Models for Addressing Complex Trauma

1. Introduction

1.1 Introduction

Welcome to the National Adoption Competency Mental Health Training for Mental Health Professionals. This lesson is: Models for Addressing Complex Trauma, which focuses on trauma-informed treatment models to enhance your clinical practice.

1.2 Section 1: Lesson Objectives

At the end of this lesson, you will be able to synthesize therapeutic interventions in your clinical practice that:

- Establish safety and readiness to process emotions
- Build coping and regulatory skills with children and youth
- Assist parents to provide structure and routines, experiences that nurture and heal, and
- Support the development of coping and self-regulation strategies

1.3 Lesson Overview

Given the nature of complex trauma, treatment itself is complex. Treatment must be sequenced or phase-based over time. Dr. Christine Courtois describes the sequencing of healing tasks across several main stages of treatment for complex trauma:

1. Pre-treatment assessment
2. Early stage of safety, education, stabilization, skill-building, and development of the treatment alliance
3. Middle stage of trauma processing and resolution
4. Late stage of developing self-esteem, identity, and relational skills

The therapeutic work overlaps throughout the stages and there is often a need to rework stabilization skills over the course of treatment.

As each stage builds on the previous work, the child or youth acquires growing control and mastery that directly counteracts the powerlessness of victimization and its continuing after-effects.

2. Trauma Treatment and Brain Functioning

2.1 Trauma Treatment and Brain Functioning

We know that trauma, especially complex trauma, interferes with brain development and disrupts optimal brain functioning. Let’s look at a framework for understanding the role of the brain in trauma treatment.

2.2 Brain-Based Approaches

Brain-based approaches to trauma treatment can be described as "top down" or "bottom up". This graphic from the National Institute for the Clinical Application of Behavioral Medicine illustrates these two approaches.

Top-down interventive approaches are based primarily on talk therapies that use insight-oriented discussion and psychoeducation to help the client modify thoughts, emotions, and behaviors.

Bottom-up approaches are largely experiential in nature. They seek to repair brain deficits from early trauma, to calm the hyperarousal response, and to establish a sense of safety. These interventions emphasize sensory, motor, and relational activities to stimulate brain reorganization and regulation.

We will be focusing on the "bottom up" approach because we have learned that these treatment modalities have greater efficacy than more insight-oriented approaches.

2.3 Addressing Developmental Trauma from the Bottom Up

Current trauma experts, such as Drs. Bessel van der Kolk and Bruce Perry, assert that beginning with talk therapy is unlikely to work with children who have experienced early and ongoing complex trauma and who have significant brain deficits. They will likely need to experience a "bottom-up" approach to healing.

As we have learned, children's brains develop from the bottom up. This graphic depicts three levels of the brain including the brainstem, limbic brain, and cortical brain. Each of these levels is composed of multiple brain structures.

A number of strategies discussed in this lesson seek to enhance the functioning of the primitive brain, which regulates autonomic responses, and the limbic brain, which regulates attachment and emotional development. Healing at these levels prepares a child to make use of the cortical brain in therapies such as Cognitive Behavior Therapy.

2.4 Neurosequential Model of Therapeutics (NMT)

A model which conceptualizes the "bottom up" principle of trauma treatment is Dr. Bruce Perry's Neurosequential Model of Therapeutics (NMT).

Dr. Perry explains that this model "*allows identification of the key systems and areas in the brain which have been impacted by adverse developmental experiences, and helps target the selection and sequence of therapeutic, enrichment, and educational activities* (2009, p. 240)."

2.5 Activities of the Therapist Informed by NMT

NMT is an assessment lens to complement other assessment elements and to inform treatment. It involves 3 activities of the therapist:

1. Completing a developmental history
2. Assessing current functioning, including brain mapping, and
3. Recommending a sequence of interventions and enrichments

NMT emphasizes starting with the lowest part of the brain and moving in sequence to higher parts of the brain. Changing the brain requires targeting the neural systems that mediate the individual's symptom array with therapeutic activities providing patterned, repetitive, sensorimotor activities.

2.6 Attending to the Level of Brain Functioning

For optimal effectiveness, assessment and interventions need to involve all parts of the child's or youth's life. Felt safety and healthy relationships are foundational to all interventions, and multi-disciplinary approaches may be needed.

