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Lessons from the Field: Clinicians' Perceptions of Treating Complex Trauma in Siblings

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Abstract

This research set out to explore how clinicians are currently addressing treatment of siblings. The purpose of this paper is to explore clinicians' perceptions of how to treat siblings who have suffered complex trauma. The research shows that there is a growing need to look at this issue, as in 2011 there were 3.4 million reports to Child Protective Services (CPS) in regards to 6.2 million children. Of those 6.2 million, 2.0 million received a CPS response (United Department of Human and Health Services, 2011). "Complex trauma" is a term defined, for the sake of this paper, as the exposure to multiple traumatic events, often of an intrusive, interpersonal nature. Complex trauma frequently does not affect just one child, but often several victims within a family. Children are part of a larger system existing of their family, school, community, and are impacted by their environment. More than one sibling in a family often has symptoms of complex trauma, but treatment is typically focused on the child who has the more obvious behaviors. The research will rely on the Developmental Repair Model as a conceptual framework that guided interview questions and informed the researcher of one particular treatment modality to use with siblings. Salient findings revolved around themes such as *sibling as a co-regulator, joining, sense of self,* and *sibling dynamics*. The study concluded with a recommendation for further research to explore the outcomes of placing the Developmental Repair model within an agency or school and measuring its success. The research also has implications for social workers in teaching educators to focus more on what is behind the behaviors the schools are seeing, and joining with a child to establish safety and trust.

Introduction

Children need a stable living environment to promote healthy growth and development. When there are multiple factors of poverty, unsafe neighborhoods, poor diet, parents struggling to make ends meet, children can experience toxic levels of stress. According to statistics put together from the National Center for Children Exposed to Violence, studies show that child abuse occurs in 30-60% of family violence cases that involve families with children. Also, approximately 4 million adolescents have been victims of a physical assault, and 9 million have witnessed serious violence during their lifetimes. Each year, 3 to 10 million children witness domestic violence. In a 2002 study, an estimated 896,000 children were expected to have been victims of child abuse or neglect (http://www.nccev.org/resources/statistics.html).

In 2011 there were 3.4 million reports to Child Protective Services (CPS) in regards to 6.2 million children. Of those 6.2 million, 2.0 million received a CPS response (United Department of Human and Health Services, 2011). In 2011, the U.S. Department of Human Services (DHS) did a study through the National Child Abuse and Neglect Data System (NCANDS) of the Children's Bureau. DHS gathered statistics in the prevalence of reported childhood trauma in the 50 U.S. states, the District of Columbia, and the Commonwealth of Puerto Rico. There was a wide discrepancy between the number of cases that were taken on by a CPS worker, versus the amount of referrals called in, a difference of 4.2 million (United Department of Human and Health Services, 2011). Social workers often are there behind the scenes in schools, hospitals, day treatment centers, and outpatient programs, working with the remaining population of suspected child abuse cases. According to the National Association of

Social Workers (NASW), social workers are often the frontline responder in moments of crisis because of their employment at care settings (socialworkers.org).

On a more local level, the Children's Defense Fund looked at child neglect and abuse or maltreatment reports in Minnesota from 2009. In 2009 there were close to 26,000 reports of child maltreatment with the majority suffering non-medical neglect. There were 44 children who suffered life-threatening injuries, and there were 21 deaths from child neglect and abuse (www.cdf-mn.org; www.mcbw.org). Of the almost 26,000 reports, 23 percent were reported by a social worker or health practitioner, 22% were by school personnel, and 27.8% by law enforcement or the courts systems. The breakdown of where the reports were coming from listed rural Minnesota counties at the top with the highest percentages. The Children's Defense Fund also explored the numbers of children living in poverty, which is known to be particularly stressful for children's development (www.cdf-mn.org). Furthermore, the Minnesota Coalition for Battered Women reported that children who experienced childhood trauma, including exposure to domestic violence, are at "a greater risk of having serious adult health problems including tobacco use, substance abuse, obesity, cancer, heart disease, depression and a higher risk for unintended pregnancy" (www.mcbw.org).

There are many studies focused on different treatments of childhood trauma, and best practices within those treatments (nctsn.org). Anne Gearity (2009) defines complex trauma as a "relatively new designation for children exposed to environmental and relational assaults that capture how children become extremely vulnerable when trauma-related helplessness combines with relational helplessness" (p.27). It is not an easy term to define, and researchers often use a variety of definitions. "Complex trauma" is a term defined, for the sake of this paper, as the exposure to multiple traumatic events, often of an intrusive, interpersonal nature. The effects of

complex trauma on an individual are wide spread and long-lasting. These events are typically severe and ubiquitous. Some examples of these events can be abuse (physical, emotional) and/or extreme neglect. They oftentimes happen early in a child's life, and if not treated can disrupt a child's normal development and sense of self. According to the Center on the Developing Child at Harvard University, a toxic stress response can happen when a child experiences repeated and/or prolonged intense adversity. This prolonged activation can disrupt the development of the brain and other organ systems and create or increase the risk of future medical issues (http://developingchild.harvard.edu/).

The ACES , adverse childhood experiences study, a longitudinal study, was designed and explored over the last few decades by many researchers, but primarily by principal researchers, Anda, Felitti, and Permanente (http://acestudy.org/home, 1995). One outcome of this study explored how "evidence from neurobiology suggests that early life stress such as abuse and related adverse experiences cause enduring brain dysfunction that, in turn affects health and quality of life throughout the lifespan" (Anda, Felitte, Bremner, et al., 2006, p.175). Early chronic childhood abuse has a direct link to "numerous differences in the structure and physiology of the brain that expectedly would affect multiple human functions and behaviors" (p. 175). The researchers found that the effects of traumatic stress have harmful effects on "developing neural networks and on the neuroendocrine systems that regulate them … [suggesting] that this veiled cascade of events represents a common pathway to a variety of important long-term behavioral, health, and social problems" (Anda, Felitte, Bremner, et al., 2006, p. 180). Complex trauma leads to these physiological changes that affect areas of the brain such as the amygdala, and hippocampus.

Complex trauma frequently does not affect just one child, but often several victims within a family. Children are part of a larger system consisting of their family, school and community and are impacted by their environment. Bowen's Family Systems Theory (1966) supports this concept through its research on complex family interactions, and how it is natural in a family for its members to be emotionally connected. Family members, specifically siblings, connect emotionally through soliciting each other's attention, approval, and support and reacting to each other's needs, expectations, and distress. While individual family members are independent to some degree, changes in the family structure can impact the connection of one person to another (The Bowen Center, www. thebowencenter.org, Nichols, 2013). Often in families of complex trauma they are missing this connection in that "their families remain ineffective in changing these patterns and they became estranged from the larger social community as a result" (Gerity, 2009, p. 7).

The purpose of this paper is to explore clinicians' perceptions of how to treat siblings who have suffered complex trauma. The remaining chapters will cover the literature review and conceptual framework, the methodology, the findings, and the discussion. The study was addressed through a qualitative study with interviews of professionals in the field who treat childhood trauma.

Literature Review

The literature on child trauma and sibling relationships focuses mainly on the prevalence of the problem, the definition of trauma, different types of sibling relationships, and different treatment responses. Very few research studies focus on trauma treatment approaches within sibling relationships. This literature review will first report on the prevalence of the problem, then will look at the definition of trauma. It will then explore different types of sibling relationships, and lastly look at treatment interventions, including the Developmental Repair model in working with siblings.

Prevalence

As reported in the DHS 2011 Child Maltreatment report, there were 3.4 million referrals to Child Protective Services (CPS) in regards to 6.2 million children. Of those 6.2 million, only 2.0 million received a CPS response. In the child maltreatment report (DHS, 2011), it was found that 3.3 million children from 46 states received preventative services from CPS. This means that there was enough of a concern in the home to warrant CPS's involvement to prevent future cases of neglect and abuse. Also it has been found that child abuse occurs in 30-60% of family violence cases that involve families with children. (http://www.nccev.org/resources/statistics.html). In Minnesota in 2009 there were close to 26,000 reports of child maltreatment with the majority suffering non-medical neglect. There were 44 children who suffered life-threatening injuries, and there were 21 deaths from child neglect and abuse (www.cdf-mn.org; www.mcbw.org).

