. Symptoms were assessed before, during, and after treatment, and the therapeutic alliance was assessed twice during the

course of treatment using the Therapeutic Alliance Scale for Children. Results found similar alliance scores in both treatment conditions, but TF-CBT participants had significantly lower trauma symptoms post-treatment. Not surprisingly, the alliance ratings were significant predictors of reduction in trauma symptoms; however, this was only the case with TF-CBT and not with the TAU group. The authors therefore concluded that it's possible that the therapeutic alliance is particularly important in treatments such as TF-CBT that require youth to engage in specific tasks.

In the U.S., a study called The Children Recover after Family Trauma (CRAFT) Project was conducted from 2004-2009 to evaluate the effectiveness of TF-CBT compared with child center therapy in an urban community domestic violence center. Results showed that TF-CBT led to a significantly greater reduction in symptoms than child centered therapy for these youth (Cohen, Mannarino, & Iyengar, 2011). Those receiving TF-CBT also experienced fewer incidents of revictimization and fewer psychiatric hospitalizations. The California Institute of Mental Health (2010) has been gathering similar data on the effectiveness of TF-CBT with families experiencing domestic violence and/or living in violent neighborhoods, and has found TF-CBT to be effective across multiple sites.

Lang, Ford, and Fitzgerald (2010) express some uncertainty about the use of TF-CBT with children presenting with symptoms of complex trauma because of the minimal amount of research on the use of this treatment strategy with children living in threatening and unstable environments. Lang, Ford, and Fitzgerald (2010) also mention that this decision can be further complicated by the uncertainty and delicacy often present in the therapeutic setting when working with a traumatized child. They emphasize the

important of careful assessment of the child's level of treatment readiness based on his or her symptomology prior to beginning each component of this approach. In certain instances, they noted, incorporating other therapeutic paradigms may be indicated.

In a review of TF-CBT literature, Bol (2008) draws attention to a number of limitations in the diversity of participants, small sample sizes, possible bias due to a limited number of referral sites, and lack of reporting on or explanation of effect size. Deblinger, Mannarino, Cohen, Runyon, and Steer (2011) discuss similar limitations, and suggest that greater research is needed to determine the most effective aspects of TF-CBT. One of the biggest questions that they believe needs to be answered is whether the exposure component that occurs during the creation of the trauma narrative is in fact beneficial. Deblinger et al. point out that there is little evidence for its use with young children who have been victimized, and the optimal level of exposure required for this population is unclear. In an attempt to begin to learn more about this, they conducted a study that sought to appraise various effects of TF-CBT with and without the trauma narrative. The study randomly assigned 210 children ages 4 to 11 years-old and their primary caregivers to one of four groups. All of the children had experienced multiple incidents of abuse. The four groups included 8 sessions without the narrative, 8 sessions with the narrative, 16 sessions without the narrative, and 16 sessions with the narrative. All of the groups received psychoeducation, relaxation skills, affect regulation, cognitive coping, physical safety, and parenting skills training. Overall, Deblinger et al. (2011) found positive results for TF-CBT's ability to improve affective and behavioral performance and parenting skills, though across each group differences were noted. In the 16 sessions non-narrative group, more improvements were reported in parenting skills

than in the narrative groups. Furthermore, children treated without the narrative were described by their parents as having fewer externalizing behaviors than those children treated with it, which the authors surmised could have been the result of more time and focus on parenting abilities for those not receiving the narrative. Regardless of treatment length, however, children in the narrative groups reported lowered levels of anxiety related to the abuse. The results also suggest that longer treatment length and a reduction in avoidance and re-experiencing symptoms.

Research has also identified that child behavior problems might be exacerbated when the narrative was included. Specifically, the effect of the trauma narrative was studied by Grasso, Joselow, Marquez, and Webb in 2011. These authors suggest that worsening symptoms could be the result of increased reminders of the trauma as the narrative is developed. They leave room for the possibility that this does not discount the value of the narrative, as it could be that things need to get worse before they get better. Grasso et al. (2011) also found that parents reported that their own mood got worse during the narrative. This, they note, could increase the chances of a parent's psychological health being compromised during this phase, which could have a negative impact on the child. Clinicians who participated in the NCTSN focus groups expressed further problems using the narrative component of TF-CBT with children and adolescents experiencing complex trauma (Amaya-Jackson & DeRosa, 2007). They found this difficult because their histories are often incomplete and contain multiple traumatic events, which makes it difficult to select the focus of the narrative. Also, in cases of neglect and community and domestic violence, the trauma is often ongoing, which leaves the final reflection piece of the narrative difficult to do. They also noted that this model

assumes that both the child and caregiver can quickly learn strategies to self-regulate, that caregiver capacity and attachment issues will be adequately addressed by parenting classes or individual therapy, or that a child's sense of safety in a chaotic environment is addressed by a safety plan (Amaya-Jackson & DeRosa, 2007). Likewise, Griffin (2009) contends that individuals with a history of neglect may not be a good fit for narrative processing of specific events because this type of cause-effect analysis is less clear in cases of neglect.

Although not speaking specifically of TF-CBT, Ryle (2009) takes an even more critical stand toward CBT in general, arguing that it "operates only on the surface," is too concerned and focused on techniques, and fails to consider cultural context in its approach to change so-called negative thoughts, feelings, and behaviors. Moreover, he argues that there is not sufficient attention given to the therapeutic relationship. In response to some of this criticism, Cohen, Mannarino, Kliethermes, & Murray (2012) recently published an article proposing possible additions and/or adjustments to the TF-CBT approach. While they do acknowledge the need for some adjustments to other components, they fully defend the narrative component stating,

> Because youth experiencing ongoing traumas are continually resensitized to fear-inducing memories related to these new traumas, therapists have questioned whether creating narratives about past traumatic experiences could effectively decrease learned fear and avoidance for these youth, and whether creating narratives might even be harmful to these youth. TF-CBT therapists and trainers have anecdotally expressed that creating narratives are particularly helpful in some ways for youth experiencing ongoing traumas. First, hearing youths'

> acknowledging the "real danger" situations and how they are impacting youths' current behaviors, emotions, and reactions to triggers. Second, describing traumatic experiences within the safety of the therapy session, even if traumatic episodes continue to recur, allows youth to engage in some perspective taking, cognitive processing, and contextualization. This aids in differentiating real versus perceived or overgeneralized danger cues. Finally, youth gain increased ability to distinguish between real danger and trauma reminders by including descriptions of both types of situations in their narratives and their thoughts and feelings related to this.

This response assumes the child's readiness for cognitive processing. As discussed in Chapter I, complex trauma can have debilitating effects on the developing brain that limit cognitive processing. Perry (2001) and van der Kolk (1994) contend that trauma is primarily processed in the nonverbal realms of the brain, and CBT interventions alone may therefore not be the most effective strategy. In such cases, Raider, Steele, Delillo-Storey, Jacobs, and Kuban (2008) propose using cognitive-behavioral interventions after or alongside sensory activities. Cohen et al. (2012), however, do not address concerns about youth that may not be able to engage in cognitive work for these reasons.

