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Richard Kagan & Joseph Spinazzola

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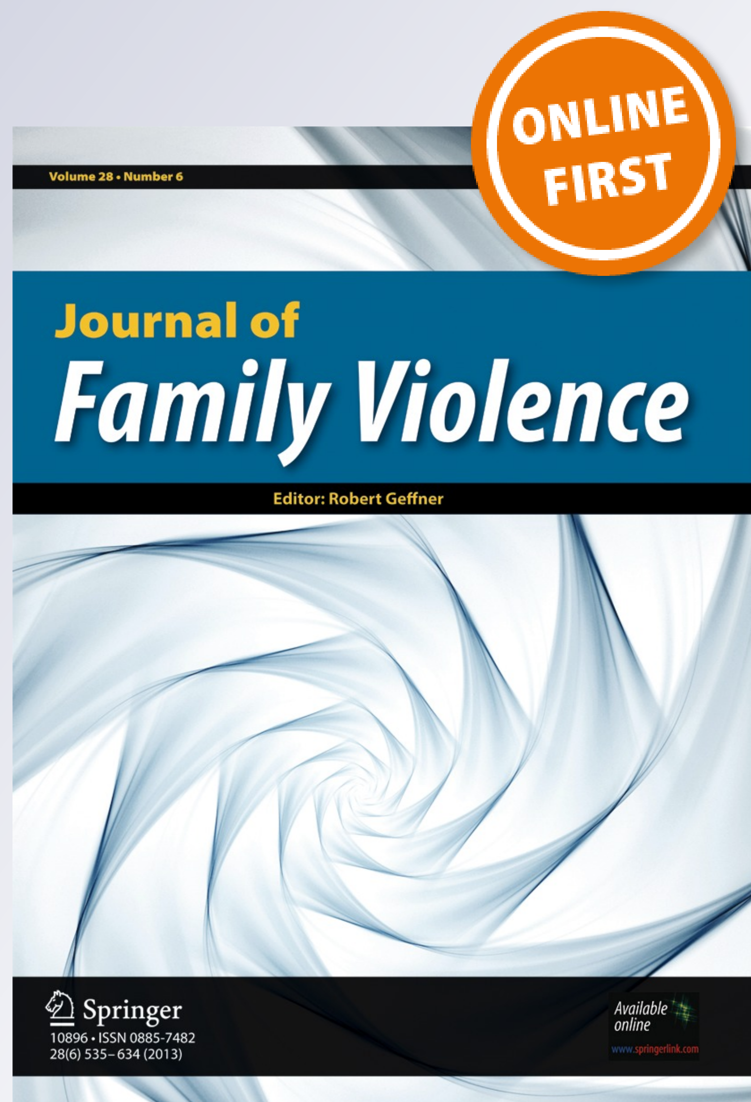

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Real Life Heroes in Residential Treatment: Implementation of an Integrated Model of Trauma and Resiliency-Focused Treatment for Children and Adolescents with Complex PTSD

Richard Kagan · Joseph Spinazzola

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Abstract Real Life Heroes (RLH) engages children and caregivers to rebuild (or build) emotionally supportive relationships, develop self-regulation and co-regulation skills, reduce traumatic stress reactions, and integrate a positive self-image through conjoint life story work. RLH includes psychoeducation, a life story workbook, multi-modal creative arts, and a toolkit to help practitioners implement National Child Traumatic Stress Network recommended components of treatment for Complex PTSD as a child and family transition from residential treatment to home and community-based programs. A case study and results from pilot studies highlight utility of the model for residential treatment and how RLH can help residential treatment programs implement evidence-supported trauma and resiliency-focused treatment including incorporation of NCTSN curricula to provide an integrated framework for practitioners, residential counselors, county case managers, educators, resource parents, home-based counselors, mentors, and other caring adults.

Keywords Trauma · Residential treatment · Complex PTSD · Real life heroes

Challenges in Residential Treatment

Approximately 50,000 children are treated each year in residential treatment programs in the United States (Vaughn 2005). Referral to residential treatment often follows dangerous behaviors by a child to self or others including significant and repeated harm to others, self-abuse, or suicide attempts and multiple previous treatment services, often including psychiatric hospitalizations. In a large national study comparing youths in residential treatment with youths in other treatment programs, Briggs and colleagues (2012) found higher rates of trauma exposure and higher rates of functional impairments for the youths placed into residential treatment. In their study, 92 % of youth in residential treatment had experienced multiple traumatic events.

Moreover, youth in residential treatment settings were more likely to have behavior problems (80 % vs. 69 %), attachment problems (70 % vs. 43 %), runaway behaviors (30 % vs. 5 %), substance use problems (42 % vs. 8 %), suicidal ideation (30 % vs. 13 %), self-injurious behavior (28 % vs. 12 %), and involvement in criminal activity (30 % vs. 6 %). The most frequent types of trauma exposure for these youth included exposure to chronic and severe neglect, caregiver substance abuse, domestic violence, multiple moves or placement disruptions, loss of primary caregivers, emotional abuse, physical abuse, and sexual abuse. In one study (Hussey and Guo 2002), 47 % of 142 youths in residential treatment were found to have experienced sexual abuse, 63 % experienced physical abuse, and 69 % had significant histories of neglect. Similarly, in a large study of children in foster care, Greeson et al. (2011) found that children and adolescents in foster care programs had experienced a mean of 4.7 types of traumas including at least one caregiver-related trauma (e.g., abuse or neglect). Experiences of interpersonal trauma (e.g., abuse, assault) have been linked to higher risk for development of Posttraumatic Stress Disorder (PTD) than experiences of non-interpersonal traumas (e.g., auto accidents, natural disasters (Charuvastra and Cloitre 2008)).