Herrick and Piccus (2005) estimated that in cases of children who are in foster care placements, over two-thirds have siblings. The authors for this study used a bias sample, and had a subjective stance prior to conducting their research. For a sample, Herrick and Piccus

(2005) looked at themes established from cases they previously encountered. Other researchers, such as Hindle (2007), are finding that in trauma cases, oftentimes sibling pairs are referred during a time of anxiety and at a crisis point. The researchers found that they were then often asked whether to keep the siblings together or separate them for placement purposes (Hindle, 2007). Buroni (1998) also looked at sibling relationships, and found that sibling struggles have existed since the time of Cain and Abel in the Bible, and are a common find.

Trauma treatment is typically done independently with individuals or with a group treatment focus. One exception to this was McGarvey and Haen (2005). They wrote up a case study from their facility and acknowledged that their case was "an exception to the norm of trauma cases seen on our inpatient unit" (p. 395). McGarvey and Haen had a case of two brothers who had endured repeated trauma, abuse and neglect from their mother, and who in the course of treatment benefited from both individual sessions dedicated to discussing the sibling relationship and from group sessions together with their sibling as well group sessions with other children. The researchers wrote the case study illustrating that "strategies that developed from working with the boys have proven helpful in treating other traumatized children within [the agency]" (McGarvey & Haen, 2005, p. 395). McGarvey and Haen noticed that their case had a huge impact on the program and staff, as the staff had never before encountered a case of such extreme abuse as the brothers had endured.

Definition of Trauma

Complex trauma is often defined as the exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure (nctsn.org). These events are typically severe and pervasive, such as abuse (physical, emotional) and/or profound neglect. They usually begin early in life and can disrupt a child's development

and their formation of a self (nctsn.org). Trauma can have devastating effects on a child's physiology, emotions, ability to think, learn, and concentrate, impulse control, self-image, and relationships with others.

The Center on the Developing Child, at Harvard University, researched how the brain handles toxic stress that leads to complex trauma. *Toxic stress* refers to "strong, frequent, or prolonged activation of the body's stress management system" (Center on the Developing Child, working paper 3, p.2). Events that are chronic and are experienced without the support or care from an adult can adversely impact the brain architecture. As the report explains, science says that neural circuits in the brain that are specifically for dealing with stress are exceptionally malleable during the fetal and early years of childhood. Toxic stress experienced during this time period can "affect developing brain circuits and hormonal systems in a way that leads to poorly controlled stress response systems that will be overly reactive or slow to shut down when faced with threats throughout the lifespan" (p.2). Also, frequent or repeated activation of brain systems that respond to stress can lead to increased vulnerability to a variety of behavioral and physiological disorders over a child's lifetime.

Gearity (2009) defines trauma as events that cause "shock, surprise or sickening anticipation" (p.26). Gearity (2009), and Terr (1991) both look at traumas as events that are endangering, causing the child to feel helpless and "breaking past ordinary coping and defensive operations" (Terr, 1991). These are events that cause a child to need to develop survival mechanisms (healthy or unhealthy) to be able to make sense of the situation.

Leavitt, Gardner, Gallagher and Schamess (1998) define trauma in their work with children as a collection of basic traumas, which interfere with and change normal emotional

development. Trauma is often coupled with a DSM diagnosis of Post-Traumatic Stress Disorder (PTSD). In McGarvey and Haen's (2005) study, they explained that the siblings who were the focus of their case study had PTSD symptoms, suicidal ideation, sleep disturbance, and hyperactivity, all as a result of being chronically abused and traumatized by their mother.

Different types of sibling relationships

There are several studies that explore different types of sibling relationships, or what the impact of sibling relationships has on family systems. Buroni (1998) researched how sibling relationships can comprise a "complex web of emotions and feelings linked to elements of a cognitive, cultural and social kind which are not easy to disentangle" (p. 307). Buroni looked at instances throughout time- from the book of Genesis in the Old Testament, to Freud's, and other famous people's work- which portrayed sibling relationships. In another study Hamlin and Timberlake (1981) suggested that siblings can exert a "powerful influence" within their family system and therefore the sibling group should be examined as a course of treatment (p. 101).

Jealousy is a common emotion seen in sibling relationship dynamics. Volling, McElwain, and Miller (2002) recognize sibling jealousy as the "most powerful jealousy of youth" (p. 583). The parent-child relationship that is threatened in sibling jealousy is the most impressible relationship of a young child's early life. However, the authors also went on to describe jealousy between young siblings as an area under-researched. For their study, Volling, McElwain, and Miller (2002) looked at sibling pairs and other family members from 60 families with parents still married to one another, through a short-term longitudinal study investigating sibling relationships from infancy and early childhood. Families were selected through a convenience sample, and had to meet three criteria to remain eligible for the study: intact marital status, full participation from both mother and father, and having at least two children in the family, one of

whom was under one year of age, and the second child between the ages of two and six. Through several laboratory visits, the researchers observed sibling interactions and interactions with the mother and father. Jealousy was a common prevailing emotional trait that emerged during the sessions with one parent and one sibling (Volling, McElwain, & Miler, 2002).

In an interesting study that explored siblings relationships within trauma work, Leavitt, Gardner, Gallagher and Schamess (1998) found that there are four different categories that traumatized siblings fall into, *absent, adult lockout, half and half, and trauma shield*. The "absent" category is described by Leavitt, et al. (1998) as "traumatized children have failed to form enough connection to an adult even to seek out other relationships" (p. 58). Since they have not had any sort of meaningful attachment with an adult they are also unable to attach to their sibling as a possible safety source, and therefore their sibling has very little significance to them. An example to illustrate this category would be two brothers who were placed in foster care together and have a style of relating that appears disconnected. The brothers acknowledge each other as family, but do not seek out each other to play or for comfort. They do not have a "reciprocal investment" in each other (Leavitt, et al., 1998).

The *adult lockout* category describes how siblings have developed such a strong bond with each other that it serves as a substitute relationship or even a barrier to that of an adult or parent figure (Leavitt, et al., 1998). This category is illustrated by siblings ignoring their caregivers and instead relying on each other to parent the other. In siblings who witnessed and suffered from physical abuse, the interactions between the two siblings can take the form of hitting, fighting, pushing, tackling, etc as a way to "keep each other in line" (p. 63).

The third category, the *half and half*, consists of reenactment of traumatic events with their sibling due to the flawed attachments the siblings had to their caregiver (p.65). This sibling relationship is often the most violent, and is seen as a love-hate relationship with each other. This often plays out as "the siblings' relationship [becomes] both too important as a substitute source of nurturing and threatening as a potential cause for abandonment" (p.66). The siblings are confused about their psychological connection to a caregiver, and act out a push/pull relationship with each other to achieve maximum comfort from that caregiver.

The last category, the *trauma shield*, can often become a disadvantage to the siblings. In this category, the siblings use each other as a shield from the abuse and interrupt the development process. They become fixated at the same developmental level and exhibit similar interpretations of their struggles despite the chronological age difference. Typically, in this category one sibling identifies as the aggressor/protector, while the other identifies as the victim. The "aggressor" goes out of his or her way to do everything to protect the other sibling from harm, even putting himself or herself into danger. The "victim" in turn, is very fearful of adults and is extremely sensitive. The victim, when afraid, will signal to the aggressor to go into protective mode to get what he/she wants (Leavitt, et al., 1998, p.68). Without a healthy attachment to an adult, traumatized children cannot continue their developmental growth. In a normal childhood, young children practice early reconciliation, imitation, idealization, and identification with an older sibling as a sign of a positive attachment.

In the course of their work, McGarvey and Haen (2005) discovered that they had to alter their course of treatment in order to address the sibling dynamics. The authors saw within the hospital milieu new symptoms and themes emerge from the case of the two brothers during treatment. McGarvey and Haen noticed that the brothers were reenacting with each other and

other patients the traumas from their relationship from their caregiver, as seen in Leavitt's, et al. (1998) study on the different type of sibling relationships. The authors recognized that this sibling dynamic needed to be addressed in order to proceed in the course of treatment.