Dialectical Behavioral Therapy. I have chosen to examine Dialectical Behavioral Therapy (DBT) as a potential treatment approach for complex trauma because of its focus on affect regulation and distress tolerance. As I discussed in the previous chapter, emotional dysregulation is one of the primary symptoms associated with cases of complex trauma. Additionally, results from research by Stepp, Burke, Hipwell, and Loeber (2012) shows a progression from difficulties with affect regulation and

relationships to later problems with impulse control. This not only points to the importance of early intervention, but also to the possibility that affect regulation, distress tolerance, and mindfulness skills taught in DBT may prevent further symptom development. Another reason this approach is interesting to consider is its initial focus on establishing safety and behavioral control. Eichler (2012) concludes that the neurobiological impact of complex trauma may affect a child's ability to engage in the cognitive and narrative work required in TF-CBT. DBT, however, begins with a focus on mindfulness and other skills that could help prepare adolescents for this more cognitively-focused work (Ford, 2013). Moreover, Cohen, Mannarino, Kliethermes, and Murray (2012) note that TF-CBT may not be a good fit for children or adolescents who are currently experiencing suicidal thoughts or are using alcohol, drugs, or other substances because TF-CBT's exposure component may aggravate these behaviors. They also mention that it is not designed for those who are exhibiting self-injurious behavior or those with a history of running away. DBT, on the other hand, was created specifically for individuals presenting with these types of acute symptoms. In addition, DBT focuses on current symptomatology and does not delve into the past narrative, which as discussed in the previous section is a highly contentious issue. Finally, unlike in TF-CBT and most other models, DBT therapists can be accessed by phone at any time clients need support. This increased access to support could prove hugely valuable to youth with particularly challenging and overwhelming lives outside of the office.

DBT is a cognitive-behaviorally-based treatment originally developed by Marsha Linehan for adults with symptoms including suicidality and severe behavioral dysregulation (Linehan, 1993). Behaviorism plays a major role in the DBT approach,

influencing the way problems are defined, the ways behaviors are assessed, and the interventions that are used. Behavioral theory within this model suggests that problematic behaviors result from a combination of skill deficits and external factors (Linehan, 1993). From this perspective, cued responding, reinforcement, and/or cognitive factors elicit behaviors. These behaviors are also understood to serve an important function for the individual, and DBT therapists therefore work closely with clients to understand these underlying needs. To do this, a detailed chain analysis is used to dissect a specific problematic experience. Similar to the CBT triangle, this chain analysis seeks to identify the links between thoughts, behaviors, and emotions, and closely examines the contextual factors fueling this internal experience. Once this is understood, the therapist can support the client in finding alternative ways to meet these needs. For example, if an adolescent is presenting with non-suicidal self-injury (superficial cutting, burning, etc.), from a DBT perspective this is understood as the child's best-understood method of regulating otherwise overwhelming emotions. Treatment for this would thus focus on coming up with healthier alternatives to self-harm that would likewise help the individual regulate these intense emotional experiences. Primary DBT interventions based in behavioral theory include behavioral skills training, exposure, contingency management, and cognitive restructuring (Linehan, 1993).

Several other theories enhance the cognitive-behaviorally based DBT framework. In DBT, symptoms are believed to surface from a biologically based vulnerability to emotional dysregulation that is exacerbated by an invalidating and unsupportive environment, a notion referred to as biosocial theory (Linehan & Schmidt, 1995). Linehan (1993) discusses how the symptoms of Borderline Personality Disorder can

result from caregivers' invalidating responses to a child's emotion dysregulation paired with the child's biological vulnerability. This is relevant to early experiences of complex trauma because 75% of adults diagnosed with Borderline Personality Disorder have a history of chronic childhood abuse and neglect (Zanarini et al., 1997). From a biosocial theory perspective, a number of invalidating aspects can be lined to such ongoing trauma. Also, the previously discussed chain analysis examines the function of the behavior, and very often the behavior is a way to elicit a response from others and to get them to acknowledge otherwise overlooked pain and suffering. DBT therefore expands on traditional behavior therapy by examining the function of the behaviors and then including interventions that explicitly validate the individual's emotional experience. Biosocial theory also influences when and how certain problem behaviors are addressed in treatment. For example, if the assessment indicates that a client's behaviors are related to emotional dysregulation, the first part of treatment focuses on techniques for self-regulation, such as mindfulness, grounding, and sensory approaches. This is different from many exposure-focused approaches like TF-CBT that require the ability to tolerate and experience challenging emotions soon into treatment. DBT instead focused on strategies that modulate rather than accentuate emotional experiencing prioritizes safety, behavioral control, and connection to the therapist (Linehan, 1993). For example, complex trauma-related symptoms that are not behaviors, such as flashback and intrusions, would be treated in the beginning phase of therapy only if they directly contribute to the unsafe behaviors. Direct focus on these other trauma symptoms only progresses when clients possess the skills to tolerate more intense emotional experiencing.

Dialectics is the final theoretical cornerstone of DBT. Dialectical theory views reality as comprised of opposing forces that are constantly in flux, referred to as thesis and antithesis (Linehan & Schmidt, 1995). Opposite views can therefore exist simultaneously, and this tension is seen not only as part of reality, but also as necessary for change. This concept can be especially helpful for children and adolescents who have been abused or neglected by their caregivers and are often left with confusing and contradictory beliefs and feelings towards these family members (i.e. feeling both love and hate toward a caregiver, or seeing a caregiver as both protector and abuser). DBT interventions include both change and acceptance-oriented techniques for dealing with these complex emotional experiences.

DBT was first developed for adults but has since been modified for use with adolescents. Klein and Miller (2011) provide several modifications to make DBT more developmentally appropriate for adolescents. First, caregivers are included in multifamily skills training groups designed to enhance generalization and reinforcement of skills and structure adolescents' environments. Parents thus serve as models and coaches for their adolescents by utilizing and implementing skills. Also, in this skills training parents learn a common vocabulary for therapeutic techniques, and are then better able to provide their adolescents with ongoing validation and support. Telephone coaching and consultation is an important aspect of individual DBT, and in some cases family members can also receive this type of support. Moreover, family sessions are conducted as needed; on average selected family members will attend 3 to 4 sessions out of the adolescent's 16 weeks of individual therapy. Another adaptation involves attending to dialectical dilemmas specific to child-caregiver relationships. The first dialectical dilemma is

excessive leniency versus authoritarian control, in other words, either placing too few limits on the adolescent, or being excessively permissive, and the goal of treatment is to help parents and adolescents find a middle ground (Klein & Miller, 2011). The second dialectical dilemma is normalizing pathological behaviors versus pathologizing normative behaviors. Some caregivers, for example, may write off certain behaviors as "kids just being kids," when in fact these should stand out as red flags, while others become overly concerned with behaviors that in fact fall within the norm. The final dialectical dilemma is fostering dependence versus forcing autonomy. Fostering dependence occurs when parents are overly protective and provide excessive caretaking, whereas forcing autonomy occurs when parents cut ties before an adolescent is developmentally ready to be self-sufficient. Another interesting modification from adult DBT is that treatment length was reduced from 1 year to 16 weeks. According to Klein and Miller (2011), a shorter treatment length was thought to be more appealing to adolescents because they often miss therapy appointments or fail to complete long-term treatment.