Children in child welfare programs have evidenced a high rate of developmental impairment including delays in receptive language, expressive language, fine motor skills, sequential processing, visual processing, inattention, and memory (Richardson et al. 2008). In this study, Richardson and

R. Kagan (✉)
Sidney Albert Training and Research Institute, Parsons Child and Family Center, 60 Academy Rd, Albany, NY 12208, USA
e-mail: kaganr@parsonscenter.org

J. Spinazzola
The Trauma Center at Justice Resource Institute, 1269 Beacon St, Brookline, MA 02446, USA

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colleagues found several of these developmental delays to be significantly correlated with the number of types of maltreatment events experienced by children. Interestingly, all children in their child welfare sample, regardless of history of maltreatment, exhibited significant difficulties with inattention. Children in this study were also reported to have significant levels of aggression, breaking rules, social difficulties, and total behavior problems.

Multiple exposures to interpersonal victimization and neglect and the accompanying breakdown of primary relationships with caregivers have been associated in children and adolescents with complex adaptation to trauma across a number of core domains of functioning essential to healthy child development including: regulation of affect and impulses, cognitive functioning, dissociation, somatization, relationships and sense of self (Cook et al. 2005). The phenomological expression of clinical impairment associated with disruptions across these domains has, at times, been conceptualized in syndromal terms as Complex Posttraumatic Stress Disorder (Complex PTSD; see for example Ford and Cloitre 2009).

Best practice guidelines (Ford and Cloitre 2009) for children with Complex PTSD include use of evidence-supported interventions that build (or rebuild) child *and* caregiver self-regulation skills; and the secure attuned relationships between children and caregivers necessary for children to have the safety needed for traumatic memory desensitization and re-integration of identity. These authors recommend several components of treatment of Complex PTSD in children: 1) Interventions addressing safety and stability for the child and family; 2) Establishment of a 'triadic relational bridge' linking child, primary caretaker, and therapist; 3) Adoption of relational and strengths-based approaches to diagnosis, treatment planning, and outcome monitoring; 4) Emphasis on enhancement of self-regulatory capacity through-out all phases of treatment across multiple areas of functioning: emotional/affective, cognitive (e.g., attention, memory, decision making, information processing); conative (e.g., awareness, motivation, impulse control); somatic/physiological; and relational); 5) Utilization of a three-phase process for addressing traumatic memories with criteria to determine 'with whom', 'when' and 'how' to address traumas and how to adapt interventions for each child, family, and program; and 6) Prevention and management of relational discontinuities and psychosocial crises.

To date, no controlled research studies have examined the distinct or additive benefit of multi-component or phase-based approaches to treatment of traumatic stress-related disorders in children; however, a small number of studies on traumatized adults have been conducted that have begun to address these critically important questions. Most notably in this regard, Cloitre et al. (2010) found that treatment for adults with PTSD related to childhood abuse were more effective when treatment was provided sequentially, emphasized early establishment of therapeutic alliance, and addressed problems with affect regulation and interpersonal relationships prior to undertaking the exposure and processing of trauma-related memories and narrative construction. Moreover, a recently published expert consensus survey produced by the International Society for Traumatic Stress Studies similarly recommended a sequential or phase-based approach to intervention with adults impacted by complex posttraumatic stress (Cloitre et al. 2011). In the absence of research with child-specific population, cautious extrapolation from this emerging body treatment outcome research on adults with histories of childhood interpersonal trauma would seem to merit consideration.

Child welfare and mental health services for children in placement have often been hampered by disparate, silo-like services and the lack of availability of mental health practitioners who can provide and sustain evidence-supported trauma and attachment-focused treatment, especially as children transition from program to program (Zelechoski et al. 2013). Implementation of evidence-based treatment in child welfare programs often requires adaptation of research-based interventions in order to engage and serve children and families referred with high-risk externalizing behaviors; children who have not disclosed the most significant traumas in their lives; and children who lack a safe, non-offending caregiver able and willing to participate in treatment and provide a safe stable home for the child.

Child welfare programs have often prioritized treatment of high-risk behavioral problems and DSM-IV-TR diagnoses, without addressing youth's exposure to traumas, trauma reactions, and how trauma is linked to youth's problems (Kisiel and Lyons 2001; Kletzka and Siegfried 2008). Few foster care programs integrate an understanding of trauma into knowledge, policy, tools, and practice (Conradi et al. 2011); even though children in foster and residential programs typically have experienced multiple traumas including severe abuse or neglect leading to placement; separations from family members, friends, home schools, community; uncertainty over where they will live next; and whether, or not, they will return to their families (Pecora 2007).