Treatment Interventions

Often in inpatient settings, it is the first time a traumatized child feels truly safe within their milieu and can begin to be treated (McGarvey & Haen, 2005). Thus many therapists try to create a safe milieu in their treatment, addressing the issue of safety first with traumatized children (Leavitt, et al., 1998; Leavitt, et al., 1996; Herrick & Piccus, 2005; Hamlin & Timberlake, 1981). Using safety as a starting point, therapists are then able to expand their treatment into a variety of methods.

A very unique treatment response was done by McGarvey and Haen (2005). The focus of their treatment was three different phases within an inpatient setting: the establishment of safety, grief and loss, and reconnection with ordinary life. McGarvey and Haen found that the brothers were reenacting a lot of the trauma with each other outside of their individual treatment sessions on the inpatient unit. The therapists, therefore, decided that these reenactments needed to be addressed within the course of their treatment, and collaborated on methods to treat the brothers individually and as a group to address the emotional responses.

One part of the authors' treatment was to help the brothers develop a sense of self, and increase their feelings of self-worth. The brothers held the shared experiences, and at first the authors separated the boys to help them establish their own sense of self in order to address and make sense of the traumas they experienced and help the brothers address the grief they shared over the experience (McGarvey and Haen, 2005).

Establishing safety was another part of the authors' treatment structure. According to McGarvey and Haen, "[g]ranting them a consistent schedule that they were easily able to understand and explaining what they could expect each day were keys to establishing safety and trust" (p. 398). Only after establishing safety and trust were the authors able to move on to treating the grief and loss and reconnecting with ordinary life for the brothers. The brothers were able to make some sense of their horrible trauma and begin healing as they prepared to reenter life outside the inpatient hospital setting. This method of treatment was seen as unique because it had been typically done only individually in this setting.

A more common treatment response is group treatment. Hamlin and Timberlake (1981) used a group treatment method to promote a better adaptive level of functioning with group members through reducing distress in the group members and increasing feelings of positive regard for the self and siblings. This was also used alongside individual and/or family treatment. The authors found that this treatment method, though often effective, was not always utilized by other therapists, as it could be difficult (Hamlin and Timberlake, 1981).

Leavitt, Morrison, Gardner and Gallagher (1996), also used a group therapy model for treatment, but designed it more as a group play therapy treatment. Leavitt, et al. (1996) described how the researchers used an eighteen-week psychotherapy group that was designed specifically for sibling pairs traumatized by the loss of a parent from AIDS. The group had a total of ten children, who ranged in ages from seven to twelve. They focused on three main themes: a sense of belonging, relationships used to promote self-soothing strategies, and grief and loss surrounding eventual loss of a parent with AIDS. The group play therapy was done in a directive fashion with a specific activity planned each session for the siblings to participate in together.

Other researchers focused on program evaluations of the current practices that therapists were doing. Hindle (2007) examined the protocol for placement of siblings in foster care using a psychoanalytic model. Hindle recognized the importance of sibling relationships, and saw the relationship between siblings as exceptional in its intimacy, and it can be either a relationship used to provoke or support one another (2007). Hindle looked at themes that emerged from six cases studies of her current practices that had interviews with siblings, and assessments completed of each sibling pair, in regards to their complicated circumstances. Hindle found themes such as cumulative trauma, persisting fear, loss, reenactments, and relatedness (Hindle, 2007). The data helped inform Hindle within her own practice whether to keep sibling pairs together in foster placements or in different settings.

Pepler, Catallo, and Moore (2000) published a program evaluation that explored the effectiveness of interventions for children exposed to domestic violence. In the case of siblings, the researchers found that treatment interventions should aim at being supportive in problem solving and in mediating conflicts that occur between siblings. They recommended using a family therapy technique to guide treatment.

Developmental Repair

Developmental Repair is a unique treatment model that was created as a result of a program evaluation and collaboration with staff at Washburn Center for Children located in Minneapolis, Minnesota. The staff at the agency found that more traditional behavioral models were no longer adequately meeting the needs of their clients. "Washburn, a non-profit community mental health agency…had served these children for many years but struggled with treatment efficacy, especially as children's symptoms and needs increased" (Gearity, 2009, p. 7). Developmental Repair was developed from a combination of research and literature that also

focused around repairing relationships and emotional regulation as a result of early trauma exposure. It is an intervention model used with young children who have severe disruptive behaviors and who cannot regulate themselves. It looks at the behavioral challenges in children as a result of intermittent and disorganized early learning (Gearity, 2009).

Interventions attend to four main domain areas that intersect within learning and from "patterns of functioning" that children have learned as ways to survive in their environment: *relating, thinking, feeling, and acting* (Gearity, 2009, p.44). In the *relating* domain, an intervention is used that "actively helps children seek and use adult help. This is in contrast to other interventions that ask children to accommodate to adult expectations" (p. 44). In the *thinking* domain, Developmental Repair "works to repair reflective thinking, and help children organize interpersonal expectations and associations…help children become aware of thoughts that reveal feelings and direct actions. We also help them see and understand the thoughts, feelings and intentions of others" (p.44). Again, in more traditional interventions this is contrasted by the assumption of children's cognitive awareness and intentionality. The *feeling* domain "actively helps children feel and understand their emotions…As children know their emotions, they can better manage emotional distress and behavioral upset" (p.44). This domain assists with emotional regulation in children. Lastly, the *acting* domain "actively helps children to become motivated to learn new patterns, or new ways of functioning that increase internal behavior control and improve social inclusion" (p. 44). As Gearity (2009) found, "all four domains contribute to children's capacity for self regulation…these four areas are interactive and intertwined, so intervention activity is continually shifting among, and engaging with, all these domains" (p.44). The research in this paper relies on the Developmental Repair model as a framework for this study.

Summary

The research states the importance of recognizing different types of sibling relationships (Buroni, 1998; Volling, McElwain, & Miller, 2002; Hamlin & Timberlake, 1981; Leavitt, et al., 1998), and having them inform treatment practices. There are a lot of common findings in using a group treatment technique with sibling pairs (McGarvey & Haen, 2007; Leavitt, et al., 1996; Hamlin & Timberlake, 1981). Only Peppler, Catallo, amd Moore (2000) looked at using a family therapy approach in treatment. Other researchers investigated using different assessments to determine whether siblings should be kept together in foster care placements or apart (Herrick & Piccus, 2005; Hindle, 2007).

However, there is a gap in literature surrounding trauma treatment and sibling relationships. With the high prevalence of this problem as seen by the DHS statistics and The National Center for Children Exposed to Violence, trauma is definitely happening to children and in many cases to more than one child within the home. Further research needs to be explored to look at outcome results in trauma treatment with siblings, and in the occurrence of practitioners seeing siblings in their caseload for treatment. This research study aims to explore what clinicians are currently doing to treat complex trauma in siblings.

Conceptual Framework

This study used the Developmental Repair model as the conceptual framework as a guide for the research. Developmental Repair is a unique model that is focused around repairing relationships and emotional regulation as a result of early trauma exposure. It is an intervention model used with young children who have severe disruptive behaviors and who cannot regulate themselves. It looks at the behavioral challenges in children as a result of intermittent and disorganized early learning (Gearity, 2009). The researcher chose this model because of its use in enmeshing attachment and development theories along with the family systems theory to provide a broad picture of what a child's environment includes and how it impacts the child.

One concept in Developmental Repair is *mentalizing*. *Mentalizing* is, according to Gearity (2009), "interpreting human behavior in terms of intentional mental states (needs, desires, feelings, goals, and reasons)" (p.32). Mentalizing has also been looked at by other researchers such as Fonagy, Asen, Gergely, and Target (2000, 2007, and 2012). Fonagy (2000) defines in one article mentalizing as the "understanding of one's own as well as others' behavior in mental state terms" (Fonagy, 2000, p. 1131). Mentalizing is defined as having overlapping functions that:

> "compel us to interpret (human) actions as caused by intentional sates (beliefs, desires, wishes)…[it] enables humans to infer, attribute and represent the intentional mental states of others-a capacity that can clearly extend to generate representation of one's own mind " (Fonagy, Gergely, & Target, 2007, p. 289).

