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Mental Health Professionals' Perspectives of Best Practices with Children who have Experienced Complex Trauma

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Mental Health Professionals' Perspectives of Best Practices with Children who have
Experienced Complex Trauma

Submitted by Holly A. Hagen
May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

Complex trauma in early childhood has the ability to impact a child's development in multiple domains, thus influencing development throughout the rest of their life. The purpose of this study was to explore best practices with children who have experienced complex trauma from the perspective of mental health professionals, with a focus on children between the ages of three and five. Qualitative interviews were conducted with six mental health professionals who were asked to discuss the presentation, interventions, and outcomes of a case where the child experienced complex trauma. Consistent with previous literature, all participants in this study reported self-regulation deficits and relational impairments for the case they discussed. Additionally, all six participants utilized play therapy and expressed the importance of collaboration with other adults and systems in the child's life in order for treatment to be successful, exemplifying the need to utilize an ecological approach. Other practices used by professionals included Cognitive Behavioral Therapies, feelings/emotion interventions, EMDR, and relational interventions such as including the parents/caregivers in treatment, addressing the attachment needs, and coaching parents. Overall, participants utilize a combination of approaches and interventions in order to provide best practices, always emphasizing safety, attachment, and development.

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This paper is in memory of my grandmother, Mitzie Jeslene Hagen, who encouraged me to further my education by going to graduate school. Though no longer with us, she continues to encourage and inspire me in all that I do. Grandma, I miss you and love you very, very, very, very, very much (times infinity plus one)—this one's for you!

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Introduction

Trauma is a universal experience that impacts people regardless of creed, nationality, race, gender, and age, among others. Though trauma is detrimental to all human beings, it is exceptionally damaging when it is experienced by a child (Cook et al., 2003). Fear is intensified as children are vulnerable by nature and, in the case of severe or chronic trauma, brain development is often impaired (Perry et al., 1995). In addition, childhood trauma is not simply impactful on the individual child, but on all other systems including families, communities, and society (Cook et al., 2003). In any given year, it is estimated that approximately 5 million children in the United States have experienced some type of traumatic event (Perry, 2003). Furthermore, over eight million children in America suffer from severe, trauma-related psychiatric issues (Perry & Szalavitz, 2006). With such prevalence, it is pertinent that the adults in children's lives understand the impact that chronic trauma has on children, how it may present, and effective ways for helping chronically traumatized children.

Trauma is defined as, "a psychologically distressing event that is outside the range of usual human experience... [and] involves a sense of intense fear, terror, and helplessness" (ChildTrauma Academy, 2002). Some forms of traumatic events include physical abuse, sexual abuse, neglect, natural disasters, being the victim of a violent crime, or witnessing violence. While some trauma occurs during a single event, other trauma experiences happen in re-occurring events. When children experience multiple, chronic, prolonged trauma early in life, it is referred to as complex trauma (van der Kolk, 2005). This type of trauma is often interpersonal in nature in that it occurs within the caregiving system, and frequently involves maltreatment in the form of sexual abuse,

physical abuse, neglect, and/or witnessing domestic violence (van der Kolk, 2005; Cook et al., 2003). Children rely on parents or caregivers to meet their basic needs of survival and to provide them with a sense safety. When parents cannot do this, and especially when the fear is at the hands of the caregiver, it can have serious short-term and long-term consequences for the child (Siegel, 1999).

For children, trauma is an experience that has an exceptionally profound effect due to the immense physical, emotional, cognitive, behavioral and relational development that is occurring in the brain during infancy and childhood (van der Kolk, 2005). When children do not experience caregivers who are safe or reliable, their brains do not form in a coherent fashion, thus creating maladaptive pathways and impaired functioning (Perry et al., 1995). In comparison to trauma that occurs in adulthood, trauma during childhood affects the development of core emotional regulation, body regulation, and social capacities; namely an inability to develop self-regulation and relational impairments (Cook et al., 2005). Due to extreme behaviors and deficits in several areas of functioning, children are diagnosed with various disorders including but not limited to Posttraumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Separation Anxiety Disorder, and Conduct Disorder (Cook et al., 2003; Cook et al., 2005; Ferderico et al., 2008; Schwarz & Perry, 1994; Terr, 1991; van der Kolk, 2003; van der Kolk, 2005).

Experiences of trauma in childhood may not only have a profound effect on a child's ability to currently function, but can have long-lasting implications for further complications later in life (van der Kolk, 2005). Nearly the entire criminal justice population in the United States is made up of people who have experienced childhood

trauma (Teplin as cited in van der Kolk, 2005). For children, trauma not only leaves them more vulnerable to subsequent trauma exposure, but may also lead to an often perpetuating cycle of intergenerational maltreatment (Cook et. al, 2003).

Due to the widespread nature of trauma and the severe impact that it has on development throughout the lifespan, it is essential for mental health professionals to have knowledge of this issue and best practices with traumatized clients. Though there is much research on effective treatments for adults with PTSD, research on treating children with PTSD is scant according to Faust and Katchen (2004). In addition, research often only includes children who meet the full criteria for PTSD, and not necessarily children who have experienced complex trauma but not diagnosed with PTSD due to the lack of certain symptoms (Faust & Katchen, 2004). Recently, research on the ways in which trauma impacts children developmentally has expanded significantly. With the devastating impact that trauma has on children for the rest of their lives, it is pertinent that mental health professionals are aware of this and know ways of intervening effectively. Furthermore, this topic is especially important for social workers given the fact that the majority of mental health professionals are clinically trained social workers (NASW, 2000).

Early intervention is preferred in order to provide safety for children and to help them return to a normal developmental trajectory. School officials are often the ones to notice when children have behavioral issues or cognitive deficits, and then look to mental health professionals for expertise and support when behavioral interventions do not work. These interventions are often hurtful rather than helpful for children who have experienced complex trauma (Johnson, 1989). When children have not had the

opportunity to heal from the trauma, they may be unable to change their behavior, and will not appear to improve with behavioral intervention, as their main focus is on survival. Without knowing about the trauma, school professionals may have an increased view that the child is “bad” due to their inability to improve behaviors. They may respond to the child with discipline or criticism. For traumatized children, discipline or criticism may further their view of the world as unsafe or harmful, thus perpetuating the damage of the trauma and the development of a poor sense of self (Siegel, 1999).

The purpose of this study is to gain a further understanding of complex trauma in childhood and ways of working with traumatized children from the perspective of mental health professionals. Mental health professionals are typically psychologists, psychiatrists, social workers, psychiatric mental health nurses, or licensed professional counselors (NAMI, 2011). For the purpose of this study, there will be a focus on mental health professionals who work with children who have experienced complex trauma. More specifically, this study will seek to look at how trauma is worked with in therapy with children ages 3-5 and what kind of collaboration (if any) is done with family members and school personnel. This study focuses on children between the ages of three and five as this is the age that they will enter school and may first be recognized by school professionals as presenting with emotional, behavioral, cognitive, and/or social deficits. A review of the literature will be provided, followed by the conceptual framework that will be used to guide the research process. A qualitative research method, which will be described in the methods section of the paper, will be utilized in interviewing 8 to 10 mental health professionals who have experience working with complexly traumatized children.

Literature Review

The following literature review will seek to provide the reader with a further understanding of childhood trauma and more specifically, complex trauma. A definition of childhood trauma will be provided followed by the effects of trauma on children within the areas of neurobiology and attachment. Next, this paper will address the way in which trauma presents in children, including common diagnoses, issues with self-regulation, relational impairments, and the differing presentations of boys and girls. Thereafter, this paper will include a discussion about the ways in which mental health professionals are currently working with traumatized children in regards to therapies, theories, collaboration, and the role of the parent/caregiver. Lastly, the literature review will provide a brief discussion of gaps in the literature.

Definition of Childhood Trauma

According to Terr (1991) childhood trauma is, “the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations” (p. 11). With this definition, it is important to note that all trauma is “external” in that it begins with experience(s) or event(s) outside of the individual’s mind (Terr, 1991). No trauma originates within the mind of a child (Terr, 1991). Terr (1991) states four distinguishing characteristics of childhood trauma; “1) strongly visualized or otherwise repeatedly perceived memories, 2) repetitive behaviors, 3) trauma-specific fears, and 4) changed attitudes about people, aspects of life, and the future” (p. 12). In regards to memory, it is important to note the different types of memory, implicit and explicit. When a child experiences preverbal trauma during infancy or toddlerhood, memory of the trauma is implicit memory, or

memory that is unconscious and affectively/emotionally based (Allen, 1995). Though the child cannot verbalize what happened or remember distinct details of the experience, they often have internal images or visualizations that are often roused by reminders of the traumatic event such as feelings, locations, people, smells, positional memories, or tactile memories (Allen, 1995; Terr, 1991). However, visualizations can also occur spontaneously when there is no reminder of the event (Terr, 1991). Children may even have visualizations if they did not directly see what was happening during the traumatic event (Terr, 1991). In response to these images, children may not have the words to describe that they re-see, and will therefore show it through behaviors such as playing it out or drawing what they visualize (Terr, 1988).

In contrast, explicit memory is a type of memory that is conscious and language based and is often associated with intentional remembering (Allen, 1995). Explicit memory appears to emerge during the preschool years when children acquire language skills (Allen, 1995). Even when children have acquired language skills, they may not be able to describe the traumatic event because it was stored as a body memory or state memory rather than a verbal, explicit memory. When memories are fragmented or cut off from another part of an individual's mind or consciousness, it is said to be a type of defense mechanism referred to as dissociation (Briere & Scott, 2006). The DSM-IV-TR defines dissociation as, "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (American Psychiatric Association, 2000, p. 519).

As stated, trauma can occur with a single event, or re-occurring events. Terr (1991) describes these differing forms of trauma as type I traumas and type II traumas.

Type I traumas occur when there is one unanticipated, terrorizing single event or blow. Children (over the age of 28 to 36 months) who have experienced type I trauma, and were conscious during the event, do not often forget what happened during the event, and are able to recall distinct details and memories from what took place (Terr, 1991). In addition, these children will ask the question, “how could I have avoided it?” or “why me?” and try to find explanations for why the event occurred (Terr, 1991, p. 15). Often, hallucinations or visual misperceptions will occur shortly after the incident, or even after much time has passed (Terr, 1991). For example, after the traumatic death of a loved one, a child might say that they can visually see the person who has died. Events commonly associated with type I trauma, or single-event trauma include physical or sexual abuse, natural disasters, motor vehicle accidents, acts of threat or terrorism, witnessing community violence, and the death or loss of a loved one (NCTSN, 2008).

Comparatively, type II trauma in childhood is categorized by “long-standing or repeated exposure to extreme external events” (Terr, 1991, p. 15). Type II trauma is also known as chronic or repeated trauma (NCTSN, 2011). Unlike children who have experienced type I trauma, children with type II trauma disorders cannot fully remember distinct details, and have incomplete memories of what actually occurred (Terr, 1991). These children will seek to answer the question, “how will I avoid it the next time?” (Terr, 1991, p. 15). Children with type II trauma experiences will have massive denial, going years without talking about the trauma, and may forget entire sections of their childhood. In the classroom, these children will avoid talking about themselves in order to hide the traumatization from others. Aggressiveness or rage against the self and others is common. In order to mentally escape from their emotions, children may also self-

hypnotize or dissociate. (Terr, 1991). The following is a list of experiences that may lead to type II trauma disorders:

- Abuse (physical, sexual, emotional)
- Neglect (including abandonment)
- Witnessing domestic violence
- Bullying
- Life-threatening illness in a caregiver
- Community violence (e.g. shootings, stabbings, robbery, or fighting at home, in the neighborhood, or at school)
- Life-threatening health situations and/or painful medical procedures
- Living in chronically chaotic environments in which housing and financial resources are not consistently available
- Acts or threats of terrorism (viewed in person or on television)
- Parent mental illness
- Homelessness

At times, there may be a crossover of type I and type II trauma when there is one traumatic event that continues to shock the child for much time after the event. This is most typical when a child has lost a loved one and has to deal with continuous grief, or when a child has disfigurement, disability, or pain due to an ongoing illness, prolonged hospitalization, or a severe accident. (Terr, 1991)

In infancy and early childhood, traumatic experiences most often occur within the child's caregiving system. Van der Kolk (2005) uses the term "complex trauma" to define an experience of multiple, chronic and prolonged, developmentally adverse traumatic

events, most often associated with abuse or violence during the early stages of development. Type II or complex trauma will be the focus of this study.