Residential treatment programs face the challenge of utilizing a placement away from family members to create safety and healing for severely troubled children who have often experienced relationship traumas, often involving primary caregivers, and have been unable to live safely within their homes and communities (Zelechoski et al. 2013). Many youth in these programs have lost emotionally supportive relationships and their families have experienced multiple traumas. Placement typically follows tremendous stress for the child, family, and community, along with often unspoken fears that can be easily obscured by the high risk, self-abusive or aggressive behaviors that threaten families, practitioners, and group care programs. Reenactments of traumatic stress and

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the dangerous behaviors can all too easily lead treatment centers to develop parallel patterns of fragmented, chaotic, and abusive interactions that increase secondary traumatic stress in residential staff and break down the effectiveness of the organizations 'operating system' (Bloom and Farragher 2010). Mental health practitioners and residential counselors have reported high levels of stress and 'burn-out' and retention of skilled practitioners is a major concern in child and family services (Acker 2012).

Trauma and Resiliency-Focused Residential Treatment

From a resiliency perspective, residential treatment marks the start of a new opportunity that includes the potential for implementing recommended components of treatment for children impacted by complex trauma. This means facing the combined challenges of rebuilding or building safe, protective, and nurturing relationships with primary caregivers while at the same helping children develop self-regulation skills, desensitizing traumatic stress reactions to reminders of past traumas, and maintaining through-out treatment, an awareness of children's sensitivity to further relational traumas and the importance of helping children and caregivers prevent or recover from further disruptions of supportive relationships.

In the service of these goals, the Sanctuary model (Bloom and Farragher 2010) provides organizational principles and an 'operating system' to create trauma-informed communities in group care programs. Evaluation of the systematic implementation of this model has demonstrated reduced behavioral problems for youth during their time in residential treatment (Rivard et al. 2003). This systems-level model supports incorporation of one or more problem-specific treatment models into a residential treatment program's overall service continuum.

Accordingly, therapists and teams working in organizations utilizing Sanctuary can select from a number of evidence-supported trauma treatment models that best match the needs of children and families in their programs. Trauma-specific treatment models that have empirical support and/or demonstrated clinical promise for use with youth in residential care settings include the following: Attachment, Regulation & Competency (ARC, Hodgdon et al. 2013; Kinniburgh et al. 2005); Integrated Treatment of Complex Trauma (ICT; Lanktree and Briere 2008); Real Life Heroes (RLH; Kagan 2004; 2007a, b, 2009); Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS; DeRosa et al. 2005; Habib et al. 2013); Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford and Hawke 2012; Ford and Russo 2006); Trauma-Focused CBT (TF-CBT; Cohen et al. 2006), and Trauma Systems Therapy (TST; Brown et al. 2013; Saxe et al. 2007).

Real Life Heroes (RLH) differs from other trauma treatment models in its focus on the developmental needs of children ages 6–12 (as well as adolescents functioning at a latency-level in terms of their social, emotional or cognitive development) and its prioritization of treatment for guilt and shame associated with high risk behaviors (e.g. self-abuse, aggressiveness) that can lead to placement in residential treatment programs. (For a detailed consideration of other intervention models and approaches being utilized with latency aged children in residential treatment settings, see Knoverek et al. 2013). RLH includes primary roles for residential counselors, parents, resource parents, mentors, and other caring adults in relationship-focused treatment that counters the effects of interpersonal traumas and works to increase a child's pride in his/her abilities, family and cultural heritage as an 'antidote to shame' (Herman 2011). The RLH format includes a child workbook and session rituals designed to provide an easy-to-learn and transferable structure which allows children and caregivers to continue trauma treatment as they move from residential treatment to foster care or family-based treatment and thereby endeavors to reduce the distress that is often engendered by transitions of youth between programs and therapists and other service providers.

RLH was specifically developed to help traumatized children in placement programs, or at high risk of placement, who were not improving with cognitive behavioral therapies and other trauma-informed interventions which focused primarily on the child's development of self-regulation skills and desensitization to traumatic memories and reminders. RLH was also developed to provide trauma-informed treatment for children who did not meet the criteria for other treatment models, including children who had not yet disclosed primary traumatic experiences, and children living in placement programs who lacked safe, non-offending caregivers who were able and willing to participate in trauma therapy. The present article delineates the utility of RLH to address and overcome the challenges of implementing trauma-informed residential treatment. It includes results of two outcome studies, lessons learned from real-world application of the model, and a case study illustrating application with a high risk youth in residential treatment.

How Does Real Life Heroes Work?

Real Life Heroes provides practitioners with 'ready-to-go' tools including a life storybook, manual, creative arts activities, and psychoeducational resources developed to engage high risk children and caregivers in trauma-focused services and promote fidelity in implementation of phase-based treatment components. RLH helps practitioners reframe referrals based on diagnosed pathologies, dangerous behaviors, and blame into a shared 'journey,' a 'pathway' to healing and recovery focused on rebuilding (or building) emotionally supportive and enduring relationships and promoting development of affect regulation skills for children and caregivers.

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The model utilizes the metaphor of the heroes' journey (Campbell 1968) and stresses the importance of engaging caregivers and a collaborative team of caring adults working together with an integrated trauma and resiliency-centered framework to help children with Complex PTSD. Creative arts and shared life storybook activities help children and caregivers develop the safety, attunement, emotional support and affect modulation skills postulated to be necessary prerequisites for the most complexly traumatized children to be able to undertake and tolerate integration of traumatic memories (Cook et al. 2005).