Here again is the graphic for NMT, which illustrates the focus for addressing deficits at each level of brain functioning across the systems in the child's or youth's life.

After determining what level of brain functioning is the most important to target first, treatment will focus on specific goals at each level. Click each level to learn more.

1. Primitive brain: Develop felt safety and stability at home and in school and increase the child's or youth's sensory-motor regulation, particularly in calming stress responses

2. Limbic brain: Form secure attachments and regulate emotions and behavior, primarily through therapeutic parenting and processing traumatic memories

3. Cortical brain: Develop the child's or youth's sense of identity and mastery, integrate their life story, and strengthen reciprocal relationships

2.7 Repairing Developmental Trauma

The 6 R's are a framework that were developed by Dr. Bruce Perry and can support our work therapeutically. This framework helps parents to create the developmental experiences needed to heal trauma and incorporate these experiences into their daily interactions, which promotes the child's regulation, ability to relate, and reason.

These experiences are:

- Relational (which creates emotional safety for the child or youth)
- Relevant (which is developmentally matched to the child or youth)
- Repetitive (which is patterned)
- Rewarding (which is pleasurable, affirming, or motivating)
- Rhythmic (which is resonant with a child's or youth's neural patterns)
- Respectful (of individual child or youth, family, and culture)

In order to impact a poorly organized brainstem and the related dysregulation, attention, arousal, and impulsivity, Dr. Perry recommends *"any variety of patterned, repetitive somatosensory activities (which provide these brain areas with the patterned neural activation necessary for reorganization), such as music, movement, yoga (breathing), and drumming or therapeutic massage."*

Dr. Perry also states *"Once there is improvement in self-regulation, the therapeutic work can move to more relational-related problems (limbic) using more traditional play or arts therapies; ultimately, once fundamental dyadic relational skills have improved, the therapeutic techniques can be more verbal and insight oriented (cortical) using any variety of cognitive-behavioral or psychodynamic approach"* (Perry, 2009, p. 252).

2.8 Additional Brain-Based Approaches

While NMT is gaining popularity, there are other brain-based approaches that are being developed and studied. Therapists may want to consider or learn more about the following approaches in their practice. Click each of the approaches on the screen to learn about them.

Neurofeedback: Neurofeedback is a type of biofeedback that aims to change the way the brain responds to certain stimuli. Brainwaves are measured to provide real-time feedback about how the brain reacts to certain triggers to help teach self-control of brain functions.

Mindfulness Meditation: Studies have indicated that practicing mindfulness meditation regularly can measurably change structures of the brain related to learning, emotional regulation, and introspection.

Eye Movement Desensitization and Reprocessing (EMDR): The first three stages of Eye Movement Desensitization and Reprocessing (EMDR) focus on identifying core issues, teaching client coping skills, and mapping out how the core issues might be desensitized and reprocessed. These stages guide the brain in creating healthier neural networks.

Brainspotting: Brainspotting is a newer brain-based therapy that involves identifying and focusing on "brainspots" or eye positions correlating with stored traumatic experiences. Using these eye spots taps into implicit memory networks and can unlock powerful material previously untouched by verbal approaches.

3. Therapeutic Parenting

3.1 Therapeutic Parenting

A primary pathway for healing trauma at all three levels of brain functioning is therapeutic parenting.

3.2 Creating Healing Environments

Parents are primary change agents for helping to build their child's self-esteem and structuring a healing environment throughout their life. They help to calm the stress response by facilitating felt safety and using therapeutic parenting strategies to develop their child's emotional and behavioral regulation.

3.3 Trust-Based Parenting Video

Let's watch this video made by Drs. Purvis and Cross, the creators of TBRI®. They describe the need for therapeutic parenting in healing trauma.

[Video Transcript]

DR. KARYN PURVIS: Well, the title tells you everything that we value. TBRI, Trust-Based Relational Intervention, has at its core, building an attuned, trusting relationship with our child. It has three sets of principles, and they deal with and look at the child as a whole.

CHILD: [TO FEMALE] Can you open this for me, please?

FEMALE: [TO CHILD] I sure can.