Effects of Trauma on Children

As described, childhood trauma is induced in various ways and can be categorized into different types. When assessing the impact of complex trauma on children, it is necessary to look at attachment and neurobiology, as both play an integral role in subsequent development.

Attachment

Brain development and attachment are intricately intertwined: one does not occur without the other (Van der Kolk, 2005). Siegel (1999) states that, “[t]hese (attachment) relationships are crucial in organizing not only ongoing experience, but the neuronal growth of the developing brain” (p. 68). In relation to trauma, van der Kolk (2003) states that, “[i]t is virtually impossible to discuss trauma in children without addressing the quality of parental attachment bond” (p. 294). The early caregiving relationship provides children with a relational context to develop early models of self, other, and self in relation to others (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; Cook, Spinazzola, Ford, & Lanktree, 2005).

When children experience a secure attachment relationship with their caregiver, they are more likely to grow healthy developmental capacities such as self-regulation, communication, curiosity, and sense of agency (Cook et al., 2003; Cook et al., 2005). Caregivers of secure infants are said to be available, perceptive, and responsive to their child, providing the child with nurturance and stimulation in response to infant cues (Cook et al., 2003). Secure attachments begin with attunement or the act of the caregiver

matching the infant's affect state in order for the child to realize that their feelings are "understood" and "felt" by the caregiver (Siegel, 1999, p. 70). There will be times of misattunement, which signal the need for the caregiver to repair or regulate the infant's negative state (Schoore & Schoore, 2008). By doing so, the caregiver helps the child learn that they can recover from overwhelming or negative feelings and that the caregiver is trustworthy. "[A]ffect attunement" occurs when a parent is sensitive to the signals of their child, thus forming a connection between the two and a secure attachment (Siegel, 1999, p. 70). In secure attachment relationships, caregivers are also able to effectively meet their child's needs and are emotionally available (Ainsworth, 1978). During times of stress, these parents soothe their children through physical and emotional nurturance, which allows the child to later develop their own capacity to self-regulate and respond to subsequent stress (van der Kolk, 2003). Caregivers in secure attachment relationships are also attuned to situations where they need to back away instead of persisting with direct contact, which may overwhelm the child (Siegel, 1999). With this, the child forms an internal image of their caregiver as a "secure base," which they hold in their mind and can bring forward to help comfort them during times of stress when away from their caregiver (Siegel, 1999, p. 71). Having this allows the child to explore the world through play, exploration, and social interactions, and to separate and mature in a healthy manner (Siegel, 1999). Secure individuals are said to develop a secure sense of self, which is crucial to the individual's development and relationships with others throughout the rest of their life (Siegel, 1999).

In contrast, insecurely attached children have experienced inconsistent responses from caregivers and are classified as avoidant, ambivalent, or disorganized (Cook et al.,

2003). Cook et. al (2003) estimate that over 80% of maltreated children have experienced insecure attachment patterns. Trauma in the form of maltreatment has devastating effects as it disrupts all facets of development. When human connection occurs (in the form of an attachment relationship), neuronal connections within the brain begin to form, allowing the child to acquire developmental capacities such as self regulation (Siegel, 1999). In insecure attachment relationships, the human connection is disrupted, thus disrupting the connection of fundamental neuronal connections as well. Furthermore, “[i]nsecure attachment may serve as a significant risk factor in the development of psychopathology” (Siegel, 1999, p. 68).

When children have avoidant attachment patterns, they have had caregivers who are unresponsive and predictably reject or dismiss the child’s emotional cues (Ainsworth, 1978). In result, these children often develop a poor sense of self, learning that they cannot trust their own emotions and relationships. They have difficulty in attachment relationships with adults and peers as they do not identify the need for attachment, along with a restricted ability to feel emotion (Ainsworth, 1978). These children may present as loners or as highly independent individuals as adults (Siegel, 1999).

Children with ambivalent attachment patterns often have a caregiver that is inconsistently available, sensitive, perceptive, and effective (Ainsworth, 1978). The parent’s response to the child is either detached, or excessively intrusive to the child and their emotions. Quite often, the parent is preoccupied with their past so much, that it intrudes on their ability to respond and communicate effectively with their child. These children learn to disconnect from others in order to cope with their anxiety and uncertainty about relationships with others (Siegel, 1999).

Lastly, disorganized attachment patterns occur when the parent or caregiver is frightened, disoriented, or displays frightening behaviors toward the child (Siegel, 1999). When a parent appears frightened, it is often due to unresolved trauma or loss, which causes the parent to have confusing responses to the infant. The parent is unable to be the haven of safety for their child, and therefore cannot soothe their baby in reaction to stress as they have not learned to soothe themselves. In the case of frightening behaviors towards the child, the parent is the source of fear (most often in cases of abuse and neglect) (Siegel, 1999). This is even more detrimental as the parent may never be the child's source of safety. In either case, the attachment figure is unable to protect their child from traumatic experiences, and cannot respond with soothing or regulation in response to trauma. In disorganized dyads, the repair process (when the caregiver is not attuned) never occurs and goes "well beyond misattunement or missed opportunity for connection or repair" (Siegel, 1999, p. 117).

Children rely on adults, particularly their parents or caregiver, to meet their survival needs and keep them safe (Gearity, 2009). When parents are unable to do so for long periods of time (i.e. repeated abuse and/or neglect or when a parent is so overwhelmed by trauma that they cannot respond to their child) and the child is exposed to prolonged or intense stress, the child's development is altered, along with the way in which they react to stressful or threatening experiences throughout the rest of their life (Gearity, 2009). These children may respond to high or even low levels of stress or threat with aggressive or dissociative behaviors because their brain has been altered to act as if the individual is under constant threat (Perry, 2009). Evidently, neurobiology and

attachment rely on one another to shape the way in which the child develops, along with the way the child views and interacts with the world.

Neurobiology

When trauma occurs within the attachment relationship and in early childhood, it has a profound impact on brain development, which occurs at a rapid pace during the early years of life. Due to the hierarchical nature of development in the brain, developing from the inside to the outside, trauma that occurs in utero or during infancy is said to have the most devastating impact as it will alter the way in which all subsequent parts of the brain develop (Perry, 2009). The human brain is made up of over 100 million neurons (brain cells) which send messages to one another through neurotransmitters (Perry, 2009). These messages thus create connections between neurons, which are called synapses, and allow various parts of the brain to work together.

In order to respond to external stress or threat, the human body engages in specific mental and physical responses such as changing chemical levels to help the person survive. In adults, the brain's ability to respond to stress (e.g. the stress response system) is typically already formed and able to signal the person to "fight or flight" (Perry et al., 1995). New experiences are able to be stored as new information, and subsequent behavior changes. For children however, this system has yet to form. New experiences are not simply stored, but impact the way in which the brain organizes and develops (Perry et al., 1995). Children need adults, particularly their parent or caretaker, to keep them safe and soothe them in overwhelming situations (Gearity, 2009). They cannot "fight or flight" as they do not have the physical or mental capacity to do so. Through consistent, patterned responses from adults, children's brains create healthy

pathways between neurons, thus allowing the child to learn to soothe themselves later on. When a child is consistently left to deal with threat or stress on their own, maladaptive pathways are formed, and their brain is adapted to respond as if it were under constant threat (Perry, 2009). “States” become “Traits,” and these maladaptive responses to threat are often irreversible (Perry et al., 1995).

How Trauma Presents in Children

When a child has experienced complex trauma, they may present with a variety of symptoms due to impairment that spans across multiple domains (Cook et al., 2003). Cozolino (2010) states that chronic trauma is difficult to identify, diagnose, and treat because it is often hidden behind other symptoms and becomes a part of the individual’s personality. Common diagnoses will be discussed, along with two major impairments that are unique to the developmental effects of complex trauma: self-regulation and relational impairments (Cook et al., 2005).

Common Diagnoses

One of the most common diagnoses associated with trauma is Posttraumatic Stress Disorder (PTSD). According to the DSM-IV-TR, there are three major symptoms or elements that make up a PTSD diagnosis which must occur for more than one month and cause significant distress or impairment in important areas of functioning (social, occupational, etc.) (American Psychiatric Association, 2000). These are: 1) persistent re-experiencing of the traumatic event (in children this may be repetitive play which expresses aspects of the trauma, trauma-specific re-enactment, or recurrent frightening dreams), 2) avoidance of stimuli associated with the trauma and numbing of general responsiveness (avoidance of places or people that remind the child of the trauma), and 3)

persistent symptoms of increased arousal (sleeping difficulties, irritability or anger outbursts, difficulty concentrating, hypervigilance, or exaggerated startle response) (American Psychiatric Association, 2000). Frederico et al. (2008) found that the most common diagnoses for children who experienced relational trauma were PTSD and Reactive Attachment Disorder (RAD). This study looked at existing data from the Take Two program, a developmental therapeutic service for abused and neglected children in Victoria, Australia. Though PTSD was one of the most common diagnoses, Frederico et al. (2008) explain that traumatized or deprived children may not always meet the full criteria for PTSD. Comparatively, PTSD does not necessarily capture the developmental impact that trauma has on the child (Cook et al., 2003; Cook et al., 2005; Perry & Pollard, 1995; van der Kolk, 2005).

Though PTSD is commonly associated with complex trauma, Cook et al. (2005) state that PTSD is not the most common diagnosis given to children with histories of chronic trauma. Instead, these children are often diagnosed with a list of other diagnoses including Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder, Generalized Anxiety Disorder, Separation Anxiety Disorder, and Reactive Attachment Disorder, depression, eating disorders, sleep disorders, and communication disorders (Cook et al., 2003; Cook et al., 2005; Frederico et al., 2008; Schwarz & Perry, 1994; Terr, 1991; van der Kolk, 2003; van der Kolk, 2005). These diagnoses only look at one aspect of the child's experience, and fail to look at the whole picture (Cook et al., 2003). With this, treatment is often based on that diagnosis, and may do more harm than good (Cook et al., 2005).

Self-Regulation and Relational Impairments

When a child has a history of complex or chronic trauma, they often present with impairments in their ability to self-regulate. As described, one's ability to self-regulate develops properly when they have had a caregiver that is responsive and soothes the child in response to stress. Thus, self-regulation involves a person's ability to soothe themselves in response to stress. When a child's stress response system has been altered due to chronic trauma, they may exhibit extreme hyperarousal, which appears as exaggerated reactivity including aggressive behaviors, or hypoarousal, which may appear as daydreaming and includes disengagement, numbing, or avoiding (Perry et al., 1995). Freezing is a mechanism that hyperaroused or hypoaroused children may utilize in response to anxiety, and will appear as if the child's body is actually frozen (Perry et al., 1995). This allows the child to organize their thoughts and scan the environment for further potential threat (Perry et al., 1995). This mechanism often leads to a label of oppositional-defiant behavior (Perry et al., 1995).

When self-regulatory functions are impaired, it leads to issues in self-definition which includes a poor sense of self (including body image), poor ability to modulate affect and control impulses (including aggression towards self and others), and uncertainty that others will be reliable and predictable, which leads to distrust, suspiciousness, and problems with intimacy (Cole & Putnam, 1992). These impairments may lead to social isolation as the child has difficulty reading social cues, and cannot form relationships due to their inability to trust others. In addition, a child may appear to be hypervigilant in that they are so focused on determining an actual threat that they become uninterested in activities that other children are interested in and lash out in

response to any source of impending threat (van der Kolk, 2003). Traumatized children may be seen as bullies due to their aggressive behavior in response to perceiving other children as a threat (van der Kolk, 2003). Traumatized children may therefore be labeled as the “bad” child by teachers, parents, and others. When the trauma originated within the home, the parent’s disciplinary technique (in response to the child’s non-compliance or “bad” behaviors at school or home) may cause further traumatization (emotional or physical abuse). Thus, the cycle of trauma is perpetuated if no intervention is provided.

When children have experienced repeated traumatic events, it is not uncommon for them to look at all of the adult figures in their life as the perpetrator. Often, the other adults in the child’s life will be their parents, teacher, and childcare workers. The child may reenact the trauma with these adults. Some of these adults may not realize that the child is re-enacting trauma, and may see only the “bad” behavior that the child exhibits. Thus, adults will intervene with punishment or have their own trauma response to the behavior after misinterpretation, perpetuating the dysregulation and inability to feel safe. (Streeck-Fischer & van der Kolk, 2000).