The RLH Practitioner's Manual and toolkit integrates core components of treatment for Complex PTSD (Relationships, Emotional Self and Co-regulation, Action, and Life Story Integration) from referral and assessment through service planning, treatment sessions, treatment reviews, three-month outcome evaluations, and discharge from group care. The Manual includes psychoeducation on traumatic stress and integrated tools for assessment, service planning, prioritization of interventions, and adaptations for special populations. The model was especially designed to help practitioners and caregivers counter the hopelessness and co-occurring acute and longstanding distress often seen with children placed into residential treatment facilities. RLH combines attachment-enhancing interventions, creative arts, and cognitive behavioral therapy, to provide a structured system of trauma therapy that focuses on restoring children's sense of hope and capacity to develop trust in emotionally supportive relationships.

Inclusion of multi-modal, multi-sensory, and nonverbal activities in each session helps practitioners to engage troubled children, caregivers, and residential staff to work together to cultivate trust with caregivers, to promote affect regulation and co-regulation skills, to reduce high risk behaviors that led to placement, and to implement recommended components of treatment for complex adaptation to chronic interpersonal trauma including Complex PTSD (Cook et al. 2005; Ford and Cloitre 2009). This includes re-integration of traumatic experiences using a three-chapter (beginning, middle, and end) story-telling or three-scene movie-making format that helps children *move through* memories of traumatic events toward present-focused, positive events and relationships in which they are afforded the opportunity to feel a renewed sense of safety, experience trust in caregivers, and develop and hone skills to overcome nightmares of the past. The RLH workbook and ritualized session structure is designed to engage children and caregivers in playful therapy sessions and to help maintain treatment adherence.

RLH Outcome Studies and Component Analysis

Real Life Heroes has been successfully utilized by practitioners in a wide range of child and family service programs for 15 years. A pilot study of RLH treatment with 41 children in home-based, foster care, residential treatment, and outpatient programs (Kagan et al. 2008) found that after a 12 month interval, children provided with RLH demonstrated an increasing reduction in parent reports of trauma symptoms, along with increased security/attachment of children to caregivers over time. The model is listed in the National Registry of Evidence-based Programs and Practices by the Substance Abuse Mental Health Services Administration (SAMHSA), the SAMHSA National Center for Trauma-Informed Care "Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services," and as an Evidence-supported and Promising Practice by the National Child Traumatic Stress Network (NCTSN). The 2007 RLH Practitioner's Manual was coded to assess inclusion of Intervention Objectives and Practice Elements developed by the NCTSN Core Curriculum on Childhood Trauma Task Force (Strand et al. 2012). Raters found that eight of nine core domains identified by this taskforce were addressed in the RLH manual. The only domain missing, Therapist Self-Care, has been included in RLH training programs since 2007.

Lessons learned during the 2003 to 2005 pilot study included the need to develop a stronger systems model to counter disparate child welfare services' the need to engage agency and program leadership in systems transformation; and the importance of applying a resilience model that addresses the needs of all team members including residential counselors, educators and practitioners, as well as youth and birth, kinship and adoptive parents (Kagan et al. 2008). Similarly, Briggs et al. (2012) recommended development of integrated trauma-informed services that emphasize work with families, provide support during youth transitions, and offer aftercare services as needed.

The HEROES Project incorporated RLH core components into a systems treatment model (See Fig. 1) based on an integrated series of trauma-informed and resiliency-focused training, consultation and evaluation services for child welfare programs including a residential treatment program that had already incorporated principles of the Sanctuary model (Bloom and Farragher 2010). The primary goal of this resiliency-focused initiative was to foster enduring, emotionally supportive relationships which protect children from abuse and neglect and help children resume healthy growth and skill development after experiencing traumatic stress. Organizational objectives included incorporation of trauma-informed and resiliency-focused tools into assessments, service planning, and team work including integrated resiliency-informed training for practitioners, residential counselors, parents, guardians, and other caregivers as well as activities to prevent 'compassion fatigue' and 'burn-out'.

Training programs utilized the NCTSN Resource Parent Curriculum, *Caring for Children Who Have Experienced Trauma* (Grillo et al. 2010), and the NCTSN *Child Welfare*

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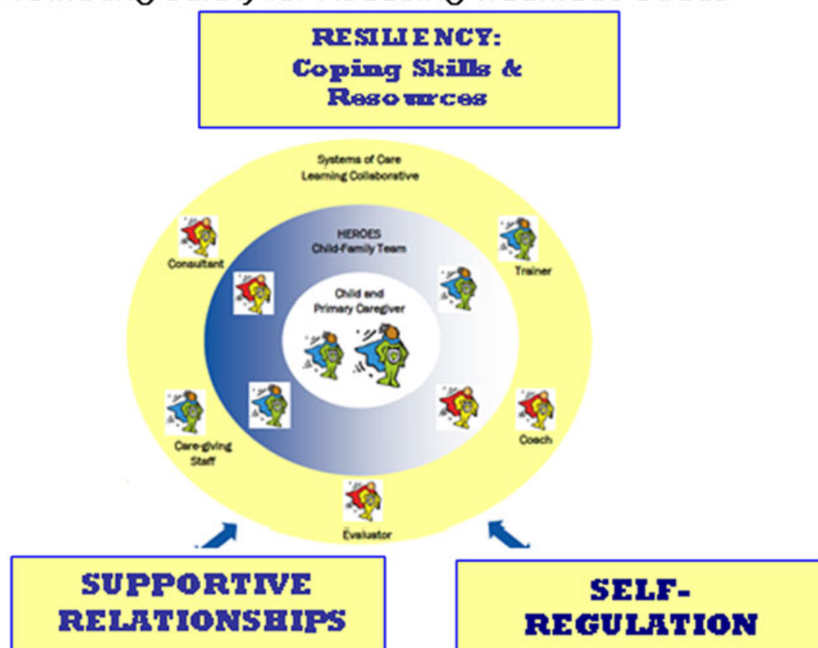