Although DBT for adolescents is relatively new, and unfortunately no randomized clinical trials yet exist for this population (two are currently underway), twelve studies conducted in a variety of settings shows some promising results for use with adolescents (Groves, Backer, van den Bosch, & Miller, 2012). I will review studies with sample populations that contain high percentages of youth impacted by complex trauma. These include youth in juvenile detention centers (National Center for Mental Health and Juvenile Justice, 2007), and those with multiple diagnoses because, as discussed in the previous chapter, this often the case with youth presenting with complex trauma due to

the absence of a formal diagnosis specific to this condition.

To date, two quasi-experimental studies on DBT with adolescents have been published, both with samples of multiply diagnosed youth with numerous life stressors, including at least two of the following: homelessness, domestic violence, neighborhood violence, or direct experience of abuse and neglect. Rathus and Miller (2002) conducted a study of depressed and suicidal adolescents treated with DBT to those with treatment as usual (TAU) in a 12-week outpatient program. Participants were predominantly female, and the majority was Latino. They found that 60% of the participants treated with DBT completed treatment compared with only 38% of the TAU group. The DBT group also had no psychiatric hospitalizations, while 13% of the TAU group was hospitalized during the 12 weeks. Adolescents in the DBT group also reported significant reductions in impulsivity, emotional dysregulation, and interpersonal problems.

Following this, Katz, Cox, Gunasekara, and Miller (2004) conducted a study comparing adolescents ages 14-17 treated with DBT and TAU for 2 weeks on an impatient unit followed by one year of outpatient treatment. All participants had been hospitalized for suicide attempts or suicidal ideation. Like the Rathus and Miller study, this sample was also heavily female (n=52), but unlike that study the majority was White (72.6%). The DBT group attended individual therapy twice weekly and skills training groups 5 times per week. Results of this study found a reduction in behavioral incidents among the group treated with DBT, as well as greater adherence to treatment compared with the TAU group. After one year of outpatient treatment in their respective models, the results reflected less difference between the two groups, as members of both demonstrated a significant and comparable reduction of suicidal ideation, self-injurious

behavior, and depressive symptoms. Symptom reduction was slightly greater for the DBT group but not statistically significant, but the authors note that this could be due to the small sample size.

A few additional studies indicate improved outcomes with DBT. Woodberry and Popenoe (2008) found positive treatment outcomes in a group of suicidal and non-suicidal self-injuring adolescents treated in an open 15-week trial of DBT in a community outpatient clinic. After DBT treatment these adolescents reported a reduction in depressive symptoms, anger, dissociative symptoms, self-injurious behavior, and suicidal ideation. Their caregivers also reported a reduction in their externalizing problem behaviors. Also noteworthy is that the caregiver reported a considerable decrease in their own depressive symptoms at the end of treatment. This finding suggests the possibility that despite its focus on the individual adolescent, DBT could improve the overall health of a family system. Another study by Trupin, Stewart, Beach, and Boesky (2002) examined a 10-month DBT treatment program with 90 incarcerated female juvenile offenders who exhibited externalizing behaviors. At the end of the course of treatment, the adolescents who received DBT were found to have fewer acts of aggression, classroom disruptions, and suicidal gestures.

Limitations of all of these studies include the small sample size, an overall lack of diversity of participants, especially in terms of ethnicity and gender, and the lack of control groups. Also, it is difficult to generalize the results of these studies because there is considerable variability in their design and in the settings in which they were applied. Moreover, not all of the studies were clear about their fidelity to the original DBT protocol, which makes it hard to compare their results to those that did include this

information.

Conclusion

In this chapter I have examined two major individually-focused treatments for complex trauma. I have traced their origins in cognitive-behavioral theory, described and compared their components, and reviewed the literature on their efficacy. This reviewer found few studies specific to complex trauma, and the studies found contained a variety of methods and very diverse samples. There were therefore very few true replications and it is clear that more research, and randomized control trials in particular, are needed. In the next chapter I will examine more systems-focused treatments for complex trauma, particularly those that focus on fostering attachment between children and adolescents and their caregivers. As I have in this chapter, I will provide some history of the foundational theories, in this case systems theory and attachment theory, and will then describe their approach and review related literature.

CHAPTER IV

Systems-Focused Treatment Models

Introduction

In this chapter I will explore the second of the two major areas of focus in my research, systems-focused therapy models for complex trauma. I will use Attachment, Self-Regulation, and Competency (ARC) and Dyadic Developmental Psychotherapy (DDP) as examples of therapeutic models developed specifically for complex trauma that take a systems-focused approach. Unlike the models previously reviewed, these have only limited empirical research reflecting their efficacy, but substantial research on complex trauma suggests the importance of their approach to treatment. This chapter will follow the same format as the last; first I will review the history and key features of the foundational theories and then discuss the related literature. Within this discussion, I will include clinical, cultural, and population considerations, as well as research on their efficacy. Additionally, this review will include divergent points of view within the profession regarding use of this theoretical approach in application to working with clients who present with complex trauma. The conclusion of this chapter will transition into a final chapter comparing systems-focused, attachment-based approaches to the individually-focused, cognitive-based approach of the last chapter.

History and Foundational Theories

Bowlby's (1969) attachment theory identifies a connection between social

development and a child's experience when trying to ensure that a caregiver meets his or her needs. He calls the organization of the feelings and behaviors associated with this attempt at attachment as the attachment behavioral system, and believes it leads to the development of one's internal working model. The caregiver's attachment organization influences the way the caregiver interacts with the child, and this process shapes the child's internal working model (Ainsworth, 1989). The concept of internal working models is similar to ideas within both psychoanalytic and object relations theories (Fairbairn, 1946, Freud, 1912), yet takes this a step further by linking the attachment behavioral system to later social development and functioning. Similar to Bowlby's (1969) concept of the attachment behavioral system is the ecological systems model coined by Urie Bronfenbrenner (1979). Bronfenbrenner emphasized the various ways the social environment influences child development. His ecological systems model provides a comprehensive understanding of the issues related to complex trauma. According to this framework, each individual is part of a network of systems that shape one's understanding of the world and interactions with others; these include family, school, peers, community, and culture. Another theory that informs the attachment-based approach that will be discussed in this chapter is intersubjective systems theory. Intersubjectivity refers to the ways individuals influence each other through shared, reciprocal experience (Trevarthen, C., 2001). For example, when caregivers experience children and lovable and full of potential, children experience themselves this way. On the other hand, when there is a dearth of this positive reciprocal experience between children and the important people in their lives, it becomes very difficult for them to believe they possess such qualities. I will discuss how this theory is applied to treatment

in more detail in the following section on specific therapeutic models.