Fonagy, Gergely and Target (2007) later discuss how mentalizing also contributes to the discovery of the sense of self. Fonagy (2000) explored how having a secure attachment with a parent/caregiver "may be a key precursor of robust reflective capacity" (p.1131), and be able develop a strong sense of self. The child is able to "'find himself in the other' as a mentalizing

individual. The development of awareness of mental states in oneself can then be generalized to the caregiver" (p. 1132). Asen and Fonagy (2012) stated that:

> "effective mentalizing is not only the capacity to read accurately one's on or another person's states of mind, thoughts and feelings. It also refers to a way of approaching relationships that reflects an expectation that one's own thinking and feelings may be enriched and changed through learning about the mental states of other people and through a readiness to take into account their perspectives, needs and feelings" (Asen & Fonagy, 2012, p. 349).

Mentalizing also builds on a concept Daniel Siegel (2012) calls "*mindsight*". Siegel defines mindsight as "the ability to see the internal world of self and others". He goes on to say that this "may be essential in healthy relationships of many kinds" (p.34). Siegel later discusses how in the brain of a child who has not suffered trauma, the brain is able "to take in information about the subjective mental state of another person…as with other aspects of mental functioning, looking toward information processing helps us to understand the 'mentalizing' ability of the mind" (p. 259). In children who have suffered trauma, their brains have learned how to shut down the capacity for mentalizing, and "may be able to disengage the components essential for reflective functioning" (p. 261). Children who have suffered trauma are not able to mentalize, and therefore often misread situations with peers or adults.

A second concept in Developmental Repair is the four developmental domains that were explored in the literature review: *relating, thinking, feeling, and acting*. These come from patterns of functioning that children have learned as ways to survive in their environment. Gearity (2009) stated that "Developmental Repair recognizes that these children must access more adaptive ways of functioning" (p. 44).

Another concept in Developmental Repair is the *arousal curve* (Gearity, 2009). In the arousal curve, the child becomes triggered by something and becomes aroused, or upset. At the

point of optimal intensity, the arousal is often enough to upset the child, but not so much as to be overwhelming. In a child with a stable attachment or no trauma history, at the point of optimal intensity, a parent or caregiver steps in to help co-regulate, helping the child soothe which provides the child with new learning. In a trauma impacted child, or dysregulated child, at the point of optimal intensity instead of having the new learning occur, the child keeps becoming overwhelmed with the emotions. The child does not have adult help available, and cannot regulate on his or her own or self soothe (Gearity, 2009).

Emotional regulation is an important concept to understand how the arousal curve affects dysregulation. Children without a stable attachment to a parent or caregiver do not have a "regulatory partner" (Gearity, 2009, p. 45). Other researchers, such as Music (2014) have found in dysregulation, traumatized children who "typically are dysregulated, cannot concentrate, can barely hold two thoughts together, are restless, sometimes hyperactive and who struggle in relationships" (p.3). He explored through a case study how maltreated children are generally "hyperaroused and hypervigilant" (p.3), and have neurobiological responses linked to the sympathetic nervous system. These children have not had an adult or caregiver to have "developed basic self-regulatory skills" as infants, and much of the work with maltreated children must begin, according to Music (2014), with a psychotherapeutic approach, "initially about moving towards emotional and bodily regulation…" (p. 3). Music also found that in working with maltreated children "we need both an awareness of the psychobiological processes involved in dysregulation and an understanding of the need to facilitate higher-order cognitive and EF [executive functioning] capacitates" (p. 4). Only after understanding this need can a therapist treat the child and teach new emotional regulation techniques.

Siegel, in his book "The Developing Mind" (2012) stated that

> "[e]motional 'dysregulation' can be seen as impairments in this capacity [nervous systems of the brain] to allow flexible and organized responses that are adaptive to the internal and external environment. When integration is impaired, coordination and balance cannot be achieved, and the system moves towards chaos, rigidity, or both" (p.269).

Siegel found that "[w]ithin the clinical setting, the relationship of therapist and patient can become the 'external constraint' that can help produce changes in the individual's capacity for self-organization" (p. 270), and therefore learn to self-regulate. Siegel stated that it is possible to recover from dyregulation, by "decreasing the disorganizing effects of a particular episode of emotional arousal" (p.287).

Gearity (2009) states "even the children who are chronically aroused need to find a safe mid-range of arousal intensity in order to know that arousal can subside" (p.42). She also states that children, "[w]ith adult empathy for their perspective… [t]hey can see what happened to them and tolerate solutions that fix their distress. They can feel regulated enough to think about what to do" (p.43). Children need to learn emotional regulation as part of their treatment and be able to make new meanings of their distress.

A last concept in Developmental Repair is *joining* (Gearity, 2009). Joining, is considered under the first domain of thinking, but is a concept strong enough on its own. Joining expands on the concepts of mentalizing and emotional regulation in that *joining* builds new patterns with children. Joining shows children that an adult is present to assist in regulation, and will not leave them when the situation becomes difficult. As Gearity (2009) states, "[t]reatment starts with joining the child. Joining means being available to children, and becoming interested in their experiences and perceptions" (p.45). This leads into establishing safety with the child or siblings and helps "children to re-activate the normative process of becoming regulated, which starts with the expectation that adults can and will help" (p. 45). Joining also helps in promoting healthy

regulation. Gearity found that "[j]oining becomes most important when difficulties emerge" (p.46). Joining helps the child, or sibling become aware that an adult will stay with the child, even when things become difficult, such as when they become dysregulated.

The researcher used the Developmental Repair model as a framework for developing interview questions that explored best practices in treating complex trauma in sibling pairs. This model was chosen based on the researchers familiarity with it, and the model fit with what the researcher initially thought were important concepts in treating complex trauma in siblings.

The next section will describe the methodology used for this study.

Methodology

Research Design

For this project the researcher performed an exploratory qualitative study using interviews that looked at clinicians' perceptions of treatment of siblings who have experienced complex trauma. The researcher chose this method because it allowed a deeper exploration of the research topic using both closed ended and open ended questions. The method also encouraged participants to be more open in their communication and broadened the information given to the researcher.

Research Setting

To allow greater diversity in the client population, the researcher requested interviews with practitioners from different community based agencies, such as mental health clinics and hospitals which serve children in the Minneapolis/St. Paul area. Agencies were contacted based upon whether they currently provide day treatment programs or have identified treatment services in trauma work with children. Interviews took place in the practitioners' offices at their agencies, or at a predetermined location that afforded privacy for confidentiality.

Sample

The sample was formed using a snowball sampling (Monette, Sullivan & DeJong, 2008) to allow access to practitioners who are currently working in the field of this study. The researcher relied on participants, committee members, and known practitioners in the field to help identify other practitioners within their scope of practice who were willing to participate in this study. Criteria for selecting study participants included their having a familiarity with the Developmental Repair model, attachment theory and child development stages. In addition,

participants should be mental health professionals with at least two years experience in the mental health field and have had experience working with siblings, especially those exposed to childhood trauma.

The researcher reached out to nine total participants, with four declining or unable to participate. The research interviewed five twin cities seasoned clinicians. From that sample, three had a background in clinical social work (LICSW); one was a licensed marriage and family therapist (LMFT), while the fifth participant held master level degrees in both social work and marriage/family therapy. All five participants were female, and while majority had practiced with children and families for six-10 years, one participant had been in practice for more than 20 years. At the time of the interviews, three were currently practicing in a day treatment setting, one clinician was a hospital social worker, and one worked in a private out-patient practice.