Fig. 1 *HEROES Project* learning collaborative

Toolkit (Child Welfare Collaborative Group, NCTSN and The California Social Work Education Center 2008) so that all service providers, residential counselors, educators, practitioners and resource parents were introduced to the HEROES trauma and resiliency framework and the NCTSN "Essential Elements for Child Welfare." A combined inter and intra-organizational learning collaborative model (Kagan et al. 2013) was implemented which engaged teams in each program to adapt RLH and NCTSN curricula to best match children in their programs. For instance, leaders of community residential services developed vignettes of adolescents in group homes for use in case study discussions as part of training programs for residential counselors that were adapted from the NCTSN Resource Parent Curriculum and that included a module on incorporating RLH into group care treatment (Gecewicz et al. 2010, personal communication).

The HEROES Project (Kagan et al. 2013) evaluated the effectiveness of RLH with 119 children in seven child and family service programs ranging from home-based family counseling to residential treatment. The study included a comparison of outcomes with children provided systematic RLH treatment compared to children provided trauma-informed 'treatment as usual' services on two critical measures for child welfare programs: 1) avoiding out-of-home placements for children in home-based care; and 2) preventing psychiatric hospitalizations of all children served. The study also evaluated the impact on measured outcomes of the number and types of interpersonal traumas experienced and the importance of implementing RLH core components with fidelity. Results included statistically significant decreases from baseline to 6 months in child behavior problems on the Child Behavior Checklist (CBCL) Internalizing and Total Behavior scales (Achenbach and Rescorla 2000), the Anger subscale of the Trauma Symptom Checklist for Children (TSCC; Briere 1996a, b), the UCLA PTSD Reaction Index-Parent Version Re-experiencing, Avoidance, Hyper arousal, and Total Symptoms scales (Steinberg and Brymer 2008) and the UCLA PTSD Index-Child Version Avoidance and Total Symptoms scales.

Significant reductions were also found with repeated measures at 3 month assessments from baseline to 9 months on the CBCL, the UCLA Parent and Child Versions, and the PTSD subscale of the TSCC. None of the children receiving RLH had placements or psychiatric hospitalizations, a positive, but not significant trend, compared to some of the children receiving trauma-informed 'treatment as usual' provided by practitioners in the same programs trained in RLH and other trauma treatments (e.g. TF-CBT), who were placed or hospitalized.

Outcome analyses focused on changes on standardized measures for children who had experienced one or more of the following types of trauma exposure: an 'impaired caregiver,' grief/loss, physical abuse, and emotional abuse. Results supported hypotheses that children receiving RLH's relationship-focused treatment would demonstrate statistically significant reductions in behavior problems reported on the CBCL. Overall, the study supported the effectiveness of implementing trauma and resiliency-focused treatment in a wide range of child welfare programs and the importance of

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providing sequential attachment-centered treatment for children with symptoms of Complex PTSD.

Case Illustration; Implementing Trauma and Resiliency-Focused Treatment with a Multiply Traumatized Youth[1]

Kianna was placed into residential treatment at age 14 following surrender of parental rights at age 11, five foster placements, and psychiatric hospitalizations where she was diagnosed with Bipolar Disorder, Dissociative Disorder, and Mild Mental Retardation. While living with her fourth foster family, she started cutting herself, threatening to kill herself, and running away. Kianna alleged that this foster family had physically abused her but this was 'unfounded.' Kianna was then moved into a pre-adoptive family. However, when she began getting into screaming 'fights' with her pre-adoptive mother, her county department of social services placed Kianna into residential treatment based on her diagnoses and behavior problems. A few months later, her pre-adoptive family stopped visiting.

Kianna obsessed over returning to her birth mother, Marilyn, and refused to work on moving to another foster family. Kianna remembered her mother repeatedly telling her that she had been forced by county authorities to give up parental rights in order to maintain contact with Kianna that she loved Kianna, and that Kianna could return to her mother as soon as she turned 18. Kianna also wished she could live again with her father; however, his address was unknown and he had not cared for Kianna since age five. She identified no other relatives or anyone else she wanted to live with and focused obsessively on returning to her mother during her first year in placement; a wish that was reinforced by her mother telling Kianna that she had completed a drug/alcohol/mental health treatment program, was no longer living with her previous alcoholic and violent boyfriend, and that she now wanted Kianna back. By age 16, with no viable family options for kinship care and Kianna's refusal to consider living in another foster family, the county social services department authorized a long-term goal of returning Kianna to her mother when she became a legal adult at age 18.