As discussed in Chapter II, when trauma occurs during critical stages of development and within the context of the caregiving relationship, it can have a particularly deleterious and lasting impact. Disrupted attachments can lead to deficits in one's ability to self-regulate, develop positive relationships, develop a strong self identity, and acquire certain cognitive skills (Hesse & Main, 2006). Systems-focused therapies for complex trauma therefore implement interventions specifically focused on strengthening the attachment system**.** The ultimate goal of the attachment-based models I will discuss in this chapter is to improve the relationship between child and caregiver so that the caregiver can be a source of safety, comfort, and security. They are trust-based, emotion-focused therapeutic models that seek to repair interpersonal ruptures and rebuild a protective relationship. As noted earlier, many early attachment-based models were designed for treatment with young children, but research suggests the importance of a secure attachment at all ages, even throughout the process in individuation. In fact, as established by such authors as Arnett and Tanner (2006), it is now recognized that many adolescents cannot progress into confident and competent adults without the consistent presence of a secure attachment figure. Adolescents on the path to adulthood continue to rely upon their caretakers for myriad forms of support. Caretakers function as a base of operations for the explorations that occur prior to adulthood, both in tangible ways, such as by providing food and shelter, as well as in nontangible ways, such as providing emotional support and guidance (Arnett and Tanner, 2006). Coleman (1988) uses the concept of social capital to refer to a social support system founded upon a secure attachment to a caretaker. He discusses how high levels of social capital in a child's life

have been linked to more positive life outcomes in the realms of career, relationships, and both physical and mental health**.**

Arnett and Tanner (2006) refer to the transition from adolescence into adulthood (roughly ages 18-25) as emerging adulthood, and believe that during this period independence from caretakers is made but not fully achieved. They identify three developmental domains in which these transitions to adulthood take place. The first of these is the cognitive domain, which is characterized by the development of logical reasoning, subjective feelings, a sense of responsibility to others, and interdependence within a larger society. The second is the emotional domain, marked by the development of some autonomy from caregivers and the ability to establish balanced intimate relationships with others. The final domain is behavioral, and is characterized by the establishment of firm impulse control and complying with social conventions. This conceptualization is reflected in research that suggests that ego development continues to take place and rely upon the caregiver relationship well into the late 20's. A study by Scharf, Mayseless, and Kivenson-Baron (2004) examined the association between attachment representations and successful coping with developmental tasks of emerging adulthood. These tasks included coping effectively with the home-leaving transition, acquiring the capacity for mature intimacy in friendships and romantic relationships while maintaining close and autonomous relationships with caregivers, and developing a sense of efficacy and individuation. They found that although these developmental tasks begin to evolve during adolescence, they are not fully developed until the third decade of life.

This research highlights the need to establish a strong child-caregiver relationship

before children enter adulthood. Of course, the sooner this is done the better, which is why many therapeutic models target early child-caregiver attachment. The examples I will use, however, are designed for use across a broad range of developmental stages. They recognize that this work is particularly important for youth whose early developmental milestones have been interrupted by trauma, leaving them without the secure base typically developed in early childhood. Numerous theorists argue that an attachment-based approach with children and their caregivers is imperative in cases of complex trauma. Among these are Henggeler et al. (1999), who believe that for many children and adolescents presenting with symptoms of complex trauma, the primary issue involved dysregulation within the system, rather than organic psychiatric disorders in the individual. They discuss how disturbances in child-caretaker relationships, peer relationships, schools, and neighborhoods as well as limited resources to support youth can all contribute to problematic symptoms. Similarly, Lieberman & van Horn (2008) contend that when trauma has occurred either because a caregiver has been the source on distress or because the caregiver has been unable to maintain the child's safety, clinical interventions must include reparative work within the attachment system. Also making a case for attachment-based work, O'Connor & Zeanah (2003) provide an example of a child with history of abuse and neglect who is then adopted by a loving and sensitive caregiver but is unable to accept and integrate this warmth and attention without the support of dyadic treatment.

Importance of Play

When appropriate given a child or adolescent's stage of development, play is used as an intervention in many attachment-based treatment models. Young children naturally

use play as a way to communicate their internal experience, master developmental tasks, and self-regulate and problem solve (Perry, Hogan, & Marlin, 2000). Caregiver reflection at times during play is particularly important because this further develops a child's sense of competency. When caregivers comment on what a child is doing, this fosters a sense of identity and competency; for example, a caregiver may exclaim, "Wow, you really like to build! That takes a lot of patience." Caregivers also foster a child's sense of self by supporting their ideas of what they may become in the future, such as when a child pretends to be a firefighter or doctor. Ongoing reflection from caregivers helps a child to internalize a unique self-identity, and to similarly begin to articulate interests and areas of strength. Blaustein and Kinniburgh (2010) identify the following aspects of self that children need to develop: the unique self, positive self, cohesive self, and future self. They note that young children lack the verbal or abstract thinking capacities to reflect on the self and therefore rely on adult narration to formulate meaning. If this has not happened because of trauma or neglect it inhibits the development of a secure sense of self. Moreover, children impacted by complex trauma often become inhibited in their ability to play, or use play as a way to repeat traumatic content without resolution, thereby causing further dysregulation. When a child's ability to play has been disrupted by trauma, attachment-based clinicians support the caregiver in facilitating this very important developmental process.

Therapeutic Models

Attachment, Self Regulation, and Competency. The Attachment, Self Regulation, and Competency (ARC) Framework is a systems-focused treatment model for children and youth impacted by complex trauma developed in partnership with the

National Child Traumatic Stress Network (NCTSN) (Blaustein & Kinniburgh, 2010). Based on their experience working with youth impacted by trauma, Blaustein and Kinniburgh (2010) created this framework to specifically address the three areas most often derailed by complex trauma: attachment, self regulation, and competency. Their work was inspired by their conviction that children impacted by complex trauma

> need a flexible model of intervention that is embedded in a developmental and social context and that can address a continuum of trauma exposures, including ongoing exposure. This model must draw from established knowledge bases about effective treatment while accounting for the skills of clinical practitioners and the needs of individual children. (Kinniburgh, Blaustein, Spinazolla, & van der Kolk, 2005, p. 424)

ARC first and foremost aims to build a stable attachment system upon which self-regulation and competency can be developed (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). Alongside the clinicians, this attachment system may include biological parents, extended relatives, foster or adoptive parents, residential program staff, and school personnel. ARC includes four specific interventions within the domain of attachment. The first of these is supporting the caregiver's regulation capacities. This is done by providing psychoeducation about the effects of trauma on the child, and, like this component of TF-CBT, intends to help depersonalize the child's problematic behaviors. While providing this psychoeducation, the clinician simultaneously validates the caregiver's responses and supports him or her in identifying, understanding, and managing affect under stress. The second intervention within the domain of attachment is fostering attunement between the caregiver and youth. Blaustein and Kinniburgh (2007)

define attunement as, "the capacity of caregivers and children to accurately read each other's cues and respond effectively," adding that it is, "the foundation for rewarding dyadic relationships" (p. 50). The third attachment intervention is supporting a consistent and appropriate response to a child's behaviors, and is similar to the skill-building approach of many parenting programs. The developers of ARC believe that this component often has limited success as a stand-alone intervention in such parenting programs, however, because it's predicated upon the development of caregiver affect regulation and attunement. The fourth and final intervention aimed at fostering stronger attachment is developing consistent routines and rituals upon which the child can rely. This helps the child feels safe and allows him or her to learn to adapt to these routines and improve self-regulation within this structured context. As evident from these interventions, caregiver involvement is essential for the success of ARC's attachment-based work, and continues to play an important role throughout the subsequent domains.