Protection of Human Subjects

Insuring confidentiality is an important part of this project. The researcher wanted practitioners to be open and honest in their interviews and took precautions to insure the information received remained confidential. The researcher recorded interviews that were later transcribed. All electronic transcriptions are kept on an encrypted flash drive that only the researcher will have access to. All data (comprising of paper field notes and electronic transcriptions) will be deleted and destroyed by July 1, 2014. Prior to the interview the researcher had each participant sign a consent form to give informed consent and to share with them the measures being taken to protect confidentiality. A transcriber used by the researcher also signed a confidentiality agreement prior to any work done on the research project. No names were used in the finished written product; interviewees were differentiated by assigned case numbers.

Instrument

The researcher conducted interviews using predetermined questions to guide the conversation (see appendix B). The questions were designed with the conceptual framework of Developmental Repair in mind, as well as findings from the literature review. In order to reduce bias, the predetermined questions were reviewed by the chair and committee members prior to any interviews taking place.

Some of the questions collected information regarding demographics and clients served. These questions collected data on ethnicity of clients, age range, and clients' current living situations. Other questions revolved around clinician and agency related information in regards to average client caseloads, frequency of client visits, clinicians' graduate level emphasis, and theoretical approaches. Finally, there were some open ended questions regarding the setting clients are seen in, ways the Developmental Repair model's concepts are used in practice, and the clinician's approach to dysregulation of a child. Clinicians were also asked what helps or hinders their work with siblings, and how they measure success.

Data Collection

Data collection was done using the following steps: 1) The researcher requested committee members to identify 2-3 potential participants for the study. 2) The researcher contacted each potential participant via email, introduced the study and provided the potential participant with the interview questions and informed consent form. 3) The researcher set up interviews with interested potential participants. 4) For potential participants who did not contact the researcher within one week, the researcher made one follow-up contact via phone or email to see if they were interested in participating in this study. 5) Prior to the start of interview, the researcher had the participant sign the consent form. 6) Interviews lasted around 45 minutes

and were conducted at the participant's worksite or an alternate site agreed on by researcher and participant. 7) The interviews were audio recorded. 8) The researcher's transcriber, after signing a confidentiality agreement, helped to transcribe interviews. 9) Each participant was asked for an additional 2-3 names of potential participants and the data collection process was repeated until the researcher had 8-10 scheduled interviews, of which 5 took place.

Data Analysis

The research data was analyzed through content analysis (Padgett, 2008) and themes were identified using a two step process. First, the researcher looked at each individual question to discover common answers. The second step sought to identify general themes that were intertwined throughout all the questions. Third, responses were compared between questions to identify other potential themes. Themes were established by a majority of two or more clinician's having a similar response.

Researcher Bias

The researcher's foundation internship placement was in one of the agencies with this target population. This experience assisted the researcher with familiarity with the topic, and with the target population. This familiarity could also hinder the study in that the researcher has worked with the target population in one specific way prior to this study, and could have developed certain perceptions. To address this bias the researcher had the committee members and chair review the interview questions prior to any interviews taking place.

The next section will report the findings from the research.

Findings

This qualitative study sought to explore how current clinicians are treating complex trauma in siblings. Questions were posed to five seasoned clinicians. Overall, two themes emerged from specific questions. Question 5, which was *Are there ways that siblings can become the co-regulator in relationships, and should they be in that role,* gave rise to the theme of *Siblings as Co-regulators.* Question 8, which was *how do you determine when your work with a client is successful,* gave rise to the theme of *Healthy Regulation*. Other themes that were generated from all the other questions included; *Joining, Client Driven Pace, Create Sense of Safety, Mentalize, Create Individuality/Sense of Self, Sibling Dynamics,* All interviews were completed within a six week time frame from February to March. Below is a report of the findings from the interviews.

Siblings as Co-Regulators

Question five from the interview asked clinicians, "Are there ways that siblings can become the co-regulator in relationships? Should they be in that role?" All five participants answered yes, siblings can become co-regulators, before going into specifics as to why that may or may not be the best option. One participant stated that:

> *"[yes, but] in an ideal world, I would say, probably not. It wouldn't be the best choice for consistent help of a co-regulator. However, in a lot of our families, their parents aren't consistent, they move a lot, so their teachers aren't consistent, and that kind of things, so their siblings are the people that are permanent and can help them" (transcript #4, p. 4).*

This participant believed that while not ideal, sometimes because a sibling is a permanent person in the life of a child's, they can substitute in the role of co-regulator, when a caregiver is not able to fulfill that role to help. A second participant stated that "*siblings can be just a wonderful asset and strength"* (transcript #1, p. 4), in regards to co-regulation. One participant stated that

definitely siblings can be co-regulators. She went on to state, "*I think you have to be careful with it, because I think that kids can take that on, and then they are becoming caregiver or caretaker, and you want them to have their own identity"* (transcript #2, p. 8). Another participant agreed with the first participant in that it was not ideal, however she went on to discuss, "…*I've seen siblings be able to be really encouraging when maybe the staff wasn't necessarily able to…the sibling can give good ideas or use touch in ways that the [dysregulated sibling] may not allow us to"* (transcript #3, p. 5). The fifth participant also agreed that siblings can be co-regulators, but not in every situation.

> "*I think that if the sibling doesn't understand what is going on, if they're not old enough or not currently able to, it can be really damaging for that sibling, so to be really mindful about how that could affect both kids* (transcript #5, p. 6).

Healthy Regulation

Question number eight asked, "How do you determine when your work with a client is successful?" The common theme discussed by all five participants was being able to self-regulate in healthy ways. Whether it is through helping siblings become co-regulators, or teaching each sibling to be able to self-regulate in appropriate ways, all five participants discussed successful treatment through teaching healthy regulation tools, as discussed from questions three and four, in how to help when a child is dysregulated and how to help the child achieve new learning. From question eight, each participant measured their success through clients being able to regulate more, and "*when there is more stability and less dysregulating crises"* (transcript #1, p. 7). Being able to "*generalize the skills"* (transcript #3, p. 9) taught during treatment, and the ability to apply those during moments of crisis while being able to self-soothe, or regulate, is another way to measure success of treatment. Two participants discussed how being able to appropriately "*express their feelings and their needs in ways that are understandable"* (transcript #2, p. 10) and "*making really really tough kids less tough"*

(transcript #4, p. 11) are how they define success and know that the child can self-regulate in a healthy manner.

Joining

In the theme of *joining*, throughout questions #2-9, each participant mentioned *joining* being a foundational skill to beginning and continuing any work with a child who has complex trauma. *Joining* with a child or sibling during not only the good moments, but also during difficult times helps the child learn that here is an adult who will stick with me or can handle my trauma. One participant said,

> *"The main component of that is to build relationships with kids. It's to give them a new understanding of how to have a relationship with both adults and with their peers…we don't assume that kids can self-regulate by themselves, so we have to join with them in order to help them do that"(transcript #4, p.1).*

Client Driven Pace

Two of the five participants spoke at length about the success of treating siblings who have complex trauma is through a *client driven pace*. One participant discussed how the way to join with a client is through "*developing trust through not pushing, go at the clients pace…always acutely aware that we are going to get there"* (transcript #1, p. 1). She also later discussed how "*constantly attending [to dysregulation]…for how this trauma processing is gonna go so that each session you're checking in, you're bringing it back…you're listening to their internal world"* (transcript #1, p. 3). The second participant discussed how following the client's lead helps the therapeutic relationship in that,

> *"Especially with kids and adolescents you know a lot of times they are getting brought here by someone and parents are stressed and kind of shaking their finger hoping someone is going to tell them to knock it off too. And so that's what you start with sometimes, and so you kind of need to really quickly be able to shift that where you can be someone that can relate to them, and that it's safe in here…so that they have a say in what kinds of things that are going to be talked about…*"(transcript #2, p. 4-5).

Create Sense of Safety

Safety was a theme often discussed during the interviews. In particular, in questions 2-5, all five participants discussed creating a sense of safety. When attending to dissociation in a child to promote new learning (question #4), or helping a child who is dysregulated in session (question #3), one participant discussed "*building resources, helping them develop kind of like a safety kit or backpack of helpers"* (transcript #2, p. 6). Two other participants also discussed how "*reassuring them of their safety"* (transcript #5, p. 4, transcript #3, p. 4) can help bring a child back to the present, or help a sibling know that their brother or sister is "*safe with the adult who is helping them"* (transcript #5, p.5).