Kianna, like many youth in care, was left in a state of 'ambiguous loss' (Boss 2000) waiting to turn 18. Marilyn did not respond to requests to participate in on-going family treatment citing multiple health, financial, family, and transportation problems; and only participated in a few treatment sessions during Kianna's first 2 years in residential treatment. Marilyn very often did not respond to calls from staff; however, she maintained periodic phone contact with Kianna and saw her during the bimonthly three-hour visits allowed by the county department of social services. Marilyn struggled with multiple addictions, severe diabetes, hospitalizations for depression and diabetes, and periods of homelessness. She also grappled with the suicidal behavior, incarceration and the addictions of Kianna's older two brothers, the youngest of whom Marilyn kept in her home because of his chronic unemployment and homelessness. Marilyn helped this son care for his youngest child, Kianna's nephew, while Kianna remained placed in residential treatment.

During her first years in the residential treatment program, Kianna was described as running away from the program; hurting herself with repeated cutting of her legs, arms, and body; maintaining generally poor hygiene; yelling and cursing staff over following rules; telling staff she saw 'dead people'; and reporting that she often wanted to die. She was absorbed with the occult, and believed that she and her mother shared secret powers, a belief reinforced by her mother and Kianna's father when Kianna was a young child.

Kianna began RLH treatment in her third year of residential treatment at age 16 in an effort to reduce her self-abusive and high risk behaviors. Like many adolescents in group care, she functioned like a much younger child cognitively, socially and emotionally. She enjoyed playing with puppets and had no real friends. RLH treatment began with engaging Kianna to work on affect recognition and regulation skills. This work was accompanied by development of a Youth Power Plan, a resiliency and trauma-focused safety plan that helps youth and caregivers, including residential staff, identify strengths, positive relationships, what the child does that helps, what adults do that helps or adds to a youth's stress, and reminders and triggers to traumatic stress reactions. Also included was a multi-sensory safety plan that prioritizes solicitation of assistance with self-regulation from adults in the child's life (co-regulation) and that delineates steps the youth can practice to help calm themselves when they begin to feel themselves going into 'alarm' mode. Kianna also began work in the RLH Life Storybook including psychoeducation on traumatic stress. Kianna became more comfortable with her therapist and the RLH session structure (e.g., thermometers to assess stress, self-control, feelings, and safety; self-regulation skill building; creative arts, movement, and storytelling to identify and develop relationships and engage in life story integration).

At this point, like many children using RLH, Kianna also began spontaneously sharing traumatic experiences mostly unknown to staff, including how she first began dissociating at age four, seeing monsters on the bathroom wall when her father routinely would lock her in the bathroom while he and friends abused drugs. She also shared nightmares of her mother's boyfriend gashing her mother's chest in a drunken rage, her mother cutting herself, and her mother attempting suicide with pills and alcohol in front of Kianna during fights

[1] Names and other details of Kianna's family have been changed to disguise their identity.

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between her mother and her boyfriend in the months leading up to Kianna's placement into foster care.

Marilyn initially missed many sessions for herself and Kianna because of break-downs of her car and, at other times, because she forgot sessions or reported being overwhelmed with personal problems. She denied or minimized traumatic events reported by her daughter including Kianna's experience of her mother attempting suicide. As a result, in addition to structured dyadic sessions with Marilyn and Kianna designed to build attunement and trust, Marilyn was also seen frequently seen alone to work on increasing her motivation and capacity to understand and validate her daughter. Gradually, over the next year, Marilyn came to be able to acknowledge and validate more of her daughter's experiences, and also to participate in more conjoint treatment sessions and RLH activities with Kianna.

Marilyn's growing attunement to her daughter was reflected in her increased willingness and ability over time to engage in mirroring activities with Kianna that were being undertaken to enhance self-regulation and foster integration of traumatic experiences; for example, Marilyn would repeat the nonverbal drumming, music, and movement-based narratives that Kianna created as she shared more of her life experiences and completed her life storybook. Marilyn also helped fill in the gaps in Kianna's understanding of what had happened to her during her early upbringing. In turn, Kianna attuned to her mother's nonverbal stories. Together, they utilized various rituals resonant to their familial and cultural heritage (e.g. rubbing lotion on each other's arms; reciting a blessing or poem) to comfort each other and counter impulses both of them had to cut themselves.

Interventions and safety plans for Kianna were targeted to her developmental age with a skill-level grade equivalent identified as 2nd to 3rd grade in most areas in contrast to her chronological age of 16. Interventions initially targeted multiple steps staff could take including close, safe, female staff asking if Kianna wanted a hug, giving her space but keeping her in eyesight; responding to threats by staying calm and recognizing Kianna's traumatic stress reactions to reminders of her past experiences of domestic violence, physical abuse, and sexual abuse by older youth; and encouraging Kianna to use calming activities she enjoyed, including balancing a peacock feather with deep breathing (after Macy et al. 2003), use of puppets, use of techniques from *Cool Cats* (Williams 2005), writing stories or poetry, and sharing through writing with residential counselors and teachers she trusted. Use of her fingers and hands for calming activities in the residential program and school was also encouraged, including gentle application of scented lotions to help Kianna replace cutting with self-soothing, as was replacement of self-shaming thoughts with self-validation, recitation of messages and prayers from her mother, and seeking support from trusted staff or by calling her mother. At the same time, Marilyn was helped to identify triggers in her home including noise, jealousy of Kianna's nephew, yelling by her older brothers, flirtations by boys in the neighborhood, and terrifying fears of her mother becoming hospitalized and dying, going back on drugs, or becoming involved in another violent relationship.