DR. KARYN PURVIS: We empower the bodies of the children.

DR. KARYN PURVIS: [TO CHILD SHE HOLDS] Because the kids won't know what a sweet heart you have.

DR. KARYN PURVIS: We connect to the little spirits of the children. And then we have a great set of principles that are called correcting principles.

DR. KARYN PURVIS: [TO CHILD] Can you ask, not tell Mama? Say, "Could I please have my fireball back?"

DR. KARYN PURVIS: And in these principles we help parents learn how to redirect their child's behavior, while still being deeply connected; while still being deeply empowering.

DR. DAVID CROSS: Our kids have experienced what I would call relationship-based traumas. They've been abandoned; they've been neglected; they've been abused; they've been institutionalized. Problems that are formed in the context of relationships can only be healed in the context of relationships.

FEMALE: [HOLDING CHILD'S FACE] I love you. You know?

DR. DAVID CROSS: The relationship is the focus; the relationship is the context. Without the relationship, we can make no progress whatsoever. So that has to be the focus--the central focus--of what we do. And relationships are based on trust.

MALE: [WITH CHILD, LOOKING AT A BIKE] You want to try it?

DR. DAVID CROSS: What we're asking children to do is give up strategies. These are the strategies that they've lived with their entire life, and they've survived.

MALE: [TALKING TO CHILD ON BIKE] Good job.

DR. DAVID CROSS: And we're asking them to give those strategies up for new strategies. Well, why would they do that if they don't trust us? So that trust has got to be the foundation for real change.

CHILD: [POINTING TO PIECE OF PAPER HE HOLDS; TO MALE] These go right here.

DR. DAVID CROSS: And that trust is based upon, not perfection in us as parents, but in our wanting what's best for that child.

MALE: [TO CHILD RIDING BIG WHEEL] There you go. Go, go, go, go!

DR. DAVID CROSS: That's where the trust is going to come from. And our being available to that child when they need us.

[FAMILY STANDING OUTSIDE TALKING TO CHILD WITH BIKE]

DR. KARYN PURVIS: Who's your buddy right now?

MALE: Either me or Mom, okay?

[End of Video]

3.4 Therapist Role in Therapeutic Parenting

As therapists, you have an essential role in teaching parents therapeutic parenting skills to complement your therapeutic interventions. ARC and TBRI are two such models developed for children and youth experiencing complex trauma. These promising practices were introduced in earlier modules, and we will explore them further in Module 9 on Therapeutic Parenting.

In the next section, we will look at specific interventions for treating trauma in children and adolescents.

4. Trauma-Focused Interventions

4.1 Trauma-Focused Interventions

In this section, we discuss three well-established clinical interventions to address the impact of trauma on children and youth: Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Child Parent Psychotherapy (CPP).

4.2 Trauma-Focused Cognitive Behavior Therapy (TF-CBT)

Trauma Focused Cognitive Behavior Therapy (TF-CBT) is the most widely used and evidence-based treatment model for child trauma.

In TF-CBT, there are individual sessions for the child and for the parents or caregivers and joint parent-child sessions.

Forming a therapeutic relationship with the child and parent is critical to TF-CBT.

4.3 P.R.A.C.T.I.C.E.

The acronym PRACTICE summarizes the specific components of TF-CBT. Click on each lettered block to learn more.

P: Psychoeducation is provided to children and their caregivers about the impact of trauma and common childhood reactions. Parenting skills are provided to optimize children's emotional and behavioral adjustment.

R: Relaxation and stress management skills are individualized for each child and parent.

A: Affective expression and modulation are taught to help children and parents identify and cope with a range of emotions.

C: Cognitive coping and processing are enhanced by illustrating the relationships among thoughts, feelings, and behaviors. This process helps children and parents modify inaccurate or unhelpful thoughts about the trauma.

T: Trauma narration, in which children describe their personal traumatic experiences, is an important component of the treatment.

I: In vivo mastery of trauma reminders is used to help children overcome their avoidance of situations that are no longer dangerous, but which remind them of the original trauma.

C: Conjoint child-parent sessions help the child and parent talk to each other about the child's trauma.