Self-regulation is the second major domain of ARC, and includes three specific interventions. Emphasizing the importance of this Kinniburgh, Blaustein, Spinazolla, and van der Kolk (2005) state,

> A young child who receives inconsistent, neglectful, or rejecting caregiving is forced to manage overwhelming experiences by relying on primitive and frequently inadequate coping skills such as aggression, dissociation, and avoidance. In the absence of resources needed to acquire the more sophisticated emotional management skills that other children develop, the child instead continues to rely on these primitive coping skills, which may lead to impaired functioning in multiple contexts. (p. 426)

The first self-regulation intervention therefore focuses on supporting the child with affect identification, including building an emotional vocabulary and identifying specific triggers to emotional states, as well as beginning to take note of their physiological responses to these triggers. The second intervention aims to develop strategies to support the child with modulation of affect so that they can develop increased tolerance for affective states. Such strategies could include breathing techniques, simple distractions such as listening to music or drawing, as well as other sensory-based interventions (Warner, Koomar, Lary, & Cook, 2013)**.** The final goal within ARC's self-regulation domain is affect expression. During this phase children are encouraged to share their emotional experience with clinician and caregiver, applying previously gained self-regulation skills so they don't become overwhelmed.

Developing competency is the final core domain of ARC. Developing concrete skills that support resilience helps children and youth feel competent in their ability to achieve future success. Because children who experience complex trauma often must focus their energy on survival, they don't always have the opportunity to develop age-appropriate competencies. As discussed in the second chapter, constant on survival impacts brain development in ways that can result in underdeveloped executive functioning. The first goal, then, within this domain is to support children with the processes of problem solving, planning, and outcome evaluation. This process may draw upon cognitive interventions that outline the links between thoughts, feelings, and behaviors and one's ability to influence these. With younger children, child-centered play with the active attunement of clinicians and caregivers is used to support this process. After this, the focus shifts to supporting self-identity and a personal narrative that

incorporates both past and present experience. This is somewhat similar to the narrative component of TF-CBT, but also includes a future-focused narrative of success. ARC culminates with a focus on traumatic experience integration in which children develop strategies to cope with potential triggers. This is especially important as many children impacted by complex trauma continue to live in environments plagued by a number of stressors including interpersonal violence and economic instability.

Research has begun to emphasize the need for a strengths-based approach to complex trauma treatment, such as emphasized in ARC's focus on resilience. Lyons, Uziel-Miller, Reyes, & Sokol (2000) found that building strengths for multi-victimized children in residential treatment programs reduced high-risk behavior and improved overall functioning regardless of any reduction of psychopathology. They therefore suggest that treatment plans include specific interventions to build strengths, rather than simply aiming to reduce problematic symptoms. Concluding their findings they state

> Most assessments focus on identifying psychopathology; clearly, understanding the strengths of children and adolescents has implications for both their functioning and the likelihood of high-risk behaviors. In reviewing case records, we have noted that often the generally required "strengths" sections of assessments are filled with statements such as "youth is a voluntary admission" or "youth likes to hang out with friends." The present findings suggest an evolving in the assessment of strengths in standard clinical care and documentation as an important priority. Second, it also may be that a part of the role of mental health services is to build strengths. A person may struggle with depression for his or her entire life, and the purpose of treatment may be to provide tools (e.g., a sense of humor, coping

> skills, social support) that help in this struggle. Understanding the effects of mental health services would thus require the assessment of new strengths that result from treatment experiences. Monitoring the development of strengths and making strength development an active aspect of treatment would be indicated by the present findings. (Lyons, Uziel-Miller, Reyes, & Sokol, 2000, p. 178)

In this study, identified strengths included a sense of humor, ability to enjoy positive life experiences, having a strong relationship with a sibling, involvement in a religious group or community services group, and identification of career aspirations. More recently, research by Griffin, Martinovich, Gawron, and Lyons (2009) found that the more strengths children in the child welfare system develop, the less likely they are to engage in high-risk behavior, even when faced with increasing traumatic events. Like Lyons et al. (2000) they propose a theoretical move away from diagnoses and trauma symptoms and toward a focus on strengths and resilience as a means of reducing the impact of trauma.

ARC has a flexible design that allows the clinician to integrate unique needs of the child and caregiver into the intervention (Blaustein and Kinniburgh 2010). These needs are identified by assessing current functioning and the developmental trauma history. ARC also acknowledges the fact that there are numerous cultural considerations that arise when working with populations affected by complex trauma. It therefore includes guidelines on how to adapt this model to meet diverse needs. Blaustein and Kinniburgh (2010) also advocate the use of symbols, metaphors, and activities from a child's culture to support the development of self-identify.

NCTSN collected program evaluation data on children treated with ARC and TF-

CBT and found that those who received ARC demonstrated a greater reduction in both internalizing and externalizing posttraumatic stress symptoms compared to those who received TF-CBT (ICF Macro, 2010). Other studies reflect similar outcomes from using ARC; research by Arvidson et al. (2011) children involved in the child-welfare system indicated that ARC significantly reduced self-reported behavioral symptoms and also led to an increase in rates of permanency (92%) compared to state averages (40%). Another study with adopted children by Hodgdon et. al (2013) demonstrated reductions of both clinician-reported PTSD symptoms as well as child and caregiver-reported behavioral symptoms. Caregivers also reported reduced distress and increased adaptive skills. Most recently, a pilot study of ARC into clinical and milieu programming at two residential treatment programs demonstrated a relationships between the use of ARC and reductions in PTSD symptoms. Particular attention was given to system-level processes and strategies for embedding ARC into the residential setting (Hodgdon, Kinniburgh, Gabowitz, Blaustein & Spinazzola, 2013).

Dyadic Developmental Psychotherapy. Dyadic Developmental Psychotherapy (DDP) is an attachment-based family therapy developed by Daniel Hughes, Ph.D., specifically designed to address issues associated with complex trauma. In the foreword to *Dyadic Developmental Psychotherapy: Essential Methods & Practices* (Becker-Weidman, 2010) Hughes summarizes the treatment goals as

> to facilitate the development on the attachment relationship between a child and his parent or caregiver, while resolving any trauma or loss that had impaired such development. DDP is similar to many models of psychotherapy in that it is grounded in the therapeutic relationship, including the experience of empathy,

which is probably the therapeutic factor that has the greatest 'evidence base' of all the factors that have been studies. Where DDP may differ from many 'relationship-based' models of psychotherapy is its specific emphasis on the attachment relationship for its organizing principle. In DDP the therapist is clear-not ambiguous-about the impact that the client is having on the therapist. In DDP the therapist is actively engaged in experiencing and communicating to his clients the impact that they are having on him. The therapist is actively discovering strengths and vulnerabilities of the client that lie under the client's behaviors (or symptoms) and in so doing enabling the client to discover the same qualities. In DDP the therapist is creating safety for the client through his consistency, predictability, and boundaries, as well as his active expression of the attitude of PACE (Playful, Accepting, Curious, and Empathetic).