Differing Presentations of Boys and Girls

Boys and girls who have experienced complex trauma may present symptoms differently. Boys tend to display symptoms externally with aggressive or acting out behavior, while girls tend to have more internal symptoms and appear more passive (Schwartz & Perry, 1994). Perry (1995) states that more maltreated boys are referred to the mental health system than maltreated girls. After trauma, boys are more likely to have sensitized hyper-arousal systems (hyperactivity, impulsivity, hypervigilance) whereas girls are more likely to have systems that are sensitized to dissociation (avoidance,

depression, dissociation) (Perry et al., 1995). Dissociation may however be a common symptom for boys in infancy or early childhood as well, as this is their only means to survival due to their inability to physically flee or fight.

How Mental Health Professionals are Currently Working with Traumatized Children: Therapies and Theories

In a survey conducted by the National Child Traumatic Stress Network (NCTSN), no clear clinical consensus emerged in regards to the most effective and available treatment modalities for children who have experienced complex trauma and their families (Spinazzola et al., 2003). The sample consisted of mental health professionals who work in 25 network sites which represented 1,699 children, or 15% of the population of children served by the network during a typical quarter (Spinazzola et al., 2003). Various age groups were represented with 38% at 6-11 years of age, 24.6% at 12-15 years of age, 22.5% at 3-5 years of age, 11.4% at 16+ years of age, and 3.5% at 0-2 years of age. The majority (78%) of the children served by the network had been exposed to multiple and/or prolonged trauma, with the average age of onset or initial exposure at five years old. *Weekly individual therapy* and *family therapy* were ranked as the most effective intervention modalities used by clinicians within the network. *Play therapy*, *expressive therapies*, *multisystemic therapy*, *group therapy*, and *self-management/coaching* were also ranked as most effective; however, clinicians also ranked these modalities as 5 of the 7 least effective intervention modalities. Two therapies rated as consistently ineffective were *pharmacotherapy* and *home-based therapies*. Despite the variance in the most/least effective intervention modalities, the majority of clinicians in the survey spontaneously identified that active caregiver

involvement in treatment was of crucial importance in effective intervention (Spinazzola et al., 2003). In addition, many clinicians stated that treatment should include combined intervention approaches along with interventions tailored to the specific needs of the child such as developmental stage, sociocultural context, and availability of environmental resources. Lastly, many clinicians identified the importance of coordinating services across service sectors such as schools, mental health, and social services (Spinazzola et al., 2003).

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), described by Judy Cohen, Anthony Mannarino, and Esther Deblinger is considered to be one of the most robust evidence-based treatment models and most effective interventions with children who have significant psychological symptoms in relation to traumatic experience(s) (Cohen, Mannarino, & Deblinger, 2006). TF-CBT is typically a short-term treatment that lasts for approximately 12 sessions, or longer due to the needs of the child and family (Child Sexual Abuse Task Force, 2004). The individual child and their parent or caregiver is provided with individual therapy, along with joint parent-child sessions. TF-CBT is a psychosocial model that integrates elements of various therapeutic approaches including cognitive-behavioral, attachment, humanistic, empowerment, and family therapy models. TF-CBT focuses on the therapeutic relationship, and encompasses the following components:

- Psychoeducation to the child and caregiver in regards to trauma in childhood (impact and common reactions)
- Parenting skills

- Relaxation and stress management skills
- Affective expression and modulation
- Cognitive coping and processing through illustration of the relationship between thoughts, feelings, and behaviors
- Trauma narration (by the child)
- *In vivo* mastery of trauma reminders (e.g. when child avoids situations that are no longer dangerous, but which remind them of the trauma)
- Conjoint child-parent sessions
- Final phase: Enhancing future safety and development

(Child Sexual Abuse Task Force, 2004)

TF-CBT was originally created to treat children who have endured sexual abuse trauma, but has been adapted to treat children that have experienced other forms of trauma such as multiple traumas (Child Sexual Abuse Task Force, 2004). In over a dozen scientific studies, children (most who had experienced sexual abuse or disaster related trauma) who received TF-CBT recovered faster and more completely in comparison to children who received other common trauma therapies, such as play therapy and community therapies (Child Sexual Abuse Task Force, 2004). In addition, children who were followed for 1 or 2 years after treatment showed that these improvements were sustained after treatment had ended, which exemplifies that the long-term effects of trauma can be mitigated with the use of TF-CBT (Child Sexual Abuse Task Force, 2004). For TF-CBT to be effective, it must be developmentally appropriate for the child, and the parent must be able to regulate their own anxiety in order to help their child through the process (Scheeringa et al., 2007).

EMDR

Eye movement desensitization and reprocessing (EMDR), described by Francine Shapiro in 1989 and developed in the 1990s, was originally created for adults with traumatic stress disorder, but has been adapted for use with children (Shapiro as cited in Rodenberg et al., 2009). In this therapy, “unprocessed memories of traumatic experiences, stored in neural networks, become linked with the adaptively processed memories of positive experiences, which are referred to as reprocessing” (Shapiro as cited in Rodenburg et al., 2009). With children who have experienced complex trauma, it is recommended that EMDR is used as a phase-oriented, multi-component approach in which the first phase focuses on stabilization, personal safety, and tolerating and modulating strong affect (Korn, 2009). After significant gains are made in this area, the second phase takes place which focuses on the traumatic memories, followed by the third phase which involves functional reintegration, self development, and new goals (Korn, 2009). Moving through the phases is not a linear process, but rather a fluid, dynamic, spiral-like process in which beliefs and coping responses about trauma are revisited and reactivated over and over (Courtois as cited in Korn, 2009).

Expressive Therapies

Expressive therapies, such as play, art, and sand tray therapy are often useful when working with children (Gil, 2006). Expressive therapies may be used as the primary or adjunctive approach in therapy. These techniques allow the child to express what they are feeling in nonverbal, symbolic ways in an environment that is both safe and non-threatening (Gil, 2006). Though, the use of these approaches may depend on the

clinician's level of training and experience as it often involves interpretation of what the child is playing out (Gil, 2006).

Play is often viewed as a natural way for children to express themselves and communicate (Gil, 2006). Therefore, in therapy, mental health professionals and children can utilize play as a way to communicate. For children who have experienced trauma, play is often repetitive, traumatic, and joyless, and this play cannot be resolved by new experiences (Gil, 2006). These children do not necessarily know how to play with others as they often disregard those around them and lack affective reaction and interpersonal skills (Gil, 2006). Through play, such as Trauma-Focused Play Therapy, mental health professionals attempt to assist the child in recreating and concluding their play with control and a sense of safety over their own play (Gil, 2006). The mental health professional can be directive by setting out certain toys and/or drawing the child's attention to these toys, or non-directive, or utilize a combination of both (Gil, 2006). Often, it is easier for children to use toys in a symbolic way rather than themselves (using language) as it is too close to the trauma, or they do not have the language capacities to do so (Gil, 2006). Though play is helpful in therapy, it can also be detrimental by retraumatizing the child if it does not achieve the goal that it sets out to accomplish (Gil, 2006).

Art is another means through which children communicate both conscious and unconscious material. It is suggested that therapist be trained in art therapy and the interpretation of children's art before utilizing this approach in practice (Gil, 2006). Often, the use of leading questions or interpretations, which seek to place meaning or affect to the child's artwork, can feel threatening to the child and may ultimately mislead

the therapeutic process (Gil, 2006). Therefore, it is encouraged that professionals seek consultation or further training before using art therapy (similar to play and sand therapy), and always allow the child to lead the process (Gil, 2006).

Lastly, sand tray therapy is an expressive therapy in which the child can freely and creatively express their internal world, often through the use of miniatures in a tray filled with sand. Similar to art and play therapies, the clinician is to limit the use of interpretation, and to say little throughout the session to allow the child to place their own meaning and affective responses to the material that they display in the sand tray (Gil, 2006). Overall in play, art, and sand tray therapies, the focus should be on the relationship between the child and the clinician rather than interpretation of specific actions or play (Gil, 2006).

Child-Parent Psychotherapy

Because self-regulation is first developed within the attachment relationship between child and caregiver, therapies that address deficits in self-regulation must often include the primary caregiver. Courtois and Ford (2009) state that, when treating children who have complex traumatic stress disorders, the therapeutic relationship should be a triadic relationship, rather than dyadic, in which the child, caregiver, and therapist are affectively linked to one another. Thus, the therapist can provide co-regulation to the child and the caregiver, and support the caregiver in assuming this role. Dyadic parent-child psychotherapies strongly utilize this approach (Courtois & Ford, 2009). Child-Parent Psychotherapy, described by Van Horn and Lieberman (2008) is a well-validated model in which the therapist provides education to the parent/caregiver about the impact

of traumatic stress, and assists them in developing skills for responding to their child in a nurturing way.

Neurosequential Model of Therapeutics

The Neurosequential Model of Therapeutics (NMT), described by Bruce Perry, is a clinical approach that does not focus on a single therapeutic technique, but rather identifies the “key systems and areas in the brain which have been impacted by adverse developmental experiences and helps target the selection and sequence of therapeutic, enrichment, and educational activities” (Perry, 2009, p. 240). The first element of the NMT model is to gain an understanding of the child’s developmental and relational history to see what early life disruptions may have impacted brain development. In the second part of NMT, an interdisciplinary staff team looks at various domains of the child’s functioning such as speech and language capability, social skills, and self-regulation skills. A brain map is then created to display the interaction between developmental insults (trauma and neglect) and the functional organization of the child’s brain. Lastly, intervention recommendations are provided based on the brain map, paying special attention to the sequence of interventions (Perry, 2009).

NMT interventions begin with the lowest part of the brain that is abnormally functioning. For example, a child may have a poorly organized brainstem, which controls self-regulation, attention, and impulsivity. To address this, intervention would need to focus on “patterned, somatosensory activities... such as music, movement, yoga (breathing), and drumming, or therapeutic massage (Perry, 2009, p. 252). Once improvements are made in these self-regulatory, brainstem functions, the therapy can then move to limbic functioning, addressing relational problems through play or art

therapies (Perry, 2009). NMT has evolved over the past 15 years, showing promising results in various clinical settings and continues to be tested (Perry, 2009).

Regardless of the type of therapy utilized, Cook et al. (2003) suggest that mental health professionals recognize and address four main goals in treating children who have experienced complex trauma. The first goal of treatment is to increase external safety within the child's home, school, and community environments. The second goal is to develop internal safety and competence. The third goal is to alter developmental trajectory in positive, health-promoting direction. The fourth goal is to foster healthy primary attachment relationship, as well as cultivating other social supports (Cook et al., 2003).

Similarly, "the Complex Trauma Workgroup of the National Child Traumatic Stress Network has identified six core components of complex trauma intervention" (Cook et al., 2005). These include: safety, self-regulation, self-reflective information processing, traumatic experiences integration, relational engagement, and positive affect enhancement (Cook et al., 2005). These components occur simultaneously in treatment, and also build on one another by utilizing a phase-based approach (Cook et al., 2005). In general, Cook et al. (2005) states that, "best practice with this population typically involves a systems approach to intervention and use of multiple intervention modalities (p. 397).

Theoretical Perspectives Utilized

Three theories were commonly identified in the literature as helpful in providing effective treatment to children who have experienced complex trauma. These

theories/perspectives are attachment theory, developmental perspective, and the ecological perspective.

Attachment theory, which was described previously, is important in treating complexly traumatized children as they often have insecure attachments. When treating young children in particular, attachment theory is critical since healthy development is dependent on the relationship between parent and child (Cook et al., 2005). Therefore, treatment will need to involve the creation of a zone of safety for the child that will allow the child to have a new relationship experience where the adult cares about them and can keep them safe (Perry et al., 1995). The repaired relational experience will not only be relevant to the relationship between therapist and child, but also to the child-caregiver dyad (Cook et al., 2005). This may involve teaching the parent new skills in order to interact with their child in a responsive and safe manner. Since caregivers may have experienced disrupted or impaired attachment relationships in their past which have caused them to have difficulty raising their own children, they may need the clinician's support/guidance in developing critical interpersonal skills such as assertiveness, cooperation, limit-setting, social empathy, and the capacity for physical and emotional intimacy (Cook et al., 2005).