E: Enhancing future safety and development, the final phase of the treatment, addresses safety, helps the child to regain developmental momentum, and covers any other skills the child needs to end treatment.

4.4 TF-CBT Video

Let's watch *What is Trauma Focused Cognitive Behavior Therapy?*

[Video Transcript]

KELLY WILSON, LCSW: Trauma-Focused Cognitive Behavioral Therapy, TF-CBT, is a highly-researched treatment model for children who have been through abuse.

CLARE LUCAS, MS, LPC-S: What I love about it is that it really helps families heal together. So it not only focuses on the child, but it actually focuses on the caregiver and the other family members as well.

JULIE PRUDHOME, MA, LPC-S: We've had some really good outcomes with parents being able finally to address their own thoughts and feelings about all this, but then that allows them to then support their child.

KELLY WILSON: It can take away the fear parents might have of, "This is going to mess up their whole life." They see their kid as a kid who says, "Yeah, this happened, but I'm still a great kid."

CLARE LUCAS: One of our goals in TF-CBT is to work ourselves out of a job and put the parent in place. And so we work very actively with the caregiver, as well as the caregiver and child together, so they are able to talk with each other once therapy has ended.

JULIE PRUDHOME: TF-CBT is made up of, actually, several different components that address all the different areas that are impacted by trauma. So we're dealing with the affective realm, which is feelings; we're dealing with cognitions, which is what kids think; and we're also dealing with how their bodies are responding. So it really covers kind of the whole range of problems that kids can develop.

KELLY WILSON: There's also a trauma narrative component that used to capture the story of the abuse, and to really give it a beginning, a middle and end, so that the child can integrate the feelings, the thoughts, the experiences, into a cohesive story that can then be carried forward in a meaningful way. Trauma narratives can be very creative. They can be written; they can be collages. It can be acted out with young children or drawn in pictures. But it's a way for the child to separate the story from themselves and look at it from a different perspective. To really be able to think back on it in a different way, to separate the past and the present.

CLARE LUCAS: I recently had a client that was a ten-year-old female. She came into Children's Safe Harbor and made a outcry of sexual abuse against her biological father. At first she was very avoidant about talking about the trauma, which is very normal. Mom also had a very difficult time, _____ because it was her husband. And so over the course of treatment we were able to help Mom with the guilt that she felt. The ten-year-old was able to start gradually, over time, talking about the trauma that had occurred and was able to realize that it was not her fault.

KELLY WILSON: The conjoint session that happens after the narrative is a very healing session, in which the child and caregiver come together and the child shares the story. It can be an extremely healing session, in which the story comes out into the open and everyone shows that they are more powerful than that story; it no longer holds control over them.

JULIE PRUDHOME: One of the effects of sexual abuse, a lot of times, is that it separates the child emotionally from their caregiver. Now the child has a huge secret that their parent can't know about. And with TF-CBT we really empower the child and the parent to be able to talk about this.

CLARE LUCAS: So they leave with new coping skills, as well as a new relationship, where hope can continue and trust continues to grow.

KELLY WILSON: TF-CBT is a model that can be taught to clinicians anywhere.

JULIE PRUDHOME: TF-CBT has made a really big impact on the way that I do therapy, and it's made the therapy that I do a lot more effective.

KELLY WILSON: Parents see not, "My child is going to be messed up forever," but, "My child is really a hero; my child is really a fighter. My child really is a warrior and has come through the other side."

[ON-SCREEN TEXT] Texas leads the nation in the number of clinicians certified in the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Thanks to The Meadows Foundation Blue Cross and Blue Shield of Texas for grants to train clinicians in TF-CBT at Texas Children's Advocacy Centers

[End of Video]

4.5 TF-CBT Reflection

What are two key points that you learned about the strengths of TF-CBT as a trauma treatment for children and adolescents? Write them here and then click the Submit button.

4.6 TF-CBT Response

You may have thought of some of these strengths of TF-CBT:

- It helps families heal together by focusing on both children and their parents
- It works actively with the parents and children together
- It is multi-dimensional in addressing the child's or youth's emotions, cognition, and physical well-being
- It focuses on trauma narratives which can be expressed by the child or youth in any number of ways
- It brings children and their parents together after the trauma narrative so the child can share the story with their parents and together learn that they are more powerful than the story

4.7 TF-CBT Evidence-Base

Let's explore the evidence-base for TF-CBT. Click on each number to learn more.