All of these features are also central in the infant or older child's attachment security that develops with his parent or caretaker. While DDP strives to have the client experience the therapist's active presence in a manner similar to how a child experiences the presence of the child's parents or caregiver, even more importantly, DDP strives to develop the child-parent relationship along the same principles. For this reason, DDP is primarily a model of family therapy, not individual therapy. The DDP therapist chooses the individual treatment modality when the child or adolescent does not live with a caregiver who is committed and able to become a source of attachment security for the child or adolescent. (Hughes, 2010, p. vii-viii)

Like ARC, DDP seeks to repair the negative internal working model of children impacted by complex trauma using an experiential approach, also referred to as enactment. As described by Hughes (2004), DDP is an active, affect modulated experience. This approach includes enacting the healthy attachment cycle, including providing safe and comforting physical contact and the interpersonal regulation of affect. Treatment involves multiple repetitions of the caregiver-child attachment cycle. This cycle begins with shared affective experiences, which at some point leads to a rupture in the relationship, and then ends with the reattunement of affective states. Another important aspect of this process is helping the child be able to tolerate the affect associated with past traumatic events in order to integrate these events and therefore reduce dissociation. While maintaining an intersubjective attuned connection, the clinician and caregiver help the child construct a narrative of past experiences.

The development and maintenance of an affectively attuned relationship between clinician, caregiver, and child sets the stage for all DDP interventions. The clinician and caregiver unconditionally accept the child's affect and behavior and use a stance of curiosity in order to better understand the latent motivation. The therapeutic relationship must be strong enough to support the child in reflecting upon aspects of traumatic memories and experiencing the associated affects without becoming dysregulated. This process enables the child to make sense of memories, a left brain function, while simultaneously regulating affect, a right brain function. Non-verbal communication such as eye contact, tone, posture, and physical contact all play an important role in this (Gray, 2002).

DDP sessions typically last about two hours and include the clinician,

caregiver(s), and child. The caregivers are in the treatment room most of the time, but if they are not they continue to view treatment from another room by closed circuit TV or a one-way mirror. The usual structure of a session involves three segments. First, the clinician meets with the caregivers and provides psychoeducation and instruction in attachment parenting methods (Gray, 2002). The caregiver's own issues that may create difficulties with developing affective attunement with their child may also be explored. Throughout this, caregivers receive support and are given the same level of attuned responsiveness that they will then provide for the child. When there are ongoing problematic behaviors, caregivers may feel blamed, devalued, incompetent, depleted, and angry, and this part of the process enables caregivers to be better able to maintain an attuned connecting relationship with their child. After this, the clinicians and the caregiver meet with the child for approximately one to one-and-a-half hours. During this time the focus is on the previously described affective attunement, enactments, and cognitive restructuring. Finally, the clinician meets with the caregiver alone again to discuss ways to create structure to provide safety and ongoing attunement for the child at home and school.

A study by Arthur Becker-Weidman (2006) examined the effectiveness of DDP in an outpatient setting. All 64 participants were between five and seventeen, met the DSM-IV criteria for Reactive Attachment Disorder, had past or current involvement with child protection agencies, and all had histories of chronic maltreatment. Some children were in the care of biological parents and some were in foster care. The study evaluated changes in symptoms using the Child Behavior Checklist (CBCL) and Randolph Attachment Disorder Questionnaire (RADQ) and found that those treated with DDP had significant

reductions in symptoms of attachment disorder, withdrawn behaviors, anxiety and depression, social problems, attention problems, rule-breaking behaviors, and aggressive behaviors. The control group showed no change in symptoms. In 2008 Becker-Weidman and Hughes conducted a follow-up to this study that indicated that the positive changes reflected in the results were maintained in the majority of participants after one year. Encouraging further research on treatments specific to complex trauma they state

> Children with the symptoms of attachment disorder and antisocial behaviors are very likely to continue these behaviors in adulthood. In addition, children with trauma-attachment disorders are more likely to develop severe personality disorders, such as Borderline Personality Disorder, Sociopathic Personality Disorder, Narcissistic Personality Disorder, and other personality disorders in adulthood. For these reasons, it is vital that effective treatment for children with trauma-attachment problems be developed and validated. DDP appears to be one such treatment.

Conclusion

By intervening at the systems level, the models I've discussed provide a treatment framework that can allow clinicians to better conceptualize and target problems that are contributing to a child's symptoms. These models aim to produce long-term treatment effects by encouraging more adaptive patterns of behavior and interaction among the youth and other important individuals, beginning with developing a secure attachment between a child and his or her caregiver. Additional research with larger sample sizes is definitely needed, but a strength of the research that does exist is that it is specific to trauma-attachment disorders related to complex trauma. In the next and final chapter, I

will reflect back on the clinical considerations outlined in Chapter II to examine the ways both systems-focused, attachment-based models and individually-focused, cognitive-based approaches can inform the treatment on complex trauma using case examples.

CHAPTER V

Discussion and Conclusion

In this final chapter I will discuss how each theory reviewed in the preceding chapters contributes to the treatment of complex trauma. I will compare the strengths and limitations of the representative models from these theories, and use a case example to discuss how interventions from both could be combined to create a comprehensive approach to treatment. The chapter will also include implications for clinical social work practice with a focus on cultural considerations. It will conclude with a discussion of the limitations of this study and recommendations for and how this review informs further research on this topic.

Review and Analysis

Spinazzola et al. (2005) explain how children and youth exposed to multiple ongoing traumatic events face the "dual problem of exposure and adaptation" (p. 433). This ongoing trauma often takes multiple forms, referred to as poly-victimization (Finkelhor, Ormrod, & Turner, 2007), including neglect, physical, sexual, verbal, and emotional abuse, and witnessing domestic and/or community violence. Each of these forms of trauma indicates the pervasive danger within which these young people are developing, and underscores the importance of intervening at the systems level. Systems-level work emphasizes including the family and other systems that surround children and youth, such as schools and community centers. This involves providing therapeutic

services as well as helping to create more trauma-informed environments. Moreover, because many of these traumatic experiences are of an interpersonal nature, children often learn to believe that relationships with others are unsafe. Clinicians must therefore be informed about how this can impact the treatment relationship and provide ample psychoeducation to caregivers so that they can respond with empathy and patience. For example, a child may interpret the clinician and/or caregiver's attempts to provide support as threatening, which may lead the child to withdraw or express anger or even violence. Without a sufficient understanding of the impact of trauma on attachment, this response may be perceived as defiance and the child may be reprimanded or alienated.

Working with individuals who have undergone multiple traumas requires attention to all of the clinical considerations discussed in Chapter II. In order to address these multifaceted issues, it can be helpful for clinicians to draw from several theoretical frameworks. Emphasizing the need for a multidimensional approach, Schmid and Goldbeck (2010) note in their study abstract that

> the psychotherapy of severe and complex trauma during adolescence is challenging because trauma-associated symptoms like attachment problems, the expectation of self-inefficacy, and dissociation may complicate therapeutic work and limit treatment outcome. Also, unless root causes of the trauma are addressed, these will continue to promote and exacerbate symptoms.