Mentalize

Four of the five participants spoke about *mentalizing*, and helping siblings learn to read each other's cues during questions 3, 4, and 8. Whether it was through "*helping them recognize what does this mean…this means your brother's really overwhelmed, he already told you and now he can't tell you anymore it's so hard" (transcript #2, p. 7),* or "*reading the situation, narrating out loud"* for the sibling (transcript #5, p.3, 5, transcript #4, p.3). One participant discussed it as "*helping them understand how they can take what they are learning here and then figure out who can do it at home"* (transcript #4, p.4).

Create Individuality/Sense of Self

All five participants discussed throughout questions 3-8, the importance of having siblings develop their own *sense of self*, and *create their own individuality*. For many of the participants, this is what has helped them in their work with siblings. One participant stated,

> *"a lot of times…they don't have a sense of self. They were so wrapped up in each other or like as brothers that they didn't have an understanding of who each kiddo was, and they are very different. And that's often how I've found it for [twin pair with complex*

> *trauma], they're very different from each other, but they're so wrapped into each other. And they're often put into the same classes at school, so they can't become independent…but I think initially, to help them grow independently and figure out who they are…is good"* (transcript #4, p. 6).

Another participant discussed how you have to be careful with siblings, and that *"you want them to have their own identity, not that their identity is to care for that sibling all the time"* (transcript #2, p.8). A third participant echoed the first participant's thoughts on twin siblings, and how *"giving them the space and ability to do that...processing of the traumas in their own different ways…is really helpful"* (transcript #5, p.8). Another participant discussed how in one case, part of her work was done in encouraging the mother to let the siblings be more independent (of each other), and stated,

> *"She was like dead set on having them dress the same way until they were like 14-15 years old, and so just kind of encouraging different areas of independence, encouraging her to give her kids different areas of independence helped their treatment"* (transcript #3, p. 9).

Sibling Dynamics

While *sibling dynamics* also can relate to the previous theme of *sense of self*, it stands on its own in how it can impact treatment. Siblings can become a co-regulator sometimes in the absence of having a parent/adult who can assist until the child is able to self-regulate. As one participant stated, it can be "*just a wonderful asset and strength"* (transcript #1, p.4). In her experience, when the sibling dynamics were on an equal level, with one not holding power over the other, the siblings were able to *use each other as a way to regulate.* One sibling would not get *"out of control because he knew how it would impact her…so she would be a motivator to continue healthy behaviors"* (transcript #1, p. 4). The same participant also went on to say that in some instances, when a sibling has been brought into a session without having much knowledge of what the other sibling has experienced from complex trauma, it can become tricky adding

> *"with this whole other dimension to the family that you are completely unaware of, and so it's hard to engage…they could be bringing in…a completely different perspective, and they could also have either resentment or harsh feelings towards the sibling. They could have, they could be so uninterested because of what they've been through, they're bringing in this whole new dynamic"* (transcript #1, p.6).

Three other participants discussed in questions 5 and 6 how *mixed up family roles, confusion or blurred roles* (transcripts 3, p. 9, transcript #5, p. 7) can make treatment more difficult. One example that another participant gave while answering question 4, was helpful in illustrating how sibling or family dynamics can affect treatment:

> *"I work with one family who have, the youngest child has autism, and you can really see that there is a really strong value that this kid …you must love her, I mean let's care for her, and she's special. And she is just a sweetheart of a kid, but what has developed in the siblings, the older sisters, is their whole identity is caught up in how good a caregiver they are, and as they get older and there's some frustration, or maybe a little anger that they're missing out on some things, but you can't be angry at her, because she's the special one, and that goes against our family value. Or there is competition between them, who cares for her better, so it can morph into a much more complicated dynamic, so I think you have to be very careful about that."* (transcript #2, p.8).

The same participant discussed in response to question 5 how during sibling sessions in treatment she likes to *"try and get out of their way when it's alright to, and partly to observe the dynamics, and to recognize them, to give them positives for what they do well together, to help them redefine who they are together"* (transcript #2, p.9).

The next section discus these findings.

Discussion

Sample

This study consisted of five seasoned clinicians with a social work or marriage/family therapist background, who ranged from six to 10 years experience, to more than 20 years experience in working with children and families. This was not a representation of the study population, as there was not much variety in the participants' backgrounds. All five participants were female, and identified as Caucasian. While there was one licensed Marriage/Family therapist, three licensed clinical Social Workers, and one who was trained in both, all operated from a systems theory and attachment based approach. All five participants were familiar with the Developmental Repair model, and had it inform part of their work.

Siblings as Co-Regulators

Question five from the interview asked participants if there are ways siblings can become co-regulators in relationships, and should the siblings be in that role. All five participants agreed that yes, siblings can become a co-regulator within their sibling relationship. However, answers varied on how that role should look as well as if the siblings should be in that role. This theme was identified as important because of the unanimity of agreement among the five participants. This means that current clinicians are noticing the importance that while a parent is an ideal co-regulator, a sibling can take that place in treatment if a primary caregiver is unable to fulfill that role.

It is important to point out that while the literature does not look into co-regulation, it does look at emotional regulation and sibling dynamics, themes later discussed. In terms of emotional regulation, Gearity (2009) stated "even the children who are chronically aroused need to find a safe mid-range of arousal intensity in order to know that arousal can subside" (p.42).

Siegel (2012) found that "[w]ithin the clinical setting, the relationship of therapist and patient can become the 'external constraint' that can help produce changes in the individual's capacity for self-organization" (p. 270), and therefore learn to self-regulate. Siegel's work was close to hinting at co-regulation, but did not delve into who (parent, caregiver, sibling) can best help the child co-regulate. The focus on sibling dynamics also hints at the idea of siblings as co-regulators. This lack of attention from the literature review is perhaps due to none of the authors looking at the specific idea of siblings as co-regulators.

Healthy Regulation

Question eight from the interview asked participants how they determine when their work with a client is successful. From the answers, a common theme of being able to self-regulate in healthy ways was discussed by all five participants. All stated that when their clients are able to get through disappointment, or crises while being able to self-regulate, they know that they have been successful in their treatment.

Since every participant during the interviews discussed this skill as a measure of success, it was considered important to include in the findings. This was supported in the literature by Music (2014) and Siegel (2012). Music (2014) found that traumatized children "typically are dysregulated, cannot concentrate, can barely hold two thoughts together, are restless, sometimes hyperactive and who struggle in relationships" (p.3). Music also found that in working with maltreated children "we need both an awareness of the psychobiological processes involved in dysregulation and an understanding of the need to facilitate higher-order cognitive and EF [executive functioning] capacitates" (p. 4). Only after understanding this need can a therapist treat the child and teach new emotional regulation techniques.

Siegel also found that "[w]ithin the clinical setting, the relationship of therapist and patient can become the 'external constraint' that can help produce changes in the individual's capacity for self-organization" (p. 270), and therefore learn to self-regulate. Siegel stated that it is possible to recover from dysregulation, by "decreasing the disorganizing effects of a particular episode of emotional arousal" (p.287). The participants found that through seeing their clients learn to self-regulate, it was possible to see the clients get through disappointments or crises without their emotions getting too big or dissociating and getting stuck in their emotional response as they did prior to treatment.

Joining

From questions #2-9, all five participants mentioned *joining* being a foundational skill to beginning and continuing any work with a child who has complex trauma. This strengthened the finding that *joining* is very crucial to any treatment in trauma work. To support this, several of the participants spoke of joining as a way to help children learn to self-regulate and build a therapeutic relationship

Majority of the literature did not look into joining as an important theme. The lack of mention in the literature may be due to it being a concept that many researchers assume the reader knows or is aware of. Joining is also seen as part of the process in promoting healthy regulation, and establishing safety, two other themes discussed from this study. However, joining is an important concept that comes from one of the four domains in the Developmental Repair Model (Gearity, 2009), *relating*. In the *relating* domain, an intervention is used to help children actively seek out and use adult help. This researcher was happily surprised that all five participants were familiar with the model and had incorporated some of its concepts within their scope of practice. This may not be true if the researcher was to attempt to broaden the research

sample in future work. Researching newer or more recent articles on treating complex trauma in children may produce more findings along the theme of joining.