Because trauma affects children differently at different ages, and because trauma has a profound effect on a child's development, it is necessary to utilize a developmental perspective in treating children who have experienced complex trauma (van der Kolk, 2003; van der Kolk, 2005). Age does not necessarily provide an accurate picture of where the child is at in their social, emotional, or physical development. Thus, mental health professionals will need to provide ongoing assessment and treatment that addresses the

specific deficits that the individual child has within these areas of development.

Interventions should be tailored to these specific problems (Jackson et al., 2009).

Childhood is a time of rapid development, and therefore a time for much capacity to change, which is why ongoing assessment is necessary (Jackson et al., 2009).

Developmental perspectives often tie in to relational perspectives (especially for young children) as treatment typically focuses on ways to strengthen the caregiver's capacity to respond and nurture their child (Perry et al., 1995).

The ecological perspective is also seen throughout the literature, as it is necessary to look at the ways in which varying systems interact, which have an impact on the child (Jackson et al., 2009). In result, treatment must involve communication between the different systems that interact with one another in the child's life (Cook et al., 2005). The ecological perspective will be further described within the conceptual framework section of this paper.

Gaps in the Literature

This researcher searched the library, journal articles, internet sites, and consulted with the librarian. Through this extensive research, a gap in the literature was that there is no clear consensus on the most effective ways in working with children who have experienced complex trauma. The databases that were utilized in researching this issue included Academic Search Premier, PILOTS, PsychARTICLES, Social Services Abstracts, and Social Work Abstracts. The key words used in searching the databases include trauma, complex trauma, chronic trauma, children, early childhood, therapy, treatment, best practice, and intervention. This researcher found various articles on the extensive research in regards to the way in which complex trauma impacts children

(developmentally), but found much less on best practices when treating these children. In addition, the importance of parental/caregiver involvement is emphasized, along with the need for the therapist to communicate with other adults in the child's life. However, there is a gap in the literature on best practices when working with the child and these other systems.

Summary

In summary, the literature is extensive on the effects of complex trauma on children in regards to attachment and neurobiology, and the way in which complex trauma presents in children. Children experience adverse effects on their development including an altered stress response, disconnection from others, and changed attitudes about people, life, and the future. Children present with a variety of symptoms such as aggression, dissociation, trauma specific fears, repetitive play or behaviors, recurrent frightening dreams, and increased arousal (sleep difficulties, irritability or anger outbursts, difficulty concentrating, hypervigilance, or exaggerated startle response). Though there is vast literature on effects and presentation, there appears to be some controversy on how to diagnose children who have experienced complex trauma. Children receive a variety of diagnoses including PTSD, ADHD, ODD, Conduct Disorder, Generalized Anxiety Disorder, Separation Anxiety Disorder, Reactive Attachment Disorder, depression, eating disorders, sleep disorders, and communication disorders. Similarly, boys and girls present differently, with boys exhibiting more externalizing behaviors such as aggression, and girls displaying more internalizing symptoms that are not as easily identifiable. Due to the vast array of symptoms and diagnoses, the literature lacks a clear consensus on the most effective ways in working

with children who have experienced complex trauma. TF-CBT is evidence-based and has shown effectiveness with children who have experienced trauma. EMDR has been adapted from adult populations to work with children who have experienced complex trauma. Additionally, clinicians have long utilized expressive therapies such as art, play, and sand tray therapies in adjunct to other therapeutic approaches, or by itself. Child-Parent Psychotherapy was discussed in the literature review as it has shown effectiveness in addressing the attachment relationship. Lastly, the Neurosequential Model of Therapeutics (NMT) addresses the neurobiological deficits that occur due to adverse developmental experiences, and then produces interventions based on assessment of these components. This literature review provided a brief summary of only a few major practices and interventions, though it noted that many others exist within the clinical research. This study seeks to identify a further understanding of complex trauma in childhood and ways of working with traumatized children from the perspective of mental health professionals.

Conceptual Framework

The ecological perspective is the conceptual framework that was utilized in carrying out this research project. With this perspective, interaction between varying levels of systems guides the way in which a clinician views the problem, and the intervention to be employed. The problem is not viewed as completely within the individual or caused entirely by the environment, but instead by the interrelationship of both (Jackson et al., 2009). For children, relationships are the key to survival as they rely on adults to meet their needs (van der Kolk, 2005). Throughout the child's life, they will interact within varying systems which dynamically interact with one another and with the child (Rogers, 2006). Four levels of systems make up the ecological perspective which include; the *micro*, *meso*, *exo*, and *macro-systems*.

The *micro-system* includes all of the roles and relationships that the individual has with their immediate environment (Rogers, 2006). These environments are places where the person has immediate contact on a daily basis, and often include home, work, school, and the neighborhood (Rogers, 2006). A child's main level of interaction is with their parents/caregivers and, with teachers and other school professionals when they begin school. Therefore, their micro-system consists of their relationships within the home, school, daycare, and neighborhood environments. Within this system level, the child's physical, emotional, and cognitive development may be assessed as well (Rogers, 2006). As this study focuses on complex trauma for children ages three to five, the micro-systems that were examined include the child's development (which is often impaired in various areas for traumatized children) along with the home and school environments (if

applicable) and the way in which mental health professionals support the child's interactions within these settings.

The *meso-system* is made up of the interactions between two or more environmental settings (micro-systems) (Rogers, 2006). These environments have the ability to impact one another in positive and negative ways. For this study, interactions between the mental health professional, parents, school personnel, and the traumatized child were focused on.

The *exo-system* includes decisions or changes that take place within settings which the individual is not necessarily an active participant, but will have a direct or indirect impact on the individual (Rogers, 2006). For children, the *exo-system* may include the parent's workplace, schools, government programs, and community agencies. Decisions made within the *exo-system* will potentially have an indirect impact on the child's development (Rogers, 2006). For example, the decision made by a parent's workplace to relocate their business will indirectly impact the child. For children who have experienced complex trauma, the court system or child protection services may make decisions that have an impact on the child.

The *macro-system* consists of cultural factors such as values, beliefs, and norms that affect the environments that a person lives in and, in result, will affect the individual's development (Rogers, 2006). For example, stigma against children with mental health issues may impact decisions made by lawmakers in regards to programs, policies, and funding. If fewer services are provided or funded by the government for children with mental health issues, this will consequently have an impact on these children. Traumatized children often have mental health issues. For the purpose of this

study, societal beliefs or attitudes about children with mental health issues or traumatized children were addressed within the interview questions by looking at the way in which others in the community respond to these children and collaborate with mental health professionals.

Methods

Research Design

This research project utilized an exploratory qualitative research design. Qualitative research was used in order to gain a more in-depth understanding of best practices for mental health professionals when working with chronically traumatized children. Single session, face-to-face interviews were conducted with research participants.

Sample

The researcher sought to interview 8-10 mental health professionals who work in a clinical setting with children that have experienced trauma. Participants had varying years of experience, with a minimum of at least one year of experience working with complexly traumatized children. Participants were from various clinical settings in order to gain an understanding of perspectives and treatment approaches that are utilized. The study included participants who have experience working with chronically or complexly traumatized children. When the researcher seeks to locate subjects with certain attributes or characteristics, snowball sampling may be used (Berg, 2009). In snowball sampling, the researcher interviews a few participants with the characteristic, and then asks them for referrals to other people who have the same attributes (Berg, 2009). This method of sampling was utilized for the purpose of this study. Participants were not excluded based on age, race, or gender, and no compensation was provided for participating in the study. The sample was a non-probability sample in that it cannot be generalized to other groups (Monette et. al, 2011).

Protection of Human Subjects

Before this study took place, the proposal was reviewed and approved by the St. Catherine University International Review Board (IRB). In order to reduce coercion, potential participants were provided with the consent form and research questions before they decided to participate or not.

Prior to participating in the study, participants reviewed and sign a consent form (Appendix C) before the interview took place. With the consent form, participants were informed that they may end the interview at any time if they wish to do so. All data, including the transcribed interviews and the consent form have been stored in a locked file in the researcher's home. This data will be destroyed May 31, 2012.

Instrument

The interviews consisted of ten questions which were formulated by the researcher. The researcher first asked demographic questions about the mental health professionals' gender, years of experience, and previous and current work settings with children who have experienced complex trauma. The researcher utilized themes from the literature and the ecological perspective which was discussed previously in the conceptual framework section. Questions sought to gain insight on how trauma presents in young children, the ways in which mental health professionals work with this population, and what kind of collaboration the professional might need to have with other adults in the child's life (i.e. school and parents).

Data Collection

The data was collected using the following steps:

1. The researcher contacted each committee member and requested 2-5 potential participants.
2. The researcher distributed a flyer (Appendix A), research questions (Appendix B) and consent form (Appendix C) to committee members in an electronic format, who then distributed these electronically to potential participants.
3. Potential participants were asked to contact the researcher.
4. Due to few potential participants contacting the researcher, the researcher requested that committee members resend electronic copy of flyer, research questions and consent form.
5. The researcher and potential participants arranged for an interview to take place in a quiet setting where privacy and confidentiality were maintained.
6. The researcher explained the consent form.
7. The subject signed the consent form if they decided to participate.
8. Audio recorded interviews took place, and lasted between 23-55 minutes.
9. The researcher asked the participant for referrals to other potential participants in order to obtain the expected 8-10 participants.

Data Analysis

Data was analyzed and interpreted through the utilization of content analysis and a grounded theory approach. Content analysis is a way to code and interpret human communications in order to find patterns, themes, biases, and meanings (Berg, 2009).

The human communication in this study was an in-person interview, which was

transcribed, or typed word for word, by the researcher following completion of the interview.

Qualitative research is characterized by its contextual nature, along with its utilization of a grounded theory approach (Monette, Sullivan, & DeJong, 2011). Grounded theory is a research methodology in which theory emerges from, or is “grounded” in the data (Monette et al., 2011, p. 225). The researcher utilized previous knowledge and information from the literature review to develop questions, along with field notes which the researcher used to develop a code list prior to transcribing. The researcher then coded the transcribed interviews based on themes from field notes and previous literature.

Researcher Bias

The researcher holds bias based on previous experiences and knowledge of working with traumatized children. This bias may have limited the study when the researcher developed interview questions and looked for themes within the data. In order to reduce the effect that the researcher’s bias had on the study, interview questions were reviewed by committee members.

Findings

This qualitative study sought to gain an in-depth understanding of mental health professionals' perspectives of best practices when working with children who have experienced complex trauma. Approximately 30 mental health professionals were offered a chance to be interviewed. Of these, six professionals responded and participated in qualitative interviews, including 4 females and 2 males. Participants had been practicing as mental health professionals between 6 and 35 years respectively, with a mean of 18.5 years, and a range of 29 years. Of the six participants, three were Licensed Psychologists (LP), two were Licensed Independent Clinical Social Workers (LICSW), and one was both a LICSW and Licensed Marriage and Family Therapist (LMFT). At the time of the interviews, all participants currently practiced in an outpatient setting, with four participants in private practice, and two in community mental health centers or agencies. In order to provide the reader with an in-depth understanding of the data, a brief description of each mental health professionals' experience with a specific client will be discussed including who referred the client, diagnostic information, key symptoms, and key history. In order to maintain confidentiality, all participants and clients were given fictitious names. After all individual descriptions are provided the cases will be discussed in regards to the themes that have been used to code the data. These themes include: deficits in self-regulation, relational impairments, and collaboration. Presentation, interventions, and outcomes will be discussed for each theme. Themes were defined by at least three participants identifying the same idea. Quotations were chosen that best represent the various themes, and will be italicized.

Mental Health Professionals' Background and Case Descriptions

Case 1: Isabelle

Isabelle is a mental health professional who has experience working with complexly traumatized children and their families. Isabelle reported that 60% of the children she works with have experienced complex trauma, and 10% of those children are between the ages of 3 and 5. Common symptoms that Isabelle sees in complexly traumatized children are difficulties with emotional regulation and difficulties with object constancy. In practice, Isabelle described utilizing various approaches/perspectives including developmental repair, object relations, attachment theory, cognitive behavioral, and van der Kolk's description of complex trauma.