When feelings of self-inefficacy are an issue, clinicians must pay careful attention to the therapeutic alliance to support continued engagement. In many cases, this relationship will take significant time to develop with children who have a hard time trusting others due to multiple betrayals of trust. Also, the noted attachment problems speak to the need

for attachment-focused work with the therapist and the caregiver. The complication of dissociation speaks to the need for the sensory interventions, as dissociation is a tendency to disconnect from one's body when overwhelmed by emotions (Warner, Koomar, & Cook, 2013). Finally, the importance of addressing root causes reiterates the need for systems work. In order to achieve and maintain long-term success, the treatment approach must include all of the systems of which a child is part. Clinicians can support this by including caregivers in attachment-focused treatment. They can also provide psychoeducation to all of the adults involved in a child's life to promote a deeper understanding of the impact of complex trauma, as well as the risk of vicarious trauma and the importance of self-care (Esaki & Larkin, 2013).

The biggest difference between the attachment-based models and the cognitive-behavioral models I've reviewed is the extent to which the caregiving system is involved. By their very nature the attachment-based models are systems focused because their primary goal is to support secure attachments. The cognitive models are more individually focused but do include caregivers for some components of the treatment. Rather than focusing on intersubjective enactments, the cognitive-behavioral models focus more on the child's internal experience and the associated feelings and behaviors, and work toward shifting these to become more adaptive.

Another major difference is that the attachment-based models place greater emphasis on experience and process, whereas the cognitive models focus more on verbalization and content. In order to connect with the experience and process, the attachment-based models must rely heavily on the clinician and caregiver's use of self. This requires that clinicians and caregivers maintain awareness of their own attachment

patterns and countertransference. Foroughe and Muller (2011) note the importance of remembering that in cases of complex trauma, many times caregivers themselves are victims of cycles of trauma, and they stress the importance of offering them ongoing support with self-regulation and processing their own stories. Hughes (2004) echoes this and also emphasizes the need for clinicians to engage in regular supervision and possibly also in individual therapy to process strong countertransference responses that arise and may be a reflection of a disrupted attachment history; he states,

> In this model of psychotherapy, which is so much based on the use of the self within the here-and-now intersubjective space, the attachment history of the therapist is likely to be activated more than it is in other models, and it is even more important that it be resolved. (p. 267)

A final distinction is that TF-CBT, DBT, and DDP are manualized models with their own specific interventions, whereas ARC is a framework for treatment. Manualized models usually follow a specific sequence and a specific timeframe. ARC allows for interventions from various models to be dropped into this framework based on the given needs. It also has an open timeframe and sequence within the three domains. With this greater flexibility comes a need for more prudent clinical judgment based on ongoing assessment and reflection with the child or adolescent.

The literature I reviewed reflects that increasingly sensory interventions are being integrated into both therapeutic approaches to support the inextricable link between emotional and physical regulation. Because trauma is often processed in nonverbal realms (Perry, 2001), many researchers contend that applying only cognitive-behavioral interventions for children and adolescents impacted by complex trauma may not be the

most effective approach (Eichler, 2012; Rothschild, 2000). Moreover, simply focusing on the child-caregiver attachment may not be enough without attention to the body. As Rothschild (2000) states, ‘‘Trauma is a psychophysical experience, even when the traumatic event causes no direct bodily harm” (p. 5). Rothschild talks about how trauma leaves an imprint on the body and becomes a subconscious memory. In cases of complex trauma, cognitive-behavioral and attachment interventions can follow or can be done alongside sensory interventions.

Given the complexity of treatment with this extremely vulnerable population, flexibility in terms of length of treatment, interventions used, and caretaker involvement can maximize positive outcomes. One of the most exciting but also challenging aspects of working with cases of complex trauma is that because of such a multitude of factors every case is so unique and may require a different approach. As mentioned in Chapter II these factors include age of onset, type of trauma, relationship to perpetrator, current living situation, and cultural considerations (Perry, 2001). Ford and Courtois (2013) conclude that the most effective therapeutic approach to address all of this involves “clinical creativity, guided by sound clinical theory, evidence-based assessment, wise clinical judgment, and an evolving evidence base” (p. 350).

Approached separately, cognitive and attachment-based treatments may address only a single domain, such as processing of negative experiences or rebuilding child-caregiver bond; however, taken together these approaches can offer a comprehensive approach to complex trauma. I will use the following case example to illustrate how these approaches could be combined. Of course as the literature stresses, ultimately determining how to approach a case requires working closely with the child to identify

his or her problems, needs, goals, and strengths.

Case Example

Maria is a 14-year-old girl who has been involve with child protective services (CPS) for most of her life. From 2 to 4 years of age she was sexually abused by her mother's boyfriend. When it was discovered, CPS placed her with an aunt, who turned out to be both emotionally and physically abusive. She returned to live with her biological mother once, but was removed again due to her mother's drug use and eventual incarceration. When her mother completed her sentence, she left the state without notifying CPS or seeing Maria. Maria remained with her aunt, in a neighborhood characterized by criminal activity and violence. In the home, Maria's aunt and uncle often fought physically, and to escape, Maria began to spend more time away from the house, with a group of older adolescents who frequently abused alcohol and drugs. At age 13, one of the older teenagers raped her. She remained a part of the group, and later referred to the perpetrator as her boyfriend. Her teachers were concerned that she seemed to change from outgoing, popular, and studious to angry, defiant, and at times even apparently purposely vengeful and cruel toward peers and adults. Maria became involved with the juvenile justice system after she and these peers were fleeing from police and crashed their car into a telephone pole. One of the girls in the group died in the accident. Maria made three serious suicide attempts prior to the age of 14—each following an alcohol binge and prescription drug use. The last attempt resulted in residential treatment for more than a year. When asked about feelings of depression, Maria claims that she has been "this way" all of her life and often finds herself thinking that the hurt and pain are just not worth living through. Maria engages in self-mutilation and often uses this as

means “to get back at” others who hurt and disappoint her. In school, Maria reportedly has difficultly paying attention in class and frequently skips class and leaves school grounds without permission, often saying that being in school “makes me so sick that I get migraines or have to puke.” Her teachers complain that she seems lost in thought, as though she is mentally someplace else. Maria reportedly experiences frequent nightmares of being attacked by “monsters with no faces,” and she endorses symptoms that are characteristic of posttraumatic stress disorder (PTSD), including intrusive thoughts of past abuse, feeling “on edge” and unsafe, and using marijuana to escape these thoughts and feelings. Also prominent are Maria’s problems with interpersonal relationships, which tend to be unstable and filled with conflict. Maria claims that she cannot trust anyone because everyone she has tried to be close to has “stabbed her in the back.” According to residential treatment facility staff, Maria is quick to anger, and her behavior is difficult to manage. Staff often has to implement hands-on restraints to stop her from physically attacking peers when she feels “disrespected.” (Ford and Courtois, 2013)

What’s most striking about this case is the sheer number of traumatic events this still very young adolescent has faced. It is a clear example of how victims of early trauma can become increasingly vulnerable to subsequent adversities. Also, although Maria does endorse symptoms of PTSD, she faces additional symptoms that do not fit into this category. In chapter II I discussed how although van der Kolk’s proposal of Developmental Trauma Disorder (DTD) did not make it into the recently published DSM V, many feel the need for a diagnosis more representative of cases like this.