Client Driven Pace

Two of the five participants spoke at length about the success of treating siblings who have complex trauma through a *client driven pace*. This was determined as an interesting finding due to the fact that both participants were not in day treatment settings, unlike the other three participants. Both participants currently work in very different clinical settings, and yet drew upon the theme of having treatment at a *client driven pace*. This may mean that in day treatment settings, this is theme is already assumed, and their pace is typically client driven. In other settings the pace may not always be client driven, and in fact, in many cases the therapist may drive the pace due to time constraints of sessions, or agency policies. In other words it is noteworthy that pacing is integral to any process. The research from this study did not specifically look at the importance of focusing on a client driven pace. McGarvey and Haen (2005) noticed in their study that they needed to adjust their pacing, and altered how they treated the brothers to better accommodate the boys' needs. This corroborates this study's findings by recognizing that the therapists allowing a more client driven pace, letting the client have choices, and not forcing treatment upon them, helps the therapist *join* with the client and establish a *sense of safety*, two other themes established from this study.

Creating Safety

Each participant in their interview discussed the issue of safety in some form, implying that treatment would not go anywhere until the client has joined with the therapist and feels the therapist will still be able to help when things get difficult. Participants discussed how helping

bring a child back to the present or helping a sibling know that their brother or sister is *safe* furthers treatment and helps the siblings start to trust the therapist.

It was surprising to not find a lot of research on creating safety in trauma work with children. This may be a topic that is often discussed among clinicians, but rarely researched due to the added complexity of attempting research work with children and meeting the standards that the Institutional Review Boards generally set for such research. Most researchers appeared to glance over the topic, assuming the reader knew more. McGarvey and Haen (2005) discussed how often in inpatient settings, it is the first time a traumatized child feels truly safe within their milieu and can begin to be treated. They went on to discuss how only after establishing safety and trust were the brothers able to move on to treating their grief and loss and reconnecting with ordinary life. Other researchers found that addressing the issue of safety first with traumatized children is a starting point for therapists to then be able to further their treatment into a variety of methods (Leavitt, et al.. 1998; Herrick & Piccus, 2005; Hamlin & Timberlake, 1981). However, few researchers from this literature review go further into the topic.

Mentalize

Four of the five participants spoke about mentalizing, throughout questions 3, 4, and 8, and helping siblings learn to read each other's cues. Mentalizing helps the siblings learn to understand what is happening within him or herself as well as with their sibling, and what their sibling may need. This is a concept emphasized in the Developmental Repair Model (Gearity, 2009) that research participants mentioned as a way to treat complex trauma.

Other researchers looked at menatilzing as an important skill to look at in treating trauma. Siegel (2012) in particular looked at how in children who have suffered trauma, their brains have

learned how to shut down the capacity for mentalizing, and "may be able to disengage the components essential for reflective functioning" (p. 261). Children who have suffered trauma are not able to mentalize, and therefore often misread situations with peers or adults. Fonagy, Gergely, Target and Asen (2000, 2007, 2012) also discussed mentalizing, but took it from an approach of how it helps a child develop a sense of self, the next theme discussed.

Create Individuality/Sense of Self

All five participants discussed throughout questions 3-8, the importance of having siblings develop their own sense of self, and create their own individuality. Many of the participants discussed how the siblings were often too intertwined with one another, and needed their own space and therapist to be able to develop a sense of self so that they could later work together on their trauma history and help each other process that trauma. This researcher can only speculate on how this makes sense due to some of the sibling dynamics as well as role confusion within families. In cases where the siblings did not experience the same trauma, but rather different ones, this strengthens the need to develop a sense of self to help the siblings be able to process their trauma and be able to relate to their sibling in a regular, healthy way.

Several of the research articles supported the theme of creating individuality/a sense of self. McGarvey and Haen (2005) specifically discussed creating a sense of self as part of the treatment process. They found that they needed to help the brothers develop a sense of self, and increase their feelings of self-worth as part of their treatment. Fonagy, Gergely, Target and Asen (2000, 2007, 2012) discussed how mentalizing promotes a learning of sense of self. As discussed earlier in the literature review, the child is able to "'find himself in the other' as a mentalizing individual. The development of awareness of mental states in oneself can then be

generalized to the caregiver" (Fonagy, 2000, p. 1132). Fonagy (2000) discussed that through mentalizing one is able to develop a sense of self.

Sibling Dynamics

Four out of the five participants discussed sibling dynamics, and how it can affect treatment both positively and negatively. In some cases the clinician will separate the siblings for a period of time, to let each develop a sense of self before bringing the siblings back together. In other cases the clinician holds sibling sessions where she can observe the interactions.

Majority of the research looked at sibling dynamics, and how they can affect treatment for siblings, and the impact they have on family systems. From Buroni's (1998) study on sibling relationships throughout the history of time, and how they can comprise a "complex web of emotions and feeling linked to elements of a cognitive, cultural and social kind which are not easy to disentangle" (p. 307); to Volling, McElwain and Miller (2002) and their study on sibling jealousy and it's affect on the parent-child relationship, researchers looked at a variety of angles in how sibling dynamics can affect treatment. Leavitt, et al (1998) described four different categories that traumatized siblings fall into, and how it affects treatment.

Researcher Reaction

The researcher was validated in initial expectations of how current clinicians are looking at the whole system of a child who has experienced complex trauma, including looking at a sibling who may be in a similar situation. Clinicians' are looking at ways to address sibling dynamics, and the importance of addressing them within therapy. The researcher was excited to learn how clinicians in different settings are using the Developmental Repair Model (Gearity, 2009), and applying it to their work. Also, the discovery of the emphasis on helping siblings

identify a sense of self, and their own individuality as a form of treatment was important to look at, as many siblings cannot be treated together right away as they are not ready. The researcher went into this study with an open mind, excited to learn what clinicians in the field are currently doing in their work. This research fulfilled the researcher's expectations and helped the researcher explore and gain an understanding of what are common themes in treating complex trauma in siblings.

Limitations and Recommendations for Future Research

There were several limitations to this research. The researcher had a small sample size of five participants instead of the expected eight to ten, and it was not representative of all clinicians in this field. Some of this was in part due to the time restraints the researcher had, which did not allow a lot of flexibility in schedule or long time frame to complete the interviews in. This was also due in part to bad weather preventing and requiring several rescheduled visits to complete the interviews, further limiting the timeframe. However, the participants interviewed granted plenty of flexibility in allowing a rescheduled time due to the bad weather, and were excited to participate in this research. Using a snowball form of generating a sample did not identify a broad array of clinicians within the field, and made it more difficult to be generalized. As part of the snowball sample steps, participants were asked to provide other potential names for possible interviews. This also proved difficult in that many participants were unable to find names due to being busy at their agencies or finding a lack of interest and/or time from other clinicians. However, the backgrounds of the participants interviewed were extensive enough to ensure a richness in depth and variety in responses. In the future, using a purposive sampling to specifically target clinicians in different types of settings may be beneficial in generating more diversity in responses. Also for future research, this researcher recommends

distributing an online survey to clinicians to gather a much larger sample size as well as to access clinicians in a variety of settings.

Another limitation was that the interview questions were very specific to attending to dysregulation and joining process. They did not look at specific treatment modalities, or theories applied to practice other than developmental repair, which may be why there was little found within the literature and the topics discussed were too narrow. However, the questions allowed for in depth exploration of clinicians perceptions of treatment. Recommendations for future research include broadening the questions to explore specific modalities besides developmental repair, as well as exploring what modalities clinicians are currently using to treat children with complex trauma and if clinicians treat siblings together or individually. This research study was a beginning look at what is being done and generating interest in the subject matter. A final recommendation would be to perform a pilot study and place the developmental repair model in an agency or school and measure its outcomes.