Isabelle discussed the case of Ben, a 5 year old boy who was referred by his foster family and a county worker. In regards to presenting symptoms, Isabelle stated that Ben was *extremely aggressive... very controlling in his play... extremely hypervigilant... anxiety prone... [had] difficulties with sleep... [would] hoard... [had] soiling issues... perseverating thought around needing to swear [and] avoidance or ambivalent... push-away behaviors* (p. 2, lines 42-64). Ben had previously been diagnosed with Anxiety, Oppositional Defiance, and Disruptive Behavior NOS. Isabelle diagnosed Ben with Reactive Attachment Disorder. Isabelle stated that Ben's mother *was anything but stable in her own life herself... there was a lot of moving and coming and going, drug use... [and] a boyfriend of his mom who was scary and would threaten him* (p. 1, lines 11-14). Ben was passed around from relative to relative, was eventually taken out of the home, and ended up with a *foster-adopt* family who referred him. Isabelle stated, *there's no doubt about it, this little boy was traumatized* (p. 1, line 23).

Case 2: Rachael

Rachael is a mental health professional who has experience working with complexly traumatized children and their families. Rachael estimated that over 80% of the children she works with have experienced complex trauma, with 30% of those children between the ages of 3 and 5. Nightmares, dysregulation, flashbacks, fearfulness, mood instability, regressive behavior, enuresis, and dissociation are common symptoms that Rachael expressed she sees with this population. The theoretical approaches/perspectives that Rachael utilizes in practice are; attachment and developmental lenses looking at relational trauma and neurobiological theories of impact of trauma in childhood.

The child that Rachael discussed was Mandy, a 5 year old girl who had been referred by the county due to symptoms of *abusive behavior* towards a younger child. Rachael also stated that Mandy was, *non-discriminate... where she would just go up to anybody and with men was sexualized, would hurt herself and run to neighbors to tell them that the parents had done it... dysregulated... difficulty with mood... difficulty with trust and with adult authority... a high need for control... nightmares and flashbacks... [and] tantruming kind of acting out* (p. 1, lines 5-36). Mandy had been previously diagnosed with Reactive Attachment Disorder, Oppositional Defiant Disorder, and they (other professionals) *were questioning Bipolar Disorder* (p. 1, line 23). Rachael diagnosed Mandy with Reactive Attachment Disorder and Posttraumatic Stress Disorder. When in the care of her biological mother, Mandy *had pretty much been handed over to strangers to fondle... in mom's presence* (p. 1, lines 19-20). Rachael added:

there was full sexual abuse that occurred at one point, she had been raped... mother was chemically dependent and mood disordered... real volatile mood

wise... there had been some physical abuse as well, and there had been locking in rooms... in reliving/replaying her own traumas, she [Mandy] was getting traumatized by her own behavior as well... disruptions in attachment... a lot of transitions that she went through in a short amount of time, so these were all pieces of the trauma... and things probably were happening from birth with mom's chemical usage and stuff that she was getting some in-utero effects of mom going through her stuff too (lines 350-362).

Case 3: Leah

Leah has experience working with complexly traumatized children and their families as a mental health professional. Leah stated that approximately 60% of the children she works with have experienced complex trauma, and 5% of these children are between the ages of 3 and 5. Common symptoms that Leah has seen include hypervigilance, high startle factors, anger, emotional dysregulation, need for control, separation anxiety, school avoidance, and somatic symptoms. The theoretical approaches/perspectives that Leah utilizes are Dyadic, Neuropsychological, and TF-CBT.

Leah talked about the case of Jerry, a 5 year old boy who was referred by his grandmother after witnessing the death of his mother, and other traumas prior to her death which will be briefly described. Jerry presented symptoms of *crying at school, school avoidance... psychosomatic symptoms, difficulty sleeping... need for control... parentified... high startle factor, so he's hypervigilant... enuresis... ambivalent attachment* (p. 1-2, lines 25-39). Jerry had no previous diagnosis, and was diagnosed by Leah with Posttraumatic Stress Disorder. Though Jerry had *foundational years* with his mother, his mother was in an accident when he was three years old, and she suffered from a Traumatic Brain Injury. Jerry then *realized a very traumatic difference between his mother... [and] she just couldn't care for him well* (p. 1, lines 10, 15). As stated, Jerry then witnessed his mother's death at the age of five. Jerry had to go get help for his

mother, and then had to sit and watch as the medical team attempted to resuscitate her, and no one attended to him or tried to take him away from the scene. Jerry's grandmother then became his primary caretaker and, although she *was very attached to him*, she was also still working and grieving her daughter's death (p. 3, line 80).

Case 4: Danielle

Danielle is a mental health professional who has experience working with complexly traumatized children and their families. Of the children that she works with, Danielle reported that 25% of these children have experienced complex trauma, and less than 5% of these children are between 3 and 5. Common symptoms that Danielle has seen in these children include difficulty in school, hard time concentrating, anger outbursts, aggression towards others, sleep difficulties, and fears (anxiety). In practice, Danielle utilizes an eclectic mix of theoretical approaches/perspectives such as child-centered play therapy, systems, and non-directive CBT.

In the interview, Danielle discussed the case of Alli, a 7 year old girl who was referred by her pediatrician due to, *difficulty in school with... concentrating, showing some aggressive behaviors towards other students and towards teachers... nightmares... fears... anger outbursts... [and] a lot of sensory stuff going on* (p. 1 & 5, lines 11-12, 21, 28, 145). Alli had no previous diagnosis, but was referred because her pediatrician suspected ADHD. Danielle first diagnosed Alli with Adjustment Disorder with Mixed Emotions and Conduct, and later diagnosed her with PTSD after it was revealed that Alli had and was experiencing *serious threatening* from her father (p. 4, line 129). Prior to learning about this, Danielle had been informed by Alli's mother that Alli had witnessed domestic violence between her mom and dad who *split up* when Alli was four years old,

but continued to have *conflict* whenever there was contact (p. 1, lines 14-15). Danielle stated that Alli was not identified until she was seven years old because, as with many other children, you *don't see that until they get into the school setting and they're required to sit and pay attention* (p. 9, lines 300-301). Additionally, Alli's mother suspected ADHD, but did not have an *idea of the implications of what trauma can do to kids' brains* (p. 9, line 296).

Case 5: Cameron

Cameron is a mental health professional with experience with complexly traumatized kids and their families. Cameron estimated that 10-15% of the children he works with have experienced complex trauma, with none of these children between the ages of 3 and 5. Common symptoms that Cameron identified for complexly traumatized children include hypersensitivity to disappointment, depressed mood, irritability, physical/verbal aggression, and extreme avoidance. In his practice with these children, Cameron expressed using the practices and theoretical theories/perspectives of CBT, EMDR, Humanistic, Systems, Solution-Focused, and narrative.

Cameron shared his experience with the case of Samuel, a 7 year old boy who was referred by his adoptive mother. Samuel displayed *internalizing symptoms* such as seeming *withdrawn... depressed... [and] very avoidant of talking about anything related to his former stage in his life where the trauma happened* (p. 1, lines 8-14). Cameron also stated that Samuel had *externalizing symptoms* such as *meltdowns* due to *small things that were disappointing to him* where he would *get really agitated, cry, scream, get verbally or physically aggressive... both in school and his home environment* (p. 1, lines 10-14). According to Cameron, Samuel had lived in *a very chaotic environment* during

his early years of life where he witnessed much domestic abuse between his biological mother and father. Additionally, both parents abused drugs and the family was *unstable economically, so they would move several times and he would change schools several times* (p. 1, lines 19-21). The major traumatic event occurred when Samuel witnessed his father murder his mother in the home. Samuel was then *left [as] an orphan* when his father was arrested, but then adopted, along with his younger sister, by their closest relatives who lived in a different State (p. 1, line 24). Though Samuel had experienced chronic traumatic experiences in his first few years of life and his family was known by Child Protective Services, Cameron stated that Samuel did not receive services until the major trauma of his mother's murder occurred. Samuel witnessing his mother's murder was the event that caused him to be in complete *shock*, whereas the *domestic abuse may not have stood out in the same way* (p. 5, lines 158-159).

Case 6: Eric

Eric is a mental health professional who previously and currently works with children who have experienced complex trauma, and their families. Eric reported that 50-75% of the children he works with have experienced complex trauma, with 95% of these children between the ages of 3 and 5. Issues with emotional regulation, behavioral regulation, and relationships are the major symptoms that Eric sees with complexly traumatized kids. Eric expressed using Attachment, Systems, Adlerian, and relationship-based approaches/perspectives in practice.

Eric discussed the case of Cindy, a three and a half year old girl whose family was originally referred to the agency by the school district. Cindy was later referred by agency staff who had worked with Cindy's siblings and her family. Agency staff

originally identified her at the age of two as needing services due to the way in which *she would stand in the middle of the room and just spin... it was the only way she could kind of get herself grounded* (p. 3, lines 79-80). Cindy also displayed symptoms of *no physical body regulation... poor behavioral and emotional regulation... [and] sensory integration* (p. 3, lines 81, 86, 96-97). Cindy began a therapeutic preschool program at the age of two and a half at the agency, where she was diagnosed with Sensory Integration Disorder, and began working with Eric individually at the age of three and a half, who diagnosed her with Disruptive Behavior Disorder. Eric stated that Cindy *had witnessed domestic violence, dad against mom, on multiple occasions, and police coming, police removing dad* (p. 2, lines 45-46). Cindy also saw her mother's drug abuse, and had a brother that was often *unregulated* and *aggressive* and would start fires in the house (p. 2, lines 52, 57). Cindy and her siblings also experienced out of home placements for short periods of time due to neglect and a lack of safety .

Themes

Deficits in Self-Regulation

Presentation. In regards to the case they discussed, participants were asked if the child appeared to have deficits in self-regulation. In response to this question, six out of six participants described deficits in self-regulation for the case that they discussed. A major way in which children displayed this deficit was aggression. Five out of six participants stated that the child displayed aggressive behaviors in some way, typically in the form of either verbal or physical aggression. For example, Isabelle described Ben's aggression when she said, *he hits, he bites, he punches, he takes things, he throws it across the room, he looks back to see how you respond, so he can come unglued in a*

minute (Case 1, p. 2, lines 42-44). Similarly, Cameron described Samuel's aggression due to difficulty regulating his feelings when he reported, *small things that were disappointing to him would really set him off, and he would have kind of a meltdown where he would just get really agitated, cry, scream, get verbally or physically aggressive, and that happened both in school and in his home environment* (Case 5, p. 1, lines 11-14).

Another common descriptor of self-regulation deficits was hypervigilance, with four out of six participants reporting this as an example of this deficit with the case they discussed. Leah gave an example of Jerry's hypervigilance when she stated, *he has an incredibly high startle factor, so he's hypervigilant if we're in here. He's very hypervigilant to any noises that might be out there, especially sirens, he's very traumatized to sirens, so if an ambulance goes by here, he will almost literally leap into my arms* (Case 3, p. 1, lines 29-31). Isabelle described Ben as *extremely hypervigilant, noticed everything around him and questioned if anything was out of place. Had amazing memory for everything in the room and where it needed to be. So that hypervigilance/anxiety prone was very, very key* (Case 2, p. 2, lines 58-60).

Another self-regulatory deficit identified by four out of six participants was control. Of the children described, some had controlling play, while others felt the need to control because they did not trust others, especially adults due to previous experiences. For instance, Rachael stated that Mandy, who had experienced sexual abuse, had *difficulty with trust and with adult authority and has a high need for control* (Case 2, p. 1, lines 27-28). Comparatively, Leah described Jerry (who had witnessed the death of his

mother) as having an, *absolute need for control, so he's like a parentified child, he tries to be the parent and controls every little detail* (Case 3, p. 1, lines 26-28).

Sleep difficulties were mentioned by three out of six participants as another self-regulation deficit. For instance, Rachael described Mandy's sleep difficulties when she stated, *physically she had a real hard time kind of with early kinds of regulation like sleep and wakeful states* (Case 2, p. 2, lines 38-39). Another example of sleep difficulties came from Isabelle who expressed that Ben would *get up in the middle of the night, wander around for hours* (Case 1, p. 2, line 61).