Maria is struggling with attention, impulse control, interpersonal relationships, and emotional regulation. She also seems to be experiencing symptoms of somatization

in the form of migraines. The impact on her self-esteem is evidenced by the fact that she aligns herself with someone who raped her and by her report that she has been "this way" her whole life. The first step in working with someone like Maria would involve developing safety and self-regulation skills. These could include coping skills, CBT techniques, and sensory interventions. Throughout this work it would be essential to remain very cognizant of how Maria's disrupted attachment patterns may surface in the therapeutic relationship. The clinician would help Maria and the adults in her life understand the connection between her behaviors and her overwhelming feelings. The clinicians and caregiver could then begin to support her in identifying and making sense of what some of these feelings. Again, it would be important to remain very attuned to her body language, moods, and overall engagement. It would also be important to regularly check-in with Maria about this so that adjustments could be made if necessary, and so that she feels more aware of her own needs and in control of her treatment.

It is possible that Maria's mother or aunt could be included in attachment-focused therapy; however, since she currently resides in a residential facility, another possibility would be to include a staff member with whom she feels comfortable to serve as the caregiver within treatment (Cohen et al., 2012). This person could support Maria with identifying her feelings as they arise in various situations in this environment, which would give her the experience of empathic attunement that she's so greatly lacked. The staff member could also work with Maria and her clinician to practice emotional regulation techniques and then help her implement these when she becomes overwhelmed. Over time this process of co-regulation could strengthen Maria's limbic

pathways and lead to the capacity for more independent self-regulation. This work can be done without a caregiver; however, Hughes (2004) explains the limitations of this:

> Attachment-based treatment can be utilized within the individual treatment format without the presence of a caregiver, but it must then be done so with even greater concern for safety. The therapist must set a slower pace since the child does not have a secure attachment outside of treatment to assist him in regulating and integrating the therapeutic experiences. Such a pace is also necessary because, without the supportive presence of an attachment figure, it will be more difficult for the therapist, alone, to co-regulate the affect associated with the emerging themes. (p. 276)

Furthermore, from a systems level perspective, it would be essential to provide psychoeducation to Maria and her caregivers (family, teachers, residential staff, etc.). Her teachers, for example, might penalize her for checking out during class because they are unaware that this is a symptom of trauma. The clinician could help them better understand her symptoms and needs to create a more attentive and supportive learning environment. Psychoeducation would be a piece of this, as might be creating a space where Maria could go to use sensory techniques to de-stimulate when she becomes triggered.

It would also be helpful to assess Maria's strengths and support her in further developing these, along with building additional competencies. Increasing her protective resources could include connecting her with a therapeutic and/or peer mentor. It would also involve helping her foster healthier boundaries and attachment patterns in her current relationships. Of course, given the plethora of traumatic experiences in a case like this,

treatment outcomes can be limited, which I will further comment on in the following section. Finally, cultural information is not provided in this case example, but in the next section I will discuss how clinicians can account for cultural factors more generally in clinical social work practice.

Implications for Clinical Social Work Practice

As noted in Chapter II, incidents of complex trauma are common in low-income neighborhoods where stressors often exist not only within families, but also within the surrounding community. Such communities often contain diverse groups of people, including both those who have lived there for generations as well as recent immigrants. Griner and Smith (2006) propose four basic methods to facilitate effective cultural adaptations. First, they suggest incorporating cultural values and the context from which they emerged into the interventions. For example, certain cultures may not support extensive emotional expression during the grieving process, but rather understand death as God's will, and therefore believe that the aftermath must focus on strength and moving forward. Second, these authors suggest that whenever possible clients get matched with clinicians of the same race/ethnicity who are fluent in their primary language to increase client perceptions of clinician understanding. Brown (2009), on the other hand, cautions that feeling the need to be seen as similar to one's client can disrupt the therapeutic alliance. He emphasizes the importance of acknowledging and embracing a stance of unknowing when it comes to understanding another's experience based on facts such as skin color, gender, or sexual orientation. He expresses concern that clinicians who are observably different from a client may internalize the idea that they are less equipped to serve this client, which can

> disconnect otherwise emotionally competent psychotherapists from their willingness to be uncertain and tentative with clients who represent the cultural other. Because of the problematic narrative of etic competence, psychotherapists frequently experience themselves as more different, more deficient, and less competent to consider engaging with clients who visibly differ from them. In work with survivors of complex trauma, where the psychotherapist's own emotional responses will be captured, read, and interpreted by clients whose interpersonal realities have been dangerous and confusing, the presence of such distortions, and the performance anxieties placed upon themselves by therapists to emit evidence of etic knowledge, can lead to serious, difficult-to-repair ruptures in the therapeutic alliance." (Courtois and Ford, 2009, p. 171)

Griner and Smith's (2006) third guiding principle is one at the core of all quality care: interventions should be easily accessible, flexibly scheduled, and sensitive to the life demands of the clients. The fourth and final point they make is that clinicians should work collaboratively with supportive resources compatible with the client's community, spiritual traditions, and extended family; in other words, systems-level work.

As I will note in the next section, much still remains unknown when it comes to effective treatment outcomes, and this is important to consider when working with cases such as Maria's. As we begin to better understand the impacts of complex trauma on development, new models are being developed and modified in hopes of creating long-term treatment gains, but many children continue to struggle even after receiving treatments specifically designed to address complex trauma. What is clear, however, is the need for clinicians to receive substantial support in the form of individual and group

supervision, continued professional education, and a healthy life-work balance to prevent vicarious traumatization and burnout when working with such challenging and often heartbreaking cases.

Limitations of This Study and Recommendations for Further Research

All of the treatments approaches I've reviewed have been developed within the past ten years. Indeed, it is only relatively recently that we have begun to more deeply understand the neurodevelopmental impact of complex trauma, and to subsequently develop treatment specific to this complicated phenomenon. Although research and anecdotal reports now exist for a number of promising models and frameworks, much further studies are needed to fully elucidate their effectiveness. Additional randomized control studies specific to cases of complex trauma that focus on treatment outcomes and include longitudinal studies tracking sustainability of treatment gains are needed for all of the approaches. Also, further research with more diverse populations is needed, particularly that which documents cultural adaptations. Finally, the impact of the therapeutic alliance, the length of treatment, and the role of the caregiver merit further study to determine how these variables affect treatment outcomes.

This study is limited because it does not include empirical analysis of the approaches. Also, although I have worked with many children and adolescents with experiences of complex developmental trauma and have drawn from all of these theories and interventions, I haven't been officially trained in any of these approaches. One can learn a lot about a particular model by reading about it and analyzing the related research, but understanding remains limited until one experiences formal training, implementation,

and evaluation. This theoretical study served to advance my personal understanding of the complexities faced by these children and how different treatments can promote healing and resiliency. Of the many things I learned throughout this research, what stood out most was the importance of cultivating the relationships between clinician, child, and caregiver regardless of the specific interventions used. Because forming attachments can be so difficult for children who have experienced interpersonal trauma, developing such relationships requires attention to the potential functions of a child's behaviors along with ongoing attunement to their emotional state. It also requires flexibility in terms of the length and approach to treatment. Including a caregiver can prove invaluable, however, not only because it provides an opportunity to foster this attachment, but also provides a continuation of this support outside of the clinician's office. Involving as much of the child's system as possible provides the comprehensive support that is more likely to lead to lasting resilience.

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