Implications for Social Work

In the eight themes found from this research study there are several implications for social work. From the themes of *sibling as co-regulator* and *healthy regulation*, social workers should be trained in promoting healthy regulation and helping a child learn to self-regulate. If there is not a caregiver appropriate to help the child co-regulate, then the social worker can help teach the sibling to *mentalize* and read and understand their sibling's cues.

In the theme of *joining*, there is an implication of strengthening joining strategies for clinicians. This could be an important training for professionals working with children, their teachers, day care providers, etc., to educate on the importance of *joining* and how it will ultimately benefit the working relationship one has with the child. This would especially assist

schools in how they work with children who have suffered complex trauma. While schools are trying to move away from the behavioral model, many administrators/teachers still look at what the behaviors of the child are, and do not look at what may be causing these behaviors. By joining with the child they will gain a better understanding of who the child is, and see the child, not just the behavior.

The theme of creating a *sense of safety* is something that all clinicians should be trained in. Within a school setting, educating the staff, and specifically the school social worker, on what the benefits are of establishing safety with a child would reduce a lot of the overall behaviors seen, as the siblings would begin to learn to allow the adult (teacher, staff, social worker) to help them, and teach siblings and children healthy ways to regulate and ask for help when emotions get too big for a child to contain.

Lastly, the themes of *creating a sense of self* and *sibling dynamics* both illustrate that you can treat siblings together, but must factor in allowing the siblings to be able to create their own identity, and have their own individuality before treating the siblings together. Also, social workers who have a good understanding of systems theory, and are able to understand sibling dynamics will benefit in their work with siblings who have complex trauma. More needs to be done to help educate clinicians on different sibling dynamics and how they can play out in therapy in order to recognize them and address them within the session. This would help educators too in recognizing that putting siblings in the same class at school may not be the best idea, and that the siblings need time apart to develop their own sense of self, so that they can enjoy their time together as siblings.

Conclusion

There is a growing prevalence of siblings who have complex trauma. More siblings are being admitted to day treatment programs and are seeking resources for treatment of complex trauma. Clinicians are seeing more siblings from the same family, and agencies are trying to adopt policies on treating more than one family member concurrently. Schools are beginning to see more need for interventions with children who have suffered trauma, and are struggling to adopt resources to address the growing problem.

This exploratory qualitative study is a first step to give an initial overview of the growing need to treat siblings who have complex trauma, and draw attention to the matter. Many clinicians are already looking at this problem and are discovering ways to address it. Further research needs to happen to look at outcome measures of treatment, and what works in treating siblings.

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Appendix A:

Consent Form University of St. Thomas GRSW682 Research Project

Lessons from the Field: Clinician's Perceptions of Treating Complex Trauma in Siblings

I am conducting a study about clinician's perceptions of treating siblings who have experienced complex trauma. I invite you to participate in this research. You were selected as a possible participant because of your work in the day treatment setting with the population I am researching. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Elisabeth Wells, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Dr. Michael Chovanec.

Background Information:

The purpose of this exploratory study is: to look at what are clinicians currently practicing in treating siblings who have experienced the same complex trauma? The study will be addressed through a qualitative study with interviews of professionals in the field who come across treating childhood trauma.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Meet with researcher for a 45 minute interview that will be audio recorded.

Risks and Benefits of Being in the Study:

There are minimal risks of participating in this study. Practitioner's uncomfortable feelings may be triggered by review of their previous trauma work.

The study has no direct benefits.

Confidentiality:

The records of this study will be kept confidential. Research records will be kept in a locked file. An electronic copy of the transcript will be kept in a password protected file on the researcher's computer and on an encrypted flash drive. Only the researcher will have access to the password. Interviews will be audio recorded and transcribed by a transcriber. A transcriber used by the researcher will sign a confidentiality agreement prior to any work done on the research project. There will be no names used in the finished written product; an assigned case number will be used to differentiate between interviewees. Themes that are identified from the interviews and quotes from the interviews will become a part of the written research study that will be accessible through the School of Social Work. Demographic data that is collected from the interview will be used in the written report but will not be linked to any identifiable interviewees. All data will have been completely analyzed by May 2014. All data, including field notes and audio recordings will then be destroyed before July 1, 2014.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used in this study.

Contacts and Questions

My name is Elisabeth Wells. You may ask any questions you have now. If you have questions later, you may contact me at [redacted] or by email at [redacted]. If you need to get a hold of my research chair, you may contact Dr. Michael Chovanec at [redacted]. You may also contact the University of St. Thomas Institutional Review Board at [redacted] with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

_____ _____

Signature of Study Participant **Date**

_____

Print Name of Study Participant

_____ _____

Signature of Researcher **Date**

Appendix B:

Lessons from the Field: Clinician's Perspective on Treating Complex Trauma in Siblings

Interview Questions

For this interview the researcher will be asking you to answer a few demographic questions as well as some more detailed questions regarding your current practices. These questions are being asked to help identify common approaches to treatment. Please answer these questions to the best of your ability and bring with to your scheduled interview.

Demographics regarding practitioner/agency:

1. Please mark which ethnicity you identify with:

- ☐ Caucasian
- ☐ African-American
- ☐ African
- ☐ Asian
- ☐ Asian-Pacific/Islander
- ☐ Indian
- ☐ Middle-Eastern
- ☐ Native-American
- ☐ Biracial: _____
- ☐ Other: _____

2. If there is a specific culture you identify with please explain: _____

3. How many years have you been in practice with children and families?

- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16-20 years
- ☐ 20+ years

4. What was the emphasis of your graduate level schooling (please check all that apply)?

- ☐ Clinical
- ☐ Urban
- ☐ Trauma
- ☐ Grief and Loss
- ☐ Children
- ☐ Public Policy
- ☐ Couples/Families
- ☐ Individual Treatment
- ☐ Group Work
- ☐ Mental Illness
- ☐ Other: _____

5. What is your current caseload?

- ☐ 1-4
- ☐ 5-10
- ☐ 11-15
- ☐ 16-20
- ☐ 21-25
- ☐ 26-30
- ☐ 30+

6. On average, how frequently do you see your clients?

- ☐ Once a week or more
- ☐ Bi-weekly
- ☐ Monthly
- ☐ Other: _____

7. What theoretical approaches do you bring into your treatment? (Please check all that apply)

- ☐ Psychoanalytical
- ☐ Family systems theory
- ☐ Ecological theory
- ☐ Attachment/relational
- ☐ CBT
- ☐ TF-CBT
- ☐ EMDR
- ☐ Interpersonal Psychotherapy
- ☐ Structural Theory
- ☐ Other: _____

Demographics regarding client populations seen:

1. I see clients of the following ethnicities: (please check all that apply)

- ☐ Caucasian
- ☐ African-American
- ☐ Asian
- ☐ Pacific-Islander
- ☐ Indian
- ☐ Middle-eastern
- ☐ Biracial: _____
- ☐ Other: _____

2. What age range of children clients do you serve? (please check all that apply)

- ☐ 0-3
- ☐ 4-6
- ☐ 7-10
- ☐ 11-14
- ☐ 15-18

3. What percent of the children live with one or more biological parent? _____%

4. What percent of the children live within a kinship setting? _____%

5. How many kids presently on your case load live with the following?

- Biological Mother
- Biological Father
- Family Member
- Foster family
- Residential facility

Open-Ended questions:

1. Please describe the setting where you see children for therapy?

2. What is your process in joining with children who have gone through complex trauma?

3. How do you approach a child who becomes dysregulated during a session? And what effect (if any) does it have on the sibling?

4. Please describe how you attend to dissociation to achieve optimal arousal to promote new learning in your practice with siblings?

5. Are there ways that siblings can become the co-regulator in relationships?

    Should they be in that role?

6. What helps your work with siblings?

7. What hinders your work with siblings?

8. How do you determine when your work with a client is successful?

    Can you describe a case with a successful outcome?

9. Please describe a case where you attended to these four 'intersecting domains of learning and functioning: relating (seeking and using adult help), feeling (feel &understand emotions), thinking (repairing reflective thinking and organizing) and acting (help children become motivated to learn new patterns of functioning' as these areas contribute to a child's capacity to be self-regulating and socially involved.