Kianna demonstrated significant improvements in her behavior and was legally allowed to start overnight home visits when she became 18, following a long series of visits at, and then near, the residential center. Overnight home visits, however, ended abruptly after Kianna became engaged in an altercation with her older brother who had continued to live in Marilyn's home with his son. This setback evoked severe psychological distress for Kianna. It triggered traumatic memories associated with the extensive domestic violence she witnessed throughout her childhood. It also reactivated feelings of intense fear and helplessness associated with her mother's past and continued inability to provide a safe home for Kianna because of her in mother's recurrent psychiatric and substance-abuse problems and associated hospitalizations, and evictions and periods of homelessness. Above all, this incident rekindled Kianna's fears of being rejected and abandoned. Nevetheless, despite this breakdown in visits, Kianna completed the RLH workbook including three-chapter stories for her multiple traumatic experiences and a message to other children who have endured similar adversities. Kianna's level of stress and self-control initially matched the multiple ups and downs in her relationship with her mother; however, over time, she developed a greater capacity to keep herself modulated sufficiently to go to school and stay safe, even when her mother was in the hospital, or involved with another boyfriend Kianna didn't trust.

Kianna's experiences reflect the challenges of continuing trauma and attachment-centered treatment with severely and multiply stressed families and youth who have lived with disrupted and often chaotic and disorganized attachments. RLH helped Marilyn validate her daughter and helped both Marilyn and Kianna grieve years of lost opportunities for closeness when Marilyn was consumed with her addictions, conflictual and violent intimate partner relationships, and concerns for her older sons. Despite this progress, Marilyn came to two painful but important and interconnected realizations. First, that she could not keep her daughter safe in her home; but second, that she could nevertheless still love her, validate her, and help her to grow stronger. Marilyn subsequently worked to the best of her ability to help Kianna share and reduce the power of her multiple traumatic experiences using the RLH life storybook. She validated Kianna's fears of Marilyn's former boyfriend becoming violent again and ultimately helped arrange for him to apologize to Kianna over the phone for harming Marilyn and terrifying Kianna when she was younger. Marilyn also acknowledged her daughter's fears that her mother would become addicted again, threaten to kill

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herself, or die in a hospital when she was sick; how terrible Kianna felt (her worst trauma) when her mother left her in foster care; and how reminders of these multiple traumatic events led Kianna to feel alone, shut off her connections to other people, and dissociate. Finally, Marilyn validated Kianna's disclosure of how terrified she had been as a four-year old when her father kept her locked in their bathroom 'all day' while her mother was working; how Kianna's father had physically abused Kianna; and how relieved Kianna felt when Marilyn took Kianna and fled that relationship, taking a train from California back to upstate New York.

Over time, Kianna accepted that her mother would likely continue to have "ups and downs" in her life and would not be able to take Kianna back to live with her. Kianna worked with her counselors to identify choices that were within her control that would enable her to maintain connection to her mother despite this unfortunate conclusion. She could move to a community residence near her mother, see her mother weekly, and call her daily. Kianna also worked to overcome renewed feelings of shame over her fighting and she made amends with her family including apologies to her brother and nephew for her role in their fights during visits and before Kianna's placement.

Kianna's developmental growth during her last 2 years of residential treatment was promoted by her relationships with several very caring residential counselors and teachers. Kianna's favorite pastimes changed from fantasy-based play with puppets, drawing and children's books to a more age-appropriate focus on dating, adolescent-level books, and writing her own 'graphic novel.' Her hygiene improved and her dress changed to more typical high school clothes. She graduated from a special education high school. She also disclosed to her mother how she felt shamed by going off with an older youth and having sexual relations with him just a few months before her mother placed Kianna into foster care, how she had been previously sexually abused, and how she felt shamed that she had killed pet mice in frustration as a 6-year-old when her mother was asleep all day and Kianna had tried to play with the mice unsupervised but they bit her. Marilyn and Kianna also both developed more effective *Power Plans* to help prevent or reduce future reactions to memories or reminders of traumatic experiences, including how Marilyn could help her daughter get to a quiet space for one-on-one time before running away, cutting herself, or getting into fights.

Measureable improvement included changes in TSCC scores from admission to residential treatment at age 14 to age 18, even following Kianna's loss of her dream of reunification (using 17-year-old norms based on Kianna's developmental age). Specifically, Kianna exhibited decreases in T Scale Scores on the Hyperresponse scale from 82 to 58, on the Anxiety Scale from 81 to 58, on the Depression scale from 78 to 52, on the Anger scale from 77 to 40, on the Posttraumatic Stress scale from 69 to 57, on the Dissociation scale from 78 to 56, on the Overt Dissociation scale from 78 to 52, on the Dissociation-Fantasy scale from 69 to 63, and on the Sex Concerns scale from 64 to 50. Kianna's Full Scale IQ went up during her 3 years of residential treatment from 64 on the WISC III prior to admission (Verbal IQ: 69, Performance IQ: 63) to a full scale IQ of 72 (Verbal Comprehension: 76 and Perceptual Reasoning: 82) on the WAIS-IV at age 17 and a half.