Poor emotional or affect regulation was also mentioned by three out of six participants as self-regulation deficits that they saw in the case they presented. Leah explained that Jerry would have *big feelings (kicking, screaming, yelling)* when his *circle didn't come out a circle* (Case 3, p. 2, lines 42-44). Eric explained that Cindy's spinning in the middle of the room *was also emotional, when she couldn't cope with what was going on around her, it was her way of kind of shutting out the world, because when she was spinning she couldn't see anything* (Case 6, p. 3, lines 97-98).

Other ways that professionals described deficits in self-regulation include, *difficulty transitioning, dissociation, little sense of self, and psychomotor agitation*. These did not meet the full criteria to become themes (three out of six participants), but are important to note in order for the reader to gain further understanding of the ways in which complexly traumatized children present.

Interventions. After participants were asked to discuss the child's presentation of deficits in self-regulation, participants were then asked how they addressed these deficits. Participants discussed a variety of interventions that they utilized when addressing

deficits in self-regulation. Six out of six participants reported having specialized training in play therapy, and utilized play in addressing self-regulation with the child they discussed. Though play therapy was discussed, professionals mentioned different types of play therapy, or utilizing play within certain therapeutic practices such as EMDR or TF-CBT. One type of play therapy mentioned by two participants was Theraplay. Rachael stated that Theraplay *is a directive play therapy approach that uses game play that really focuses on four different elements of functioning: structure, nurture, challenge, and engagement* (Case 2, p. 2, lines 54-55). In regards to play therapy, participants mentioned different forms of play such as drawing and art therapies (with emotions and creating narratives) and sand tray therapy.

Another common therapeutic approach utilized by participants was cognitive behavioral therapies such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Cognitive Behavioral Therapy (CBT). Two out of six participants expressed using TF-CBT and one participant utilized CBT to address self-regulation deficits. For example, Cameron explained that the first part of TF-CBT addresses *affect regulation* and that in therapy he would use *naming of feelings... helping him [Samuel] notice how intense they were using a thermometer system from 0-10* (Case 5, p. 2, lines 60-62). Additionally, Cameron used *relaxation* such as *breathing* and *muscle relaxation* to address deficits in self-regulation (Case 5, p. 2, Lines 59-62). According to Cameron, the second part of TF-CBT involves the *trauma narrative*. Within the *cognitive therapies*, the use/creation of a *narrative* was the commonality between the therapies. In creating a narrative, the child is able to tell their trauma story through words, drawing, or playing out the trauma with toys (e.g. dollhouse, sand tray, animals, etc.).

In response to the self-regulation deficit of poor emotion/affect regulation, four out of six participants specifically described various emotion/feelings interventions. For example, Rachael stated that she creates a *feelings basket* with different things that parents can use when their child is dysregulated, such as *bean buckets* to help with sensory issues, or different smelling *lotions* that are soothing to the child (Case 2, p. 2, lines 73-76). With Jerry, Leah stated that she used a lot of *scaling feelings*, *expressing feelings*, and *feelings identification* (Case 3, p. 2, lines 47-48). Danielle stated that Alli (the client) and her mother would record a *video diary* of Alli talking about her feelings on her mom's cell phone a couple times a week, which was easier way for Alli to express how she was feeling. In addition, Danielle explained that, even though emotions are not directly discussed within the therapy, *there's other ways that she's dealing with those, like... sand tray or drawing and art therapy around emotions* (Case 4, p. 8, lines 267-268).

EMDR is an intervention that three out of six participants stated they were trained in, but only two out of six utilized with the case that they presented. Participants often described using EMDR while the child processed traumatizing memories through telling their trauma narrative, which was previously discussed. Rachael described various means of EMDR with kids to promote *bilateral stimulation* such as placing *tappers in kids' socks while they draw... or drumming... for kids who maybe aren't as comfortable with the touch... parents tapping on them... parents squeezing, rubbing lotion on their hands, going back and forth, or giving their back a rub... or finger puppets* (Case 2, p. 3, lines 90-95).

Another theme identified throughout the interviews to foster self-regulation was relational interventions. Eric stated that his work with Cindy and other complexly traumatized children is *relationship based* because *that's the basis for which they can start to regulate themselves... kids don't regulate on their own, they start regulating with a partner, a parent, and she [Cindy] wasn't getting that, and hadn't got that* (Case 6, p. 5, lines 141-144). Similarly, Rachael stated, *I use the attachment piece because a lot of the kids that I'm working with, a piece of the trauma is relational trauma... so using the attachment relationship that they're developing to help with the regulation as well* (Case 2, p. 3, lines 107-109). The use of relationships and attachment work will be further discussed in the relational impairments section.

Other ways of addressing deficits in self-regulation that were mentioned include; *creation of predictability, routine, structure, giving notice, creation of safety, Perry's Neurosequential Model, filial therapy, visuals, writing letters, and the use of regulation and bedtime stories.*

Outcomes. Of the six participants, three professionals were still working with the child they discussed at the time the interview took place, while the other three professionals were no longer working with the case they presented. Whether or not the professional continued to work with the child, all professionals described improved functioning, though there was some regression at times due to the non-linear process of treatment with children who have experienced complex trauma. For example Isabelle expressed that Ben had improved in self-regulation as he was *more able to catch himself and back up, and if he is tantruming, he can end it quicker...* though he had recently regressed at the time of the interview (Case 1, p. 8, lines 278-279). Additionally, Ben had

improved school functioning and was able to be in *mainstream kindergarten, which initially [they]... had no idea he could do... and he's doing it!* (Case 1, p. 6, lines 197-199). Rachael stated that Mandy was able to transition out of a day treatment setting and into a more typical setting (Case 2). Leah stated that Jerry was *at school every day, not crying in school and asking to go to the nurse, sleeping in his own bed, not enuretic...* though he continued to have a *pretty high startle response* (Case 3, p. 4, lines 113-115). Danielle stated that Alli's mom reported that treatment has made *a huge difference at home with the outbursts... night terrors and things have since gone away... school functioning has improved greatly... [and] she is able to talk about feelings* (Case 4, p. 7, lines 229-233). Similar to Ben, Danielle stated that Alli had also recently regressed, which was due to continued visitation with her father. Cameron explained that Samuel:

really did calm down in school, he would be less reactive, and at home. And he really bloomed as far as his just normal interests and development, he really got into some things that he just loved like drawing, and he learned to read, so that's like the big task for second graders... [Also] at the beginning of second grade, his standardized reading scores were in the single digits, and that's for the percentile, so he was really at the bottom of his age group, and at the end of that school year, he was in the 90th percentile, so he had really just sort of achieved his potential. (Case 5, p. 6, lines 185-191)

Lastly, Eric stated that Cindy's *body awareness, sensory development and behavioral regulation improved significantly through the combination of OT, classroom and individual therapy strategies... [and] she could self-calm at times, and at others just needed verbal prompts* (Case 6, p. 9, lines 270-273).

Relational Impairments

Presentation. Participants were asked if the child appeared to have relational impairments. Similar to deficits in self-regulation, every participant expressed relational impairments for the child that they described. In addition, every participant described

attachment issues as the main relational impairment for each child. For example, Isabelle explained that Ben had only experienced caregivers that were “*threatening and frustrating... so much of what he knew was that you really can’t count on anybody... you have needs and they leave*” (Case 1, p. 6, lines 216-218). With this, Ben “*particularly targets people who are close to him [with aggression], so his foster mom will get it, the teacher will get it*” (Case 1, p. 2, lines 46-47). Furthermore, Isabelle stated that, *this [Ben] is a boy who desperately needed caregivers to get him, to be in tune with him, to be in his world, to know how to be a bigger, stronger, wiser, kinder other*” (Case 1, p. 5, lines 149-151).

Another theme that emerged throughout three of six interviews was the lack of safe boundaries. This theme emerged when participants discussed the way in which children presented in their relationships with other adults who were not necessarily their caregivers. Rachael described Mandy’s relational impairments in stating that *she would go up to strangers and just jump into their laps... [she] did not trust adults to know how to use them... would triangulate, [and] do a lot of splitting of adults*. (Case 2, p. 5, lines 158-160). Similarly, Leah talked about Jerry’s difficulties with adults in that *he’s asking other people to be his mom now... not his grandmother*, but other people such as his *uncle’s girlfriend*. Leah (the professional) stated that she *did not want him to just trust [her] because she was still a stranger*, so she required Jerry’s grandmother to be in at least the first three sessions (Case 3, p. 3, lines 110-111).

Lastly, participants identified relational impairments with peers. This theme was discussed by three of six participants. For example, Danielle described Alli as having *aggressive behaviors towards... other students* (Case 4, p. 1, lines 11-12). Similarly,

Isabelle stated that Ben would think, '*somebody's over, they're going to take all my stuff*' and he was *so stuff oriented, so focused on things*, which Isabelle has seen a lot with kids who have experienced complex trauma *because that's all they have* (p. 8, lines 276-278). Another illustration of social difficulties was described by Rachael when she stated that *Mandy would make friends really quickly, but then she would lose them too. She didn't play fair, [and would] steal* (Case 2, p. 11, line 384).

Interventions. After participants were asked if the child displayed relational impairments, a follow up question was asked which inquired about the ways in which professionals addressed these impairments. A major finding was parent/caregiver involvement in the therapy to address relational impairments. Six out of six participants expressed the need for parent/caregiver involvement. However, there was much variation in the amount of caregiver involvement and context of caregiver involvement. For example, Isabelle stated that Ben's parents were involved in *every session*, with sessions consisting of either Mom or Dad, or both together (Case 1). In contrast, Rachael stated that she did a combination of individual and family sessions; some sessions were with Mandy individually, while other sessions consisted of Mandy and her parents, and others only involving Mandy's parents (mainly before they adopted Mandy) (Case 2). Comparatively, Leah stated that she requested Jerry's grandmother be a part of the first three sessions (so that Jerry could get to know her), and then his grandmother only met with her (Leah) for the first 5-10 minutes in all subsequent sessions for an update (Case 3). Danielle explained that she did half of the session with Alli individually, and then the last half of the session with Alli and her mother (Case 4). Cameron explained that Samuel's adoptive parents were involved in helping to record the trauma narrative (after

Samuel had been working with Cameron for some time) (Case 5). Lastly, Eric stated that Cindy's mother was involved in the last six months of therapy because *the therapy shifted from being really focused on her [Cindy] and developing her own regulation and awareness to trying to help heal their relationship [Cindy and her mother]* (Case 6, p. 6, lines 193-195).

As stated, every participant expressed attachment issues for the case they discussed. Consequently, six out of six participants also described interventions that addressed these attachment needs. For instance, Isabelle and Rachael stated that the child they worked with first needed to experience what it was like to have their needs met as an infant in order for them to move toward a secure attachment relationship. For example, Rachael assisted the adoptive parents in creating an *infancy narrative*, in which they told short *claiming stories* about when they were getting ready for her to come to their house, *what she deserved as a baby... and that she's valuable and important and that she deserved regular infancy kind of care* (Case 2, p. 5, lines 179-188). Rachael also worked on *attunement skills* with the parents and, similar to Isabelle and interventions used to address self-regulation, utilized *Theraplay* to address the attachment relationship. Isabelle stated that Theraplay is a *core modality that I use particularly with younger kids that is attachment-based—it reinforces secure attachment exchanges between a parent and child and looks at four domains of structure, nurturing, engaging the child, and challenging the child* (Case 1, p. 5, lines 161-163).

Another common theme in addressing relational impairments was parent coaching, which was discussed in three of six interviews. Leah stated that she used *tons of parent coaching... because this grandmother was in her own grief, and she really*

needed to start to care for this kiddo in a different way (Case 3, p. 2, lines 65-66).

Comparatively, Danielle stated that she *talked to mom and coached her on how to be a safe person, really emphasizing the importance of consistent, supportive, safe environment* (Case 4, p. 2, lines 61-62).

One additional theme that emerged across questions was safety. All participants mentioned safety in one way or another. For example, Rachael stated that in regards to dysregulation, *a big piece of the work with kids who've had complex trauma is developing a felt sense of safety. They don't really have even a knowledge of what that would mean* (Case 2, p. 3, lines 77-79). Danielle stated that she would *try and keep a distance, just to make sure that she [Alli] feels safe here. I don't want to ever put her in a situation where she feels like I'm coming into her personal space.* (Case 4, p. 5, lines 156-158). When it comes to trauma and children, Eric stated:

Trauma... is all about a breakdown in a relationship often times... for young children, when trauma is impactful, it has impacted a relationship or someone's ability to help that child manage the relationship. So I think the work that's done with them can't be seen as a sterile implementation of strategies; it's about being an available, consistent, accepting, and positive relationship for the child. (Case 6, p. 8, lines 261-266)

Outcomes. The majority (six out of six) cases expressed that they had seen improved relational functioning for the case they discussed. For instance, Isabelle explained that Ben has *some secure attachment pieces happening with his caregivers... feeling like, no matter what's happened, and he's tested that relationship significantly, they're still there* (Case 1, p. 7-8, lines 252-259). Rachael stated that Mandy was *much more discriminate with people... [and] was going to her adoptive parents as a home base, seeing them as a safe haven, which was really good* (Case 2, p. 9, lines 313-315).

Additionally, Rachael explained that Mandy was *letting adults control some stuff... [but]*

in new environments or if something was going on like phone conversations, it was really hard for her, understandably because big things have happened to her... [Mandy also] continued to struggle with peers (Case 2, p. 9, lines 320-322). Leah stated that Ben is still asking to see his mother, but it doesn't appear to be a death wish, which it really was before (Case 3, p. 4, lines 116-117). Danielle stated that Alli has definitely improved (Case 4, p. 7, line 229). For example, Danielle explained that:

A lot of her [Alli's] early sand trays were anger, conflict, like safety issues, she would do a lot in the sand tray. Now she comes in, and she'll create friendships, and communication, and how can we work together to figure out this problem kind of sand trays. (Case 4, p. 8, lines 271-274)

Similarly, Cameron saw relational improvements for Samuel (Case 5). In regards to Samuel's relationships with his adoptive family, Cameron stated that Samuel *just became part of their family really, you know they sort of integrated, and they told me subjectively they just feel like, we're a family now, and we can live our lives* (Case 5, p. 6, lines 191-193). Lastly, Eric stated that Cindy had *improved* relational development in that she *became able to interact positively and listen to limits from kids and adults and had markedly increased positive interactions and warmth with mom* (Case 6, p. 9, lines 273-275). In addition, due to her *improved self-awareness [and ability to] better identify her own feelings as well as what her peers were feeling... [she could] consequently interact more successfully* (Case 6, p. 9, lines 275-277).

Collaboration

To inquire about collaboration, professionals were asked if they collaborated with other adults in the child's life such as caregivers, school professionals, case workers, daycare workers, etc. If participants stated that they did collaborate with other adults, they were then asked how they collaborated with these adults. Every professional (six out

of six) responded by stating that they work with other adults in the child's life. Isabelle stated that collaboration is *just a part of doing child therapy. It's just fundamental* (Case 1, p. 7, line 223). All six professionals described working with the caregivers, which was previously discussed. Furthermore, all six professionals stated that they collaborated with the child's *school or day treatment (teachers, principals, special education staff, and school psych)* to assist with *within IEP meetings... staffing... behavioral interventions... [and] how to support the child within the school setting* (Case 2, Case 4, Case 5). Leah expressed that, *as a trauma worker with kids, you have to learn to collaborate with schools... with the daycare... you have to have that case management time to be able to do that so the kid's hearing the same messages everywhere* (Case 3, p. 3, lines 85-87). Other adults that professionals mentioned collaborating with were *case workers/case managers, county workers, child protection workers, guardian ad litem, pediatricians, and nurse practitioners* (Case 1, Case 2, Case 4). In regards to her experience with Ben and other traumatized children, Isabelle stated:

People saw him [Ben] differently because he was able to be different in different settings, so it particularly means people have to communicate because our kids are really good at showing bits of themselves here and bits of themselves there, and not unless everybody talks do you see the whole child. (Case 1, lines 235-238)

Discussion

Sample

This study consisted of six mental health professionals. Professionals had varying years of experience, with a range between six and thirty-five years of practice as a mental health professional. Three of these participants were very seasoned professionals, each having over 21 years of experience. The amount of years in practice might have influenced the way in which participants answered. Additionally, participants held varying mental health licenses, which quite possibly influenced participant responses. Three participants were Licensed Psychologists (LP), two were Licensed Independent Clinical Social Workers (LICSW), and one was both a LICSW and Licensed Marriage and Family Therapist (LMFT). Due to the larger amount of LPs and LICSWs than LMFTs, the sample was not representative of all mental health professionals, with an overrepresentation of LICSWs and LPs.

Deficits in Self-Regulation

Presentation. Within the area of deficits in self-regulation, children who have experienced complex trauma often appear to present with aggression. This theme was supported by five out of six participants in this study. Additionally, this theme was supported in the literature. More specifically, Cole and Putnam (1992) explained that aggression towards self and others is a part of the impaired regulatory function of poor ability to modulate affect and control impulses. Aggressiveness or rage against the self and others was also supported in Terr's explanation of Type II trauma (Terr, 1991).

Another deficit in self-regulation that was found in this study is hypervigilance, which was mentioned in by four out of six participants. This theme supports the

literature, which explains that traumatized children may appear to be hypervigilant in that they are so focused on determining an actual threat that they become uninterested in activities that other children are interested in and lash out in response to any source of impending threat (van der Kolk, 2003).

Control is another self-regulation deficit that was identified by four out of six participants in this study. This theme is also consistent with the literature. For instance, Terr (1991) explained that children with Type II traumas seek to answer the question, “how will I avoid it the next time?” (Terr, 1991, p. 15). By controlling their environment and those around them, these children are trying to avoid the trauma from happening again.

Sleep difficulties were identified by three out of six participants. This finding supports the literature, which explains that persistent symptoms of increased arousal, such as sleep difficulties, are a symptom of PTSD (APA, 2000).

Another self-regulation deficit described by three out of six participants was poor emotional or affect regulation. This strongly supports the literature, which describes a poor ability to modulate affect, often due to a lack of “affect attunement” within the attachment relationship (Putnam & Cole, 1992; Siegel, 1999, p. 70).

Interventions. Interventions reportedly utilized by participants included play therapy (such as Theraplay, art therapy, and sand tray therapy), Cognitive Behavioral Therapies (such as TF-CBT and CBT), feelings interventions, EMDR, and relational interventions. Play therapy is a theme that supports the literature, which also demonstrated that play therapy is often utilized separately and within other types of therapies (Gil, 2006). Play therapy was supported in this study as it was utilized by six

out of six participants. TF-CBT was discussed in the literature as the most validated evidenced-based treatment model that was developed for children who have experienced trauma (Cohen, Mannarino, & Deblinger, 2006). However, it is also expressed in the literature that children who have experienced long-standing interpersonal violence or abuse, will often need more than TF-CBT alone (Child Sexual Abuse Task Force, 2004). Two out of six participants in this study utilized TF-CBT with the child that they discussed. Furthermore, two out of six stated that they were fully trained, while one out of six stated having some training in TF-CBT. Comparatively, EMDR was mentioned in the literature as a therapy that is considered as an evidence-based practice with adults (Ford & Cloitre, 2009). It has been modified and tested with children with PTSD, but continues to need further testing and evidence in order to be considered a best practice with this population (Ford & Cloitre, 2009). Three out of six participants in this study were trained in EMDR, though only two out of six stated that they utilized EMDR for the case that they discussed.

Outcomes. All participants stated that they saw improved self-regulation for the case they discussed. However, four out of six participants also stated that the child displayed regression at times or at the end of therapy. This is consistent with the literature about EMDR which stated that treatment is not a linear process due to the revisiting of trauma and coping processes (Courtois as cited in Korn, 2009).

Theraplay was a specific type of play therapy that the researcher did not see in the literature about complex trauma, but that was mentioned by two of six participants as an approach that they often utilize. Though not a theme, this therapy focuses on the attachment relationship, which is necessary in promoting both self-regulation and the

improvement of relational impairments with young children who have experienced complex trauma.

Relational Impairments

Presentation. All participants expressed relational impairments for the case they discussed. This is consistent with the literature which stated that relational impairments are a common characteristic of complex trauma (Cook et al., 2003). One theme which was found through all of the interviews was attachment issues, which correlates with the literature (Cook et al., 2003; Cook et al., 2005). Additionally, relational impairments with other adults that are not the primary caregiver and with peers were identified as themes; namely, trust issues and an inability to use adults in appropriate ways. Trust issues were supportive of the literature, which stated that children who have experienced complex trauma have an uncertainty that others will be reliable and predictable, which leads to distrust, suspiciousness, and problems with intimacy (Cole & Putnam, 1992).

Interventions. Six out of six participants identified using parent/caregiver involvement in treatment by utilizing interventions that addressed attachment needs (six out of six), and parent coaching (three out of six). This is consistent with the literature review, specifically TF-CBT which involved parent psychoeducation and parenting skills (Child Sexual Abuse Task Force, 2004). Additionally, this is similar to methods used in Parent-Child Psychotherapy, which supports the parent in assuming the role as a co-regulator for the child (Courtois & Ford, 2009).

Overall, safety was supported both within this study and studies within the literature review as a common requirement in treating children who have experienced complex trauma (Child Sexual Abuse Task Force, 2004; Cook et al., 2003; Courtois &

Ford, 2009; Gil, 2006; Korn, 2009; Siegel, 1999). Six out of six participants in this study discussed safety within the interview. Due to the lack of safety that these children have experienced it is pertinent that they develop new relationships in order to learn that not all adults are going to hurt them. Mental health professionals must not only promote safety within their relationship with the child, but with other relationships and environments in the child's life, especially those with parents/caregivers.

Outcomes. All participants expressed that the child they worked with appeared to have improved relational functioning with treatment. However, many also stated that the child continued to struggle in some areas. This is similar to results in the literature which suggested that TF-CBT was the most effective evidence based treatment for children and adolescents with PTSD, but relayed a vast amount of treatments that are utilized throughout the field (Cohen, Mannarino, & Deblinger, 2006). Additionally, TF-CBT alone is not always enough for children who have experienced ongoing, interpersonal abuse or violence (Child Sexual Abuse Task Force, 2004). Due to the wide range of interventions/treatments utilized by professionals, it was also not clear in this study as to which practice was most effective. However, many interventions were used in combination with one another. The utilization of a combination of interventions/treatments appeared to be the most effective way of treating children who have experienced complex trauma within this study, as every child showed improvement from this approach, as reported by participants.

Researcher Reactions

The researcher expected to find a few common best practices that are utilized with children who have experienced complex trauma. Instead, the researcher found a

multitude of practices that professionals borrow from and use with this population. Additionally, many of these practices are not considered best practices as they have not been robustly tested, with the exception of TF-CBT. Though, the testing of one modality would be difficult to examine due to the need to utilize multiple practices with each child at different times in development. Complex trauma produces a complexity of symptoms at different developmental periods, which therefore requires a multi-modal approach. To date, no manuals (besides TF-CBT) or multi-modal approaches have been compiled and rigorously tested in order for them to be considered best practices for children between the ages of three and five. Additionally, this may not be possible to do since each child requires a unique response based on their developmental needs and complex reactions.

Limitations/Recommendations for Future Research

One limitation that made this study less reliable was the lack of a co-coder. The researcher mainly found themes that had already been identified within the literature. The use of a co-coder would strengthen future studies in order to identify other themes, and would increase the reliability of the study.

Additionally, a limitation of this research was the variety of settings that professionals within the sample were from. Participants all practiced within either private practice or outpatient community mental health. The researcher had hoped to also gain an understanding of clinicians who work with complexly traumatized children in group settings such as day treatment. Though a limitation, this allowed for the researcher to gain a more in depth understanding of individual and family approaches, which were identified in the literature as two of the most effective practices with children who have experienced complex trauma (Spinazzola et al., 2003).

Another limitation of this research was the small sample size. Eight to ten participants were expected, and only six professionals participated. The small sample size was most likely due to the limited amount of time for completing this study. Additionally, the small sample size may have been impacted by the fact that less professionals work with children between the ages of three and five. Two professionals in this study spoke about cases where the children were seven years of age. One of these children had not been identified until first grade because there was less structure in kindergarten, allowing for the symptoms to be less noticeable. Therefore, less professionals may work with this age group due to the under identification at an early age of children who have experienced complex trauma.

One suggestion for increasing sample size would be to recruit participants directly from a child therapy agency, through a face to face presentation, rather than using a snowball sample. In doing so, this would ensure that all of the professionals work with the specific age group, and through agency approval, the researcher would have permission to contact various professionals within that agency. Another suggestion for increasing sample size would be to provide incentives to participants.

Though the sample size was a limitation, the professionals who were interviewed were all seasoned professionals that had a range of 6-35 years of practice, which allowed for this study to collect data from knowledgeable and experienced professionals. Future qualitative studies would allow for further understanding of the experiences of professionals who work with complexly traumatized children between the ages of three and five.

Another limitation is that this study is unable to be generalized to the larger population of all mental health professionals that work with complex trauma due to the qualitative nature of the research design. A recommendation for future studies is to utilize an online survey which would capture a larger random sample of mental health professionals who work with children who have experienced complex trauma.

Implications for Social Work

Practice

The findings from this study provide implications for clinical social workers in practice. Clinical social workers must be aware of the symptoms of complex trauma in childhood in order to identify the children who have had these experiences, and need intervention. Aggression, hypervigilance, sleep difficulties, and poor emotional or affect regulation were identified as key symptoms by professionals in this study, along with a host of other symptoms identified in the literature review. Early identification and intervention are key components of clinical work in order to provide these children with best practices to prevent further traumatization and deficits. To promote early intervention, trainings could be provided to school teachers, daycare providers, law enforcement, doctors, and other workers in the community that may come into contact with children who have experienced complex trauma and their families, which would focus on identifying key symptoms of complex trauma in children.

With this, it is necessary that social workers assist and advocate for other professionals, specifically those in early childhood education and community workers, to gain a further understanding of symptoms of complex trauma. Collaboration is a necessity in both the prevention and intervention of complex trauma. In intervention, the

collaboration between schools, parents/caregivers, occupational therapists, and other mental health professionals is necessary.

Another implication of this study is the need for supervision when working with children who have experienced complex trauma. Given the variety of treatment modalities/interventions used that depended on the individual needs of the child and their environment, supervision would be important to aid new mental health professionals wanting to work with complex trauma issues. Supervision would also help the mental health professional in being able to be flexible in responding to the child's needs and ways of supporting the family to better understand and respond to their child. Additionally, new developmental milestones and other changes in the child's life can cause regression. Therefore, treatment takes on-going efforts, which will require time and support for both mental health professionals and their supervisors.

As described, children who have experienced complex trauma have deficits in self-regulation. To support these children on a broader level, professionals in other systems, such as school professionals could provide interventions on an ongoing basis that help children regulate such as deep breathing. Though simple, these interventions could be a way to help children learn basic self-calming techniques at an early age, which are valuable and can be utilized by those of various ages or developmental levels.

Policy

On a policy level, one change that social workers can advocate for is the addition of a diagnosis that more fully explains and represents complex trauma in childhood, especially young children between the ages of three and five. It is unclear as to what additional diagnoses or changes will be coming out with the new version of the DSM,

which is expected to be released in 2013. Without a proper diagnosis, children may continue to have needs that are unmet due to a lack of diagnosis that meets insurance needs. Additionally, without a proper diagnosis for the child, mental health professionals do not always get reimbursed for all of the necessary work that they do to support these children in various aspects of their lives. For example, there is a high need for collaboration with other adults which often occurs through phone calls, emails, or face to face meetings with school professionals, etc. If given a proper diagnosis, the need for collaboration and other services would be more recognizable, which could allow for easier reimbursement of the extra roles and tasks that mental health professionals are required to partake in when working with complexly traumatized children.

Furthermore, social workers and policy makers can advocate for policy changes and funding increases that support the need for service provision in multiple domains for children who have experienced complex trauma. Policy makers must be made aware of the effects that adverse experiences in childhood can have on a child's development, and all subsequent development. Additionally, these experiences affect children differently at different times of brain development, which signifies the need for prevention and early intervention. These children do not have the means to defend themselves or keep themselves safe when the actual traumatic events are occurring, so it is obvious that they will need policy makers and social workers to stand up for their needs, as it is not possible for them to speak for themselves in policy making decisions either. With this, there needs to be ways to funnel research of complex trauma and success stories to the legislature. Like the case stories provided in this study, the legislature needs to have personable examples and possibly visuals of how complex trauma affects young children,

and what is required for treatment to be successful. Without this, policy makers may not be able to look past the negative image and stigma that the system seems to have issued to these children, and will inevitably continue to under-fund services that are crucially important to the future of complexly traumatized children.

Research

This study implies that further research is needed in order to gain more understanding of best practices with young children who have experienced complex trauma. More research is needed on the way in which trauma impacts brain development. With additional research and evidence, complex trauma could be considered a medical diagnosis, making treatment more available, as the medical model is most widely accepted and utilized.

As described in this study and previous literature, it is clear that there cannot be one, single best practice. Instead, mental health professionals must utilize interventions and practices from a variety of theories and approaches. Therefore, researchers can continue to look at the ways in which mental health professionals address the complex needs of this population, paying specific attention to the developmental needs that these children present. One way to provide consolidated information of the various practices utilized would be to focus on common factors across practice models that are utilized with young children who have experienced complex trauma. With the six core components of complex trauma intervention described by the NCTSN, future studies could employ a qualitative approach to examine the specific interventions that mental health professionals currently utilize in addressing these core components (Cook et al., 2005).

Also, practices and collaboration must be looked at within a variety of settings, as these children present with an array of complex needs which require various services including individual, social, educational, familial, and community services. Future research could also utilize a program evaluation design, which would focus on one program where a particular practice model is used in order to assess outcome. This would provide more specific, in-depth findings in the effectiveness of current practices that are being utilized by mental health professionals.

Conclusion

The purpose of this study was to gain a further understanding of mental health professionals' perspectives of best practices with children who have experienced complex trauma. This study provided the reader with a unique look into the experiences of six mental health professionals and their work with a complexly traumatized child. Children had experienced a multitude of chronic, relational trauma, and developed both deficits in self-regulation and relational impairments, which were discussed in the previous literature. Common symptoms of deficits in self-regulation that appeared in this study include aggression, hypervigilance, high need for control, sleep difficulties, and poor emotional or affect regulation. Common relational impairments included attachment issues, a lack of safe boundaries (specifically an inability to use adults in appropriate ways and trust issues), and difficulty in peer relationships. To address deficits in self-regulation, professionals used various clinical approaches such as play therapy (Theraplay, art therapy, and sand tray therapy), Cognitive Behavioral Therapies (TF-CBT and CBT), feelings/emotion interventions, EMDR, and relational interventions. To address relational impairments, professionals used interventions that included the

parent/caregiver in treatment, addressed the attachment needs, and coached parents. Additionally, professionals identified collaboration between adults in the child's life as a necessity to the therapeutic process despite not always getting paid for this component of treatment. Professionals expressed that children displayed improvements in self-regulation and relational impairments, but four out of six described regression and/or needed further improvements in these areas.

Overall, complex trauma is a concept that encompasses a multitude of symptoms and deficits that children present with after experiencing prolonged, chronic forms of relational trauma. In response, mental health professionals have a complexity of interventions and practices they utilize, including those that address deficits in self-regulation and relational impairments. A focus on development, attachment, and collaboration between the interacting systems in a child's life are recommended for future studies. Continued research is necessary in order to gain an understanding of the unique experiences of mental health professionals' perspectives of best practices with children who have experienced complex trauma.

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Appendix A
Invitation Flyer

Mental Health Professionals' Perspectives of Best Practices with Children who have Experienced Complex trauma

Are you a mental health professional who works with children who have experienced complex trauma?

If so, you are invited to participate in an interview study.

The study is being conducted by Holly Hagen, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas, under the supervision of Dr. Michael G. Chovanec, a faculty member at the school.

The purpose of this study is to gain a further understanding of complex trauma in childhood and ways of working with traumatized children from the perspective of Mental Health Professionals.

Details of the study

- 45-60 minute audio taped interview
- Interview will take place in a location convenient to the participant
- Participation is voluntary and all identifying information will remain confidential

Interested in participating?

Please contact:

Holly Hagen, MSW Student

Telephone: xxx-xxx-xxxx

E-mail: xxxxxxxx@stthomas.edu

Appendix B

Interview Questions

Part I

Instructions: Please complete the following demographic questions, in writing prior to the interview.

Note: For the purpose of this study, complex trauma is defined as, the experience of multiple, chronic, prolonged trauma early in life, which is often interpersonal in nature (van der Kolk, 2005).

1. How many years have you been practicing as a mental health professional? _____
2. What licensure do you currently hold?
 - LICSW
 - LMFT
 - Other (Please specify) _____
3. What specialized training have you had in working with children and/or trauma?
 - EMDR
 - TF-CBT
 - Play Therapy
 - Neurosequential
 - Other (Please specify) _____
4. What is your gender
 - Male
 - Female
5. In what settings are you currently working in with children who have experienced complex trauma?
6. In what settings have you worked with children who have experienced complex trauma previously?
7. What percent of the children you work with would you say have experienced complex trauma?
 - a. How many of these children are between the ages of 3 and 5?
 - b. What are common symptoms that present in these children?
8. What theoretical approaches/perspectives do you utilize in practice with complexly traumatized children?

Part II

Instructions: Please review these questions before the interview and write down any key ideas that will be useful to you in the interview.

9. Without revealing your client's identity, can you discuss one particular case you have worked with where the child experienced complex trauma?
 - a. Who referred the child (i.e. court system, school professional, caregivers, etc.)?
 - b. What were the presenting symptoms?
 - c. What previous diagnosis/diagnoses was the child given prior to meeting with you?
 - d. What diagnosis/diagnoses did you give the child?
 - e. Did this child appear to have deficits in self-regulation?
 - i. If so, how did you address this?
 - ii. What other individual intervention(s) did you provide?
 - f. Did this child appear to have relational impairments?
 - i. If so, how did you address this?
 - ii. Was it necessary to address the attachment relationship? How so?
 - iii. What other familial or relational intervention(s) did you provide?
 - g. Did you collaborate with other adults in the child's life (i.e. caregivers, school professionals, case worker, daycare worker, etc.)?
 - i. If yes, with whom, and how so?
 - h. How long did you work with this child?
 - i. Did they appear to have improved functioning?
 - ii. Were there barriers to finishing treatment?
 - i. Is there anything else from this case that you would like to mention?

(If time permits, the beginning of Part II will be repeated at this time with another case example)

10. Is there anything else that you feel might be useful to me in my study?

Appendix C

Blank Consent Form

Mental Health Professionals' Perspectives of Best Practices with Children who have Experienced Complex Trauma

RESEARCH INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating Mental Health Professionals' perspectives of best practices with children who have experienced complex trauma. This study is being conducted by Holly Hagen, a student in the School of Social Work at St. Catherine University/University of St. Thomas under the supervision of Dr. Michael G. Chovanec, a faculty member at the school. You were selected as a possible participant in this research because you are a mental health professional who has experience working with complexly traumatized children. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:

The purpose of this study is to understand mental health professionals' perspectives of best practices with children who have experienced complex trauma. Approximately 8 to 10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to participate in an audio recorded interview consisting of questions about best practices with children who have experienced complex trauma. The participant and researcher will decide together the location of the interview, which will take place in a quiet setting that will maintain privacy and confidentiality. After reviewing the consent form the participant will agree to the terms and sign it. This study will take approximately 45-60 minutes over one session.

Risks and Benefits:

There are no risks or direct benefits to you for participating in this research.

Compensation:

There is no compensation for participation in this study.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. The professionals who referred me to you will not know of your participation in the study.

I will keep the research results in a password protected computer and/or a locked file cabinet in my home and only I and my advisor will have access to the records while I work on this project.

Audio recordings will be accessed only by myself, and will also be kept in a locked file cabinet in my home. I will finish analyzing the data by May 31, 2012. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University/University of St. Thomas in any way. You may refuse to answer any question in the interview if you choose. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

New Information:

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

If you have any questions, please feel free to contact me, Holly Hagen, at xxx-xxx-xxxx. You may ask questions now, or if you have any additional questions later, the faculty advisor, Michael Chovanec at xxx-xxx-xxxx, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at xxx-xxx-xxxx.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study. (If you are video- or audio-taping your subjects, include a statement such as "and I agree to be videotaped.")

Signature of Participant

Date

Signature of Researcher

Date