1. It Works

- Works for children who have experienced any trauma, including multiple traumas
- Works in as few as 12 treatment sessions
- Works even if there is no parent or caregiver to participate in treatment

2. It Applies to Children and Youth From Different Backgrounds
- Is used effectively in a variety of languages and countries
- The Indian Country Child Trauma Center has developed various adaptations to work with Native American populations

3. It Can Be Used in a Variety of Settings: Has been used successfully in clinics, schools, homes, residential treatment facilities, and inpatient settings

4. Summary: Studies that followed children for as long as one to two years after the end of TF-CBT treatment found that improvements were sustained over time. For more information on TF-CBT, please see the Resources tab.

4.8 Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. EMDR is safe and effective for children and adolescents, provided that the therapist is skilled and trained.

Dr. Ricky Greenwald, a pioneer in developing EMDR therapy for children and teens, describes EMDR as:
"A non-drug, non-hypnosis psychotherapy procedure. The therapist guides the child in concentrating on a troubling memory or emotion while moving the eyes rapidly back and forth by following the therapist's fingers. This rapid eye movement, which occurs naturally during dreaming, seems to speed the client's movement through the healing process."

Let's take a moment to watch the video *How EMDR Works*.

[Video Transcript]

MALE: If you have experienced something horrible and have developed psychological symptoms--such as flashbacks, fears, sadness, or sleep problems--you may well be helped by EMDR, a proven and effective therapy. Suppose you have been confronted with a violent crime, an accident, you have been bitten by a dog, or you have had to deal with sexual abuse or violence at home. Such a powerful experience is stored into your brain with a lot of emotions.

Once such a memory is stored in your long-term memory, it can bother you for quite a long time. The disturbing memory keeps coming back unintentionally; for example, with feelings of powerlessness or believing you are not worthwhile. EMDR Therapy can help you get rid of these complaints and feelings.

At first, an EMDR therapist will ask you to activate the memory of this disturbing experience from your long-term memory. The memory is now stored in your short-term memory, also called the "working memory." Then, the EMDR therapist will ask you to focus on this horrible event. From there, the therapist will move his fingers in front of your eyes, rapidly back and forth, and ask you to track his fingers as best and as fast as you can.

By keeping a traumatic memory in your mind and tracking the fingers of the therapist at the same time, the "working memory" gets to process a lot of information at the same time. As it is so much information, the image becomes blurred and loses its emotional charge.

When the emotional charge of an image lessens, it also becomes easier to think differently about the experience. You will notice this because you feel less powerless, or you feel worthwhile again. The intrusions have gone and you feel less anxious; you feel less depressed; you sleep better. And, because you have managed to leave the experience behind you, you start enjoying life and looking forward to the future.

[End of Video]

4.9 EMDR Principle

As you can see, with EMDR therapy, the focus of treatment is primarily experiential. The therapist does not necessarily have to know the details of the trauma that occurred because the process is internal. The youth does not have to create a storyline to relay to the therapist verbally of the trauma that occurred.

EMDR encourages the client to remain present and look at the past as if it were a movie or see it as a snapshot of their life.

EMDR is based on the principle that exploring the past in therapy is only effective if people can remain grounded in the present.

EMDR is well supported by research evidence for treating children and youth with symptoms accompanying posttraumatic stress (PTSD), attachment issues, dissociation, and self-regulation.

4.10 Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is a treatment for children ages 0 through 5 who have been exposed to trauma. Typically, the child is seen with their parents, and the dyad is the unit of treatment.

Child-Parent Psychotherapy examines how trauma and the parent's relational history affect the parent-child relationship and the child's developmental trajectory.

A central goal is to support and strengthen the parent-child relationship as a vehicle for restoring and protecting the child's mental health.

Over the course of treatment, the parent and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.

4.11 Goals of CPP

Child-Parent Psychotherapy involves weekly home-based sessions. Click on each image to learn more about the goals of CPP.

- Strengthening the parent-child relationship
- Improving the parent's understanding of the child's needs
- Restoring the child's emotional health
- Improving the child's ability to learn and be social
- Helping the child to thrive

4.12 CPP Evidence-base

A study by Lieberman, Van Horn, and Ippen found significant differences in measures of child functioning and maternal symptoms between the treatment group that received Child-Parent Psychotherapy and the comparison group. Click on each post-it note to learn more.

Symptom Reduction: Children in the Child-Parent Psychotherapy group had a significant reduction in the number of Post-Traumatic Stress Disorder (PTSD) symptoms from intake to post-treatment, whereas the comparison group did not.

Behavior Problems: The Child-Parent Psychotherapy group also showed significant reduction in behavior problems from intake to post-treatment as measured by the Child Behavioral Checklist total scores.

Avoidance Symptoms: The researchers also found a significant reduction in avoidance symptoms for mothers in the Child-Parent Psychotherapy group only.

Re-Experiencing & Hyperarousal Symptoms: There were no significant treatment effects found for re-experiencing and hyperarousal symptoms.

Current Distress: Analysis of the Global Severity Index scores, which is considered the best single indicator of current distress, showed that mothers in the Child-Parent Psychotherapy group showed a significant reduction, whereas the comparison group showed a trend in this direction but it was not statistically significant.

5. Secondary Trauma

5.1 Secondary Trauma

Let's now shift to a discussion of secondary trauma. You may remember in the last lesson we talked about the challenges for parents experiencing secondary trauma. This is also a significant concern for therapists as it can impact clinicians' ability to effectively work with children, youth, and families with significant trauma histories.

5.2 Secondary Traumatic Stress

Secondary traumatic stress is a risk that mental health professionals incur as they engage empathically with an adult or child who has experienced trauma.

5.3 Secondary Trauma & Mental Health Professionals

Secondary trauma occurs when professionals:

- Over-identify with their client's experiences and, through the process of empathy, internalize the child's trauma-related pain
- Listen to children and their parents describe horrifying situations again and again, with insufficient time to recover emotionally
- Have memories and emotions tied to unresolved personal trauma that are triggered by the client's descriptions of their traumatic experiences
- Are inadequately trained to recognize the reality of secondary trauma, its signs and symptoms, and strategies for avoiding or minimizing it

5.4 Signs & Symptoms of Secondary Trauma

Common signs and symptoms of secondary trauma include:

- Avoidance of certain clients
- Avoidance of certain topics in sessions
- Experiencing a state of heightened arousal when working with a client
- Irritability and anger following sessions
- Tardy or missed appointments
- Experiencing intrusive thoughts outside of the session
- Sleep or eating disturbances following sessions, including dreaming about clients

5.5 Secondary Trauma Reflection

When working with clients who have experienced trauma, it is important for clinicians to manage the impact of their exposure to these experiences. In the box on the screen, list three things you can do to mitigate this experience.

5.6 Secondary Trauma Response

For some possible ways of preventing secondary trauma, click each cloud.

1. Discuss these issues with your supervisor
2. Join a support group of other professionals who work with traumatized clients
3. Seek professional help if you need support and to strengthen coping
4. Set aside time to rest in between clients, as well as at the end of the day
5. Spend time with children and adolescents who are not your clients

6. Connect with people in ways other than work

7. Make sure that you eat well and get plenty of exercise

8. Use relaxation techniques

9. Be aware of the good work you do with clients; praise and empower yourself

10. Be patient with yourself and normalize the feelings that emerge in response to working with traumatized clients; cry if you need to

One model for managing secondary trauma is called Enhanced Engagement. For more information about this model, and additional information about Secondary Traumatic Stress, please check out the Resources tab.

6. Conclusion

6.1 Wrapping Up

The trauma-specific, evidence-based treatments described in this lesson are essential to the healing and recovery for children and youth who have experienced trauma and their families.

6.2 Learning Journal

Please click on the journal page to write down your reflections on this lesson.

6.3 Journal Reflection

What are your key takeaways and how will you apply these in your practice?

6.4 Journal Response

Click the "Print Results" button to print and save your answers.

6.5 Conclusion

Congratulations! You completed Models for Addressing Complex Trauma.

In the next module, we will focus on identity formation for youth in adoptive and guardianship families.