Discussion

Residential treatment presents a paradox for practitioners and agencies seeking to implement evidence-supported treatment for children with Complex PTSD. Children in placement have a critical need to re-integrate into families and communities after experiencing multiple and complex traumas and often disrupted attachments (Bloom and Farragher 2010; Briggs et al. 2012); and yet, by definition, placement in residential treatment means that these youth will be living without the intimate, enduring relationships with caring, committed adults that children like Kianna crave. Moreover, putting such youth together in group care can lead to reminders and reenactments of past stressors (e.g. in response to exposure to or involvement in yelling, screaming, cursing, hitting, self-abuse or disciplinary actions). At the same time, for many children like Kianna, placement in a well-designed, trauma-informed residential treatment setting may represent (one of) the most stable, structured and contained periods of caregiving that they have experienced. Residential treatment settings can utilize this transient opportunity to help youths to enhance their capacity for self- and co-regulation; challenge negative and self-defeating attributions; and develop more effective coping, decision-making and interpersonal skills that will help them more effectively navigate the challenges they will likely encounter when they leave the program and transition to new or former familial, foster, adoptive or community-based placements.

The case study presented in this paper, in conjunction with outcome evaluation results, indicate the promise of RLH applications in residential treatment settings serving complexly traumatized children. Collectively these findings and clinical case illustration demonstrate how residential treatment staff can advance treatment goals by helping children and families disclose, validate, and reduce traumatic stress reactions; by forging a shared understanding of the impact of trauma on development; by cultivating safety, attuned relationships, self and co-regulation; and by adopting an integrated trauma-informed framework that promotes organizational training, support and teamwork. In Kianna's case, the multimodal RLH format helped engage a youth with high risk behaviors and a hard-to-reach caregiver, restoring hope for

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change. Use of RLH also kept the focus of services on helping Kianna develop the emotionally supportive relationships and skills she needed to *move through* traumatic events and reminders or reenactments with the help and support of her mother, residential counselors, practitioners, mentors, and other caring adults.

The RLH structured format provides significant advantages for residential treatment programs. The life storybook and session structure can move with a child as the child transitions from residential treatment back to family living, and typically from therapist to therapist, to sustain the safety, self and co-regulation, and improved coping skills developed in residential treatment. This requires providing a common framework for understanding and treating traumatic stress that becomes infused into services. In the HEROES Project, this was facilitated by programs that had already incorporated Sanctuary principles and by utilizing the NCTSN Resource Parent Curriculum and Child Welfare Toolkit along with RLH to frame a trauma and resiliency-focused learning collaborative that included workshops, program-based consultation groups and individualized consultation for practitioners. However, even with the resources provided by the learning collaborative, the success of the HEROES Project depended on the commitment of program leaders to support training and implementation and to enable practitioners to prioritize the time needed for attachment-centered trauma treatment, especially in programs where practitioners were responsible for the provision of case management, crisis management, and team leadership along with individual and family treatment (Kagan et al. 2013).

RLH provides a toolkit to help residential programs develop trauma and resiliency-focused services. Step-by-step activities and use of the workbook expedites session planning for practitioners, helps prioritize the focus for sessions to match the 'ups and downs' in children's and caregiver's self-regulation and relationships, and keeps day-to-day crises from consuming treatment time. Built-in fidelity measures help supervisors ensure that evidence-supported components of trauma therapy are being implemented. Furthermore, anecdotal clinical data suggests that continued use of RLH may help to sustain child-caregiver attunement and supportive relationships through typical cycles of child, caregiver, and family problems. This pattern was observed in Kianna's case, in which the RLH structure helped sustain the progression of phase-based trauma treatment despite multiple crises in her mother's life and their relationship together.

The RLH format can function to keep multiple services and staff in residential treatment programs focused on the connection between a youth's attunement and security with caring adults and the development of positive self-regard, co-regulation and coping skills for children who have experienced relational trauma. Creative arts, movement and life story work help engage children and caregivers in playful, dyadic activities that foster trust. These modalities also provide a natural segue to developing the capacity to tell stories, an important component of later desensitization of traumatic experiences with exposure-based interventions. Building on individual, family, and cultural strengths helps encourage caring adults to become heroes for children, increasing the security needed to overcome children's nightmares from the past; and to create the safety children need for desensitization and reintegration of nurturing and painful memories. In this process, residential treatment staff can coach and support parents, resource parents, extended family members and other emotionally supportive adults to help youth develop stories of healing and transform identities as damaged, mentally ill, or dangerous youth into heroes who have experienced traumatic events and learned to seek help and use their skills to help others.

Limitations of the RLH outcome evaluation data reported in this paper include intermingling of data from children in residential treatment with data from children in home and community-based programs, lack of random assignment to treatment condition, and limited scope of available treatment as usual comparison group data. Future directions for research include randomized controlled studies comparing the cost-effectiveness of implementing RLH's relationship-focused trauma treatment against 'treatment-as-usual' with children in residential treatment. Such research will benefit from careful examination of the impact of treatment on measures of children's well-being, traumatic stress, length of stay in residential treatment and need for further hospital or residential services. Finally, future research should endeavor to ascertain factors that promote the establishment of integrated trauma and resiliency-focused service teams and the continuation of evidence-supported trauma treatment when children transition from residential treatment to community-based